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**A BIOGRAPHICAL
NARRATIVE EXPLORATION OF
INFANT FEEDING
IN AN AREA WITH LOW
BREASTFEEDING RATES**

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PhD

2022

**A BIOGRAPHICAL
NARRATIVE EXPLORATION OF
INFANT FEEDING
IN AN AREA WITH LOW
BREASTFEEDING RATES**

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requirements of the
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Abstract

Rates of breastfeeding in areas of the UK described as deprived are lower than in more affluent areas. Research so far has highlighted the individual determinants of breastfeeding, driving a dominant narrative that problematises alternative feeding practices as a behavioural issue. There is a paucity of qualitative research focussing in deprived areas and including both infant formula and breastfeeding stories. A biographical narrative methodology was chosen in this project to explore the stories women tell about their infant feeding practice; how these stories are passed through generations and across friendship groups; and how they influence the initiation and experience of breastfeeding. Nine women were interviewed in a socio-economically disadvantaged area of Newcastle upon Tyne where infant formula feeding was the norm. The analysis is presented in the shape of a narrative and considered using an ecological systems framework, in order to shed light on the contextual conditions that shape feeding practices in this area. The findings highlight how family narratives, including those of grandparents and fathers, help shape feeding practices in ways that are both very pragmatic, and informed by historical practices. Wider narratives, such as the multiple and sometimes inconsistent stories provided by health professionals and infant formula marketing campaigns were also important. Participating mothers highlighted how place shaped their feeding behaviour, in determining others' gaze and judgement over their mothering. Mothers demonstrated acute awareness of local cultural acceptance

of different feeding approaches and developed strategies to 'fit in'. Overall, narratives of extraordinary maternal identity were developed regardless of feeding method, and placed within a novel infant feeding ecological framework. Key recommendations include the provision of nuanced support and advice, that includes mothers' wider network, is available online, and framed within policies that shape marketing regulations and mothers' freedom to breastfeed in public.

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This work is dedicated to my friend Mrs Deborah Boyd.

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the Faculty Ethics Committee on 30th June 2014 with an amendment approved on 13th August 2015.

I declare that the Word Count of this Thesis is 81,015 words

Name: Justine Gallagher

Signature:

Date: 22 December 2022

Chapter 1: Introduction

1.1 Introduction

This thesis explores infant feeding practice in an area of North-East England where rates of breastfeeding are low. The area studied is classed as deprived, much like other areas with low rates of breastfeeding (Brown *et al.*, 2010). This is an important issue as families may therefore be missing out on the important health benefits breastfeeding provides for both mother and child (Ip *et al.*, 2007; Quigley, Kelly and Sacker, 2007). However, as will be demonstrated, infant feeding is a complex and often sensitive issue. Previous research suggests that women may feel judgement, shame and guilt when infant feeding does not go to plan (Earle, 2003; Brown, 2019a) or they choose not to breastfeed (Earle, 2000; 2002; Lee, 2008; Hoddinott *et al.*, 2012; Radzyminski and Clark Callister, 2016; Taylor and Wallace, 2017). Within this thesis, it is shown that the use of a biographical narrative approach enabled a sensitive approach to the research topic, by encouraging women to shape their own stories of infant feeding. The research addresses the relative absence in the literature of stories from mothers who both live in ‘disadvantaged’ areas and formula feed¹ and contributes original insights into the ways that women construct stories depending on their infant feeding methods.

¹ “Formula milk, also known as baby formula or infant formula, is usually made from cows' milk that has been treated to make it more suitable for babies”. (NHS, 2019a)

1.2 Positionality and Background

My interest in infant feeding comes from two sources. The first is my own personal experience as a mother of two children and the second, my professional experience of working with families as a Community Development Worker in Sure Start Children's Centres. My professional experience and early mothering took place in an area of North-East England where breastfeeding was not, and is still not, the norm and where by six weeks most babies are formula fed (Office for Health Improvement and Disparities (2021)).

I breastfed my son, who was born in 1999, until he was 6 weeks old. I wanted to breastfeed him for longer, as I was aware of and motivated by the health benefits for both me and my child (Ip *et al.*, 2007; Quigley, Kelly and Sacker, 2007) but felt unsupported to do so living in a community where most mothers formula fed. I felt terrible and enduring guilt for stopping sooner than I had wanted to, as if I had somehow failed him as a mother. My daughter was born in 2001 and by then I had carried out a lot of research into breastfeeding and I was able to feed her for 9 months. I stopped breastfeeding when she started to bite. Like many other researchers before me, these personal experiences and challenges became a key motivating factor for my further work and study.

I was employed as a Community Development Worker from 2003 until 2012, working in Sure Start Children's Centres in North-East England.

The area in which I worked and lived is often referred to as deprived. My role was varied and included setting up activities, arranging outings, making home visits and working with families as part of child protection plans. A major part of my role involved arranging and delivering training for parents and carers. The parents who used the centres trusted me and I often became their advocate. Some would tell me things they said they would not disclose to their health visitor such as when they weaned their babies early onto solid food. They were often worried they would 'get wrong' from their health visitor. Research from a similarly disadvantaged area in Scotland found that during the antenatal period the women there preferred to listen to and take advice from other new parents rather than professionals (Hoddinott *et al.*, 2012). At times, while working as a Community Development Worker, I felt that my role fell somewhere in-between the role of a parent and a professional. Conversations I had with the parents made me wonder where they were getting their support and knowledge from. I became interested in the stories the mothers would tell about infant feeding and curious about the 'official' stories mothers received from health professionals, as well as the personal stories they heard from family and friends. I wondered how listening to and telling these stories could be having an impact on breastfeeding rates in the area.

I have carefully considered my positionality from the beginning of this research and it is a key feature of the research design. Positionality is

a term used to describe a researcher's subjective position, their "stance or positioning... in relation to the social and political context of the study" (Rowe, 2014, p. 2). All researchers create meaning from past events and experiences in their own lives. This meaning may then impact upon the way data is generated, interpreted, and presented. It is important to consider the effects of positionality to promote self-reflection and awareness which can help researchers avoid becoming closed off to alternative perspectives. Including my position also ensures transparency for the reader. Steinke (2004, p. 190) suggests that the "...research interests, assumptions, communicative styles and biographical background..." of researchers need to be considered in the design of methods used in the research process and that the research process is "accompanied by self-observation". My personal experience, views and belief in the benefits of breastfeeding as well as my position now as an academic make up part of my positionality.

My positionality raised challenges for this research. Merriam *et al.*, (2001) describe the complexities of the insider/outsider position of research across cultures and the advantages and challenges that both positions bring. I was aware that my breastfeeding history, and identity as a supporter of breastfeeding could lead me to be viewed as an outsider in an area with a dominant formula feeding culture, and potentially damage the researcher-participant relationship. My identity as a mother who had breastfed could also identify me as someone

who could judge the women if they did not breastfeed themselves (Taylor and Wallace, 2012; Brown, 2019a). However, other factors enabled me to be seen as an insider, which for the purposes of this research quickly became a benefit. My local accent and recent employment as a Community Development Worker helped me to establish myself as an insider and build trust with the participants. However, despite my attempts to avoid making the women feel judged, I was nevertheless conscious that my position as a university researcher asking women about their mothering practice, might lead them to feel scrutinised in some way. As discussed in Chapter 4, the mothers defended their positions and choices, but it is unknown how much my academic status may have played a part in their defensiveness as, at times, they also appeared to draw me into their positions and their arguments. For example, Amy, who formula fed from birth referred to “normal people like us” when discussing “policy-makers”. Like the other participants, she saw me on her side. Like for many researchers, my positionality was thus both a potential limitation and strength. It influenced how people told their stories, but it also gave me helpful insights into what mattered to them in terms of how they presented themselves.

During my employment as a Community Development Worker, I heard mothers tell anecdotes about their infant feeding practice. Many of these stories would help the mothers explain why breastfeeding was not for them. ‘I couldn’t breastfeed because s/he was a hungry baby’

was a very common story told by the mothers who would come into the centres to see their health visitor and get their babies weighed. Having a 'big baby' with a heavier birth weight than most was also included in the stories as to why women did not, or 'could not' breastfeed. Women also told stories of their own perceived failings, stories of insufficient milk, how their 'milk didn't come in', that they 'couldn't make enough' and subsequently how the baby 'wasn't getting enough milk'. How these measurements were known was never included in their tales. Women would also tell me that 'no one in the family had been able to breastfeed' so they presumed that 'it wasn't worth trying'. Other women spoke about how they had decided not to breastfeed because they 'didn't want the baby to be spoilt', they did not want to 'be like a cow', or because they 'wanted to share feeding responsibilities with the baby's father or the grandmother'. In fact, grandmothers often played a big part in the lives of the families I worked with. I became aware of childcare arrangements that were made while the mother was still pregnant. It was common for grandmothers in the local area to look after newborn babies overnight in the grandmother's home for one or two nights a week from birth and I wondered how breastfeeding might fit into such an arrangement.

Other stories I heard dismissed any benefits relating to breastfeeding, suggesting 'formula was just as good'. I would often hear women talk about how children who had been formula fed, had grown up to become healthy adults. This was evident in statements such as, 'our

Tommy was bottle fed² and it's never done him any harm, look at how big he is now', for example. The stories that were told around infant feeding and more specifically around breastfeeding were part of the normal everyday conversations new mothers would have with each other. Positive stories about breastfeeding were not told.

The anecdotes I heard so frequently within the local community were perhaps heard more readily by myself than others because of my own experiences as a breastfeeding mother and growing interest in the subject. As a mother who had previously felt like a failure when my first experiences of breastfeeding had not gone to plan, perhaps I was listening out for these stories. The local narratives I heard positioned breastfeeding as harder to do than bottle feeding and this was embedded into the everyday life and practice of the community where I worked and lived. These stories matter because, as we know from previous research, women trust other women's words, sometimes more so than the stories from professionals (Hoddinott *et al.*, 2012) and these stories create social norms "told within social networks, across generations and influence how women feed subsequent children" (McInness *et al.*, 2013, p. 10). The aim of this research is not to judge or recommend a particular infant feeding practice, but to explore the impact of stories told and how stories and dominant narratives may influence breastfeeding practices.

² The World Health Organisation (2022b) define bottle feeding as "any liquid (including breast milk) or semi-solid food from a bottle with nipple/teat". However, this term is commonly used in the geographical area and by the participants, rather than the term 'formula feeding'.

Stories are important, and so too is language. I was acutely reminded of my own infant feeding story and the guilt I felt when I stopped feeding my son, during a session I delivered at a Children's Centre around ten years after he was born. I had just attended a breastfeeding training session and was consciously repeating the phrases I had heard being used by a respected health professional. Mothers with babies who were around three months attended weaning sessions to learn about introducing solid food. I introduced a session by saying 'those of you who have chosen to formula feed...' As soon as I said the words, one mother became extremely defensive and immediately proceeded to tell me her story. She told me that she had wanted to breastfeed but was unable to because she had a 'bigger, hungrier baby', and that her milk 'didn't come in' and she 'didn't make enough'. I had obviously touched a nerve. I felt uncomfortable and awkward for making her feel this way, and again, I wondered what factors were at play? What made her feel she was being judged? Language can be taken to reflect and reinforce broader values or systems of thought in society (Gee, 2011). Feelings of guilt or being judged are often reported by women who do not breastfeed or who end breastfeeding sooner than they had planned (Earle, 2003; Brown, 2019a). This incident reminded me of the depth of my own feelings of guilt when I stopped feeding my son and I vowed to never ask a woman about her 'choice to formula feed' again. The experience also added to my curiosity about how the language we use, and the stories we tell about infant feeding can influence practice.

These local women's stories and my own experiences can be contextualised with reference to broader societal narratives about breastfeeding. Harrington (2008, cited in Frank, 2010, p. 121) makes a clear distinction "between narrative and story", which has been adopted for this thesis. Harrington (2008, p. 24) defines a story as "living, local and specific" and narrative as "templates" that "provide us with the tropes and plotlines that help us understand the larger import of specific stories we hear, read, or see in action". Harrington (2008) suggests that we draw from these narrative templates in constructing our own specific stories. In terms of infant feeding, the most dominant narrative in UK society is Breast is Best, which is often positioned in binary opposition to narratives of Infant Formula feeding and will now be explored further.

1.3 The Dominant Narrative: Breast is Best

Throughout this thesis, the term dominant narrative will be used to represent a common story that is understood and taken for granted by a community as common practice. The terms master narrative as well as grand narrative are also used in academic literature and appear to have a similar meaning and can be used interchangeably (Squire, Andrews and Tamboulou, 2013). Nelson (2001, p. 107) describes master narratives as "widely circulated stories summarizing the socially shared understandings that make communal life intelligible to its members" as well as being "the repositories of common norms" (Nelson, 2001, p. 6). Clandinin and Connelly (2000, p. 22) describe a

grand narrative as “an unquestioned way of looking at things”. The dominant narrative about infant feeding in the UK centres around the phrase Breast is Best (Palmer, 2009) and is the notion that breastfeeding is the best and preferred way for babies to be fed. Lee (2008, p. 470) argues that “breastfeeding has come to be strongly validated as ‘best’ by a wide range of social actors: including breastfeeding campaign groups, medical authorities, parenting ‘experts’ and the State”. Research has demonstrated that most people have heard this phrase and believe it to be true, even if they do not breastfeed themselves (Earle, 2002; Shaw, Wallace and Bansal, 2003). The dominant Breast is Best narrative originated with the publication of a book aimed at breastfeeding mothers. *Breast is Best* (Stanway and Stanway, 1978) was first published in the 1970s and it continues to be a bestseller today. Figure 1.1 shows how this phrase was not common in published work prior to the 1970s, but appears to have become embedded and taken for granted in UK culture over time.

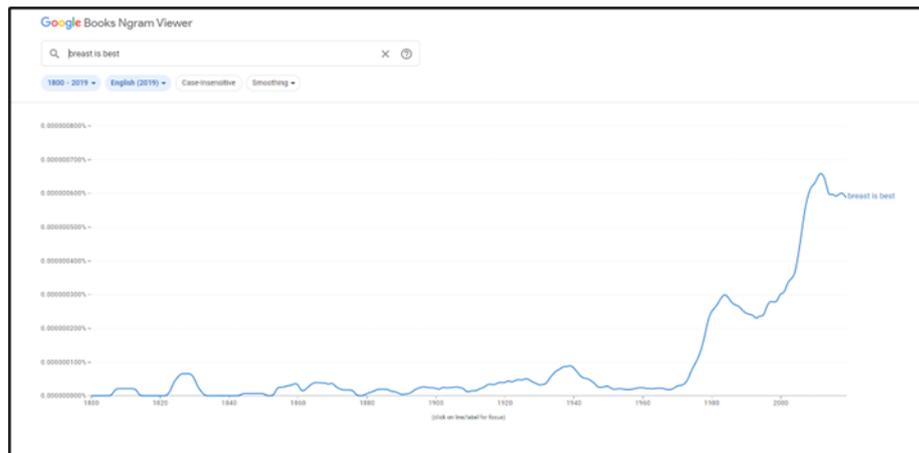


Figure 1.1 Google Books Ngram ³ of Breast is Best (Sourced from Google, 2022a)

However, despite the popularity of the phrase, the use of the word best has been problematised. The dominant narrative of Breast is Best suggests that breastfeeding provides “superfluous, optional extras” (Berry and Gribble, 2008, p. 76) and that formula feeding is the default or normal way to feed a baby (Wiessinger, 1996; Berry and Gribble, 2008; Palmer, 2009, Dixley, 2014). This is a problem for public health campaigns trying to encourage breastfeeding.

Wiessinger (1996, p. 1) argues that the word “subverts our good intentions every time we use it” and that if breastfeeding is ‘best’, then by default this makes formula feeding ‘normal’ whereas in reality, infant formula is “deficient, incomplete, and inferior” when compared to breast milk. Dixley (2014, p. 32) suggests that breastfeeding is the “biological norm” and it should not be “placed on a pedestal” or seen as “liquid gold”. Berry and Gribble (2008) argue that as a society we should move on from describing breastfeeding as ‘best’ and suggest

³ A Google Ngram is a tool used to find patterns of word usage (Byrne, 2021)

that conversations about the risk and difficulties of formula feeding are needed. However, this leads onto a second issue with the Breast is Best narrative and how it may stigmatise women who do not breastfeed.

The Breast is Best narrative is known to make women who feed their babies with infant formula feel stigmatized. However, although we know that infant formula is deficient when compared to breastmilk, (Ip *et al.*, 2007; Quigley, Kelly and Sacker, 2007) it is not appropriate to demonise infant formula, as it is lifesaving and continues to be essential for millions of babies across the world. It is also considered a low-risk practice in high income countries such as the UK. Lee (2008, p. 476) argues that Breast is Best goes beyond nutrition and “reflects the ideology of intensive mothering”. Therefore, mothers who do not breastfeed or do not breastfeed for as long as they had first intended to may feel guilty (Weissenger, 1996, Lee, 2008; Hoddinott *et al.*, 2012; Radzimirski and Callister, 2016; Earle, 2000; 2002; Taylor and Wallace, 2017). The dominant Breast is Best narrative also divides women into two binary groups of breast and formula feeders when actually the situation is much more complex. Brown (2021a, p. 272) argues that the use of Breast is Best adds fuel to the so called “mummy wars” that appear to be at the very heart of many breastfeeding debates” and divides mothers into groups who are seen to be doing their ‘best’ by breastfeeding and others who may be incorrectly perceived as falling short in their responsibilities.

It is important to point out that the Breast is Best idiom and dominant narrative did not originate from public health campaigns or the NHS. However, it is argued that public health campaigns and health care staff have had a hand in sustaining and reproducing this narrative as authoritative voices in regard to health. Despite the problematic nature of the term, the NHS make subtle use of the morally loaded Breast is Best narrative to encourage mothers to breastfeed and do the 'right' thing for their babies. Smyth (2012) suggests that the UK's breastfeeding leaflet, *Off to the best start* (Public Health England, 2018) shown in Figure 1.2 has been designed and written to appeal to the morals of new mothers.

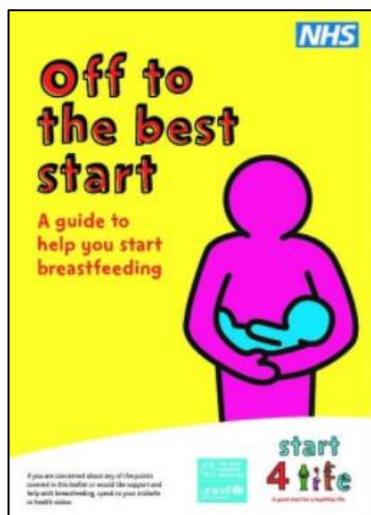


Figure 1.2 Off to the Best Start Leaflet
(Sourced from Public Health England, 2018)

Smyth (2012, p.185) argues that the written material, and specifically the use of the word 'best', suggests that "if you are committed to the goal of providing your baby with 'the best' start in life, a goal which it would seem irrational for any parent to disavow, then reason demands that you should breastfeed". Brown (2019a, p. 45) found that women

who had not breastfed for as long as they had originally intended felt anger towards those they felt were promoting breastfeeding, and experienced breastfeeding promotion as “a direct attack”, suggesting therefore that we should “get rid of Breast is Best” (Brown, 2019a, p. 113). Smyth (2012, p. 192) further argues that “breastfeeding promotion... can produce resentment, prolonged ill health, depression and anxiety”. The NHS utilise this accepted dominant narrative, appealing to the consciences of mothers, encouraging them to do the ‘best thing’, or the ‘right thing’, for their children, but they are also only partially responsible for the endurance of this narrative. Upon reflection, I believe the mother I may have upset at the weaning class may have felt stigmatised due to the dominant Breast is Best narrative in society, but she was able to defend this through language and her story. One further reason for the continuation of this narrative is the way that infant formula manufacturers have created a counter narrative, drawing from that of Breast is Best to emphasise how normal infant feeding is.

1.4 A Counter Narrative: Infant Formula is Normal

The sale of formula along with other manufactured baby food is big business. In 2013, Mason, Rawe and Wright (2013, p. 31) suggested that the global baby food industry was estimated to be worth more than £22.5 billion. Today that figure is closer to £55 billion (World Health Organization and the United Nations Children’s Fund (UNICEF), 2022). At an individual level, it has been estimated that

infant formula for one child can cost £350.00 a year and almost double that for a premium brand (*The Great Formula Milk Scandal, Dispatches*, 2019). Like any other business, infant formula companies exist to make money and therefore naturally need to adopt a different narrative to that promoted by the NHS, which encourages breastfeeding. However, rather than creating a new, separate narrative, infant formula manufacturers draw from the Breast is Best dominant narrative to help sell their products by emphasising that formula feeding is normal.

Idealised images of mothers and babies are often used in infant formula advertising. Healthy, happy babies are featured in TV commercials alongside images of their loving mothers which suggest a smooth and easy formula feeding experience, from which the babies get all the nutrients they need. As well as normalising infant formula, TV commercials can also imply that breastfeeding is difficult, and often show breastfeeding mothers in revealing, exposed and uncomfortable positions. Figure 1.3 shows two clips from a 2015 TV commercial for Aptamil follow-on Milk. The breastfeeding mother is shown in an awkward position with a significant amount of her skin exposed, she looks tired and is not smiling at the baby, instead she is watching the baby feed intently as if it required special skills and concentration. In comparison, the mother feeding infant formula appears to be happier and in a much more comfortable position.

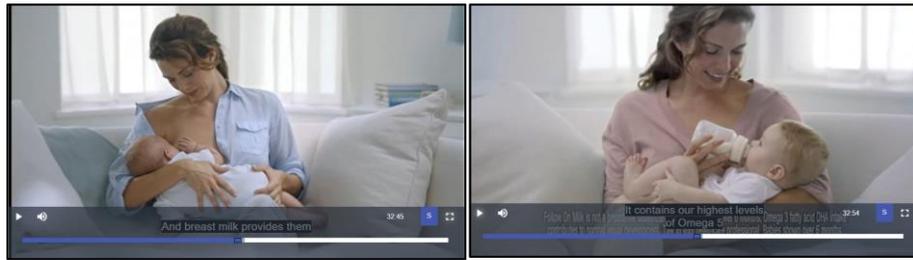


Figure 1.3 Clips from Aptamil follow-on milk TV commercial (Sourced from Aptamil, 2015)

Hinting at challenges breastfeeding mothers may face could encourage more women to use infant formula and add to the narrative that breastfeeding is not the norm.

Infant formula companies are required to trade under regulation to ensure the promotion of breastfeeding is not undermined by the marketing of breast milk substitutes. The World Health Organisation/UNICEF International Code of Marketing of Breastmilk Substitutes, more commonly referred to as 'The Code', sets guidelines for the marketing of formula milk (UNICEF, no date a) and the UK Government has adopted much of the code as law. However, companies have found ways to subvert the regulations. The marketing of follow-on milks and the use of online baby clubs are two examples of how companies are still able to market their products and reinforce formula feeding narratives constructed by the commercials, while abiding by regulations.

One particularly successful campaign in the US for Similac Infant Formula appears to challenge the Breast is Best message. In

advertising campaigns Similac call for sisters to “unite” and celebrate their differences (Harvest Films, 2015; Wechsler, 2015). However, this campaign categorises parents into groups such as breastfeeders, bottlefeeders, working mothers, yoga moms and others, presenting them in competition against each other in a public park. Hastings *et al.*, (2020) argue that this advertising campaign “changed the narrative about infant feeding”, presenting this as “no longer a matter of scientific evidence, but lifestyle choices and beliefs. Breastfeeders are positioned as just one minority, with one set of beliefs”. This advertising campaign was successful for the company, increasing product sales (Klobucher, 2015; Wechsler, 2015) and winning advertising awards (PRWeek, 2016) however it reinforces the idea of a breast verses bottle binary choice.

Marketing restrictions in the UK do not allow any promotion of infant formula intended to be given to children who are under six months. Follow-on milk is infant formula which is manufactured specifically for children who are over six months. It is claimed that follow-on milk was first created in an attempt to evade the requirements of advertising restrictions (Mason, Rawe and Wright, 2013 p. 35, Faircloth, 2006; Palmer 2009; Hastings *et al.*, 2020), since there is no nutritional need for children to change from the first infant formulas (Brown, Jones and Evans, 2020). Palmer (2009, p. 273) suggests that parents may be unable to distinguish between infant formula aimed at children over six months and that produced for children under six months. She

suggests that confusion occurs as the “brand and packaging designs are so similar” (2009, p. 273). Baby Milk Action (2021) also argue that despite the regulations, labels for first milks, follow-on milk and other products are almost identical. In Australia, where regulations go further and do not allow the promotion of either first infant or follow-on milk, research suggests that toddler milk advertisements “are functioning as defacto infant formula advertisements” (Berry, Jones and Iverson, 2012, p. 24). Companies are therefore able to promote and continue to normalise infant formula while abiding by marketing restrictions.

Infant formula manufactures also draw on the Breast is Best narrative to sell infant feeding products by suggesting they provide a similar experience to breastfeeding. Berry and Gribble (2008, p. 77) argue that “manufacturers are happy to describe breastfeeding as ‘best’ while promoting their own products as ‘like breast milk’”. Tommee Tippee, a baby accessories company have used the term “closer to nature” (Tommee Tippee, 2021a) to describe the range of formula feeding paraphernalia they sell at high street retailers in the UK. Their bottles are described as “boob like” and it is suggested that they are “shaped like a breast and feel like a breast because babies prefer it that way!” (Tommee Tippee, 2021a). In addition to this, companies sell paraphernalia aimed to support breastfeeding such as electric and manual breast pumps, nipple shields and cream. Tommee Tippee sell

breastfeeding bundles including the Complete Expressing Bundle shown in Figure 1.4 on sale for £433.91 (Tomme Tippee, 2021b).



Figure 1.4 Tommee Tippee Breastfeeding Bundle (Sourced from Tommee Tippee, 2021b)

In reality, very little equipment is needed to breastfeed a child.

Families are therefore being encouraged to spend a lot of money before their children are born on paraphernalia that may not even be needed.

Infant formula companies also market and normalise their products through online baby clubs (SMA, no date; Aptamil, 2022; Cow and Gate, 2022; Hipp Organic, 2022; Taylor, 2022; World Health Organization and the United Nations Children’s Fund (UNICEF), 2022) which Mason, Rawe and Wright (2013, p. 35) suggest help to “develop relationships with mothers and build loyalty to a brand”. Prior to the introduction of The Code, manufacturers were able to promote infant formula directly to health professionals, giving away, amongst other things, free samples of formula and bottles, teats and dummies, pens, diary covers, obstetric calculators and notepads (UNICEF, no date a; Dykes, 2006). This in turn, helped to normalise formula

feeding among healthcare professionals and give the impression that formula feeding was acceptable and indeed recommended. Many new parents are encouraged to sign up to baby clubs before their children are born and even before pregnancy with things like the use of online ovulation calculators (Hastings *et al.*, 2020). These baby clubs are open to all parents including breastfeeding mothers. The advice offered ranges from preconception planning to physical exercise, labour, weaning as well as breast and bottle feeding. These baby clubs are used to informally advertise specific brands of infant formula and normalise formula feeding in a way similar to the approach taken for professionals previously. Companies hope that breastfeeding women who join the club will turn to their now familiar and trusted brand when they choose to end breastfeeding.

In addition to narratives in circulation from the NHS and infant feeding companies, media narratives add to the complexity of infant feeding stories in the UK.

1.5 Additional Narratives: The Media

Breastfeeding and breastfeeding narratives, as will be discussed throughout this thesis, are complex issues. The binary idea that one dominant Breast is Best narrative is in competition with one counter narrative from infant formula companies paints a rather simplistic picture of infant feeding narratives. The situation is much more

nuanced. Other narratives are evident, which portray breastfeeding as difficult, humorous or a sexual act.

Stories about breastfeeding told through television, film and the media come in two forms: reports of real-life breastfeeding stories and fictitious stories. Brown (2019a, p. 34) argues that “women are misrepresented in stories designed to grab media headlines”. Real life reports of breastfeeding often relay difficult breastfeeding stories. The media draws attention to issues of breastfeeding in public on a regular basis, with women reported to have been thrown off buses (Linning, 2021) and out of stores (Shammas, 2015) or restaurants (Tomlinson, 2012). Other more unusual stories have been reported such as a breastfeeding mother being asked to face the wall in a library (Daily Mail Reporter, 2010), and being asked to stop breastfeeding in a swimming pool (Daily Mail Reporter, 2013; Philipson, 2013). These sensationalist media reports support the idea that breastfeeding is difficult, sexual and not the norm, often portraying breastfeeding mothers in a derogative way, referring to them as ‘earth mothers’ or lacking in public decency. For example, a BBC report covered the story of a women who had been asked to leave a sports shop for breastfeeding (BBC Reporter, 2014). Other media representations of breastfeeding do little to normalise it. Palmer (2009, p. 53) suggests that “a common image of breastfeeding has been of a hungry mother in a famine rather than of the millions of ordinary women who breastfeed without fuss”. The message given off is that breastfeeding

only takes place in lower-income countries when it is absolutely necessary and there is no alternative. Mass breastfeeding protests, usually carried out in response to a mother being asked to leave a store for breastfeeding in public, also make the headlines, as do mass breastfeeding protests used to highlight other issues such as climate change (Gayle and Quinn 2019). While these stories might be considered an alternative to negative media portrayals of breastfeeding (Johnston, 2014; Newton 2014 and Robinson 2014), they nevertheless appear to reinforce the sense of breastfeeding in public as an atypical or non-accepted event.

Celebrities sometimes share images of themselves breastfeeding and they do have influence over infant feeding practice. In 2018 a raft of media stories which included photographs of celebrity mothers expressing breastmilk are said to have increased breast pump sales (Reidy, 2018). Brown (2021a) observed in her research that mothers found breastfeeding celebrities aspirational, and the celebrities stories helped to promote breastfeeding positively across media platforms. However, these photographs often come with a story about breastfeeding difficulties, recent examples include the TV star Stacy Solomon (Harvey-Jenner, 2021) who describes blisters on her nipples and put a general lack of energy down to breastfeeding. The images of the mothers are often idealised (see Dean, 2021 for an example of Myleene Class breastfeeding her baby) and have been criticised for

adding to the pressure experienced by new mothers to get back into shape following pregnancy.

Recently, a range of companies have used breastfeeding to sell their products in TV commercials. Mars, the confectionery company, used a humorous breastfeeding theme in two commercials for Maltesers, one in which a woman was shown with a heavily milk stained top (Maltesers, 2021a) and another who complained about sore nipples while breastfeeding (Maltesers, 2021b). While it is a step forward to see breastfeeding represented in TV advertising, and this may contribute to normalising this practice, the emphasis on difficulties, in this case leaking breasts and sore nipples, does nothing to encourage it. Commercials by Aldi, Adidas and Sainsbury's on the other hand have been praised in the press for the way they normalise breastfeeding, representing it as a simple everyday, ordinary activity (Frizzell, 2019), discussion around the appropriate representation of breastfeeding in TV commercials further demonstrates the complexity of the issues at play.

Social media and the internet bring new challenges in regards to the narratives circulating around breastfeeding. Social media gives women access to individual breastfeeding stories at the click of a button. Breastfeeding blogs and online support groups bring breastfeeding stories to users from across the world. Facebook, who have over 2 billion users, have in the past been reported to have

removed images of women breastfeeding from their site (Sweney, 2008), although they have since changed their policy to state that they “restrict some images of female breasts if they include the nipple, but [they] always allow photos of women actively engaged in breastfeeding” (Facebook, no date). Their actions further problematize breasts and breastfeeding, adding to the narrative that breastfeeding is somehow shameful, private, difficult and not the normal way to feed babies, at least in public.

Fictitious portrayals of breastfeeding also problematize it. In film and on television, breastfeeding stories position breasts and breastfeeding as either humorous, difficult, or sexualized, or a combination of all three. In the classic British TV comedy *Little Britain* where a male adult asks his mother for ‘bitty’ (*Little Britain*, 2003) breastfeeding is seen as both humorous and sexualized. British soap operas often portray breastfeeding as difficult. Recently a character in *Emmerdale* complained about being sore after feeding her baby, drawing parallels between breastfeeding to jogger’s nipple (*Emmerdale*, 2021). In the popular *Games of Thrones* TV drama, an older child of around ten years -Robin- is seen breastfeeding. This appears to help support the storyline that his mother Lysa Arran, has mental health difficulties (*Game of Thrones*, 2011) and again has a sexual undertone. In a textual analysis of 53 fictional television breastfeeding representations, Foss (2013, p. 329) found that shows failed “to address breastfeeding challenges and convey[ed] that extended

breastfeeding or nursing in public is abnormal or obscene". Research that looked at the way breastfeeding was portrayed in the British media (Henderson, Kitzinger and Green, 2000) found that the media rarely present positive information about breastfeeding and that infant formula was more likely to be portrayed as used by ordinary women, while it was middle class women or celebrities who breastfed.

This discussion around dominant, counter and additional narratives has been helpful in reflecting back to my own personal experience and that of my involvement with families at Sure Start Children's Centres. The women's tropes and stories were familiar and repeated to me and many others in the community. Stories of how their 'milk didn't come in' and how they 'couldn't make enough milk' still uphold the dominant narrative of Breast is Best but appeared to be balanced by counter narratives about how 'bottle feeding hasn't done him or her any harm'. I continue to be interested in the infant feeding stories of women and in particular, how they rationalise their actions and choices amid the contested narratives about breastfeeding which are available. A narrative approach felt like the natural choice to investigate stories of infant feeding.

1.6 Area Profile

This research took place in the wards of Walker and Byker in Newcastle upon Tyne. To explore the social context relevant to this study an area profile is presented here. It begins with a general profile

of the city, making comparisons to local and national data regarding issues of population, ethnicity, employment and health issues. Then, more focused discussion is included regarding general information about the two wards of Walker and Byker. Finally, infant feeding rates for the two wards is presented in comparison to local and national data. The areas have been identified in this section of the thesis to aid understanding in terms of social and economic context. Other, area specific information, has been anonymised, where necessary in other parts of the thesis to avoid identifying any individual. The area profile has been based on statistics for the area at the beginning of the study.

Newcastle upon Tyne is situated in the North-East of England. Its population was estimated to be around 290,000 in 2014 (Van Der Eijk, Robinson and Black, 2016). An estimated 46,200 (16%) of these were children and young people from birth to fifteen (Van Der Eijk, Robinson and Black, 2016). The population of the city has been rising slightly in recent years (Newcastle City Council, 2021).

In 2019-2020, 11% of Newcastle's population described their ethnicity as from a minority group, although 24% of school age children are in this group which demonstrates a growing diversity of population (Newcastle City Council, 2021).

In *Fair Society, Healthy Lives*, Marmot (2010) clearly demonstrates the link between deprivation and health outcomes. He describes how

inequalities in health arise from inequalities in society, and proposes six ways in which these inequalities may be addressed (Marmot, 2010, p. 15):

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

An important and key message which came from the review was that, “reducing health inequalities is a matter of fairness and social justice” (Marmot *et al.*, 2010, p.15). The English Indices of Multiple Deprivation (IMD) “is the official measure of relative deprivation in England” (Ministry of Housing Communities and Local Government, 2019). The location of the initial waves of Sure Start Centres were based on the most deprived areas according to the Index of Multiple Deprivation (Eisenstadt, 2011), as was funding for the Neighbourhood Nurseries Initiative and other programmes aimed at supporting vulnerable children and families.

Deprivation in Newcastle upon Tyne is higher than the England average, with life expectancy being lower than the England average for both men and women (Public Health England, no date a). The area has significantly worse rates of many areas of public health, including obesity in children, smoking related deaths and early deaths from heart disease, stroke and cancer (Public Health England, no date a).

Unemployment in Newcastle upon Tyne in February 2014 was recorded as 10.1% which was significantly worse than the 7.1% England average (Public Health England, no date a). However, Newcastle upon Tyne had better than the England average, rates of homelessness, violent crime and road injuries and deaths (Public Health England, no date a).

Breastfeeding initiation rates across Newcastle upon Tyne during 2014/15 were 68.4%, which was slightly worse than the 74.3% England average (Public Health England, no date a). A comparable figure for breastfeeding rates at 6/8 weeks at the same time period can not be found, although in 2019/2020 this was 50.9% which compared to the England average of 48% at the time (Newcastle City Council, 2021).

There is a clear association between reduced rates of breastfeeding and deprivation. The most recent Infant Feeding Survey states that “the effect of deprivation on incidence of breastfeeding can be seen across all countries” (Health and Social Care Information Centre, 2012, p. 13). Brown *et al.*, (2010) found that levels of deprivation can be accurately used to predict the levels and duration of breastfeeding in an area. This gives strength to initiatives and interventions that are targeted in areas recognised as being high in deprivation.

1.6.1 Walker and Byker

Within Newcastle upon Tyne, the wards of Walker and Byker can be found neighbouring each other on the banks of the river. The two areas have similar sized populations. The population of Walker was estimated as being around 11,701 in 2011 (UK Census Data, no date a) with Byker having a similar population at 12,206 (UK Census Data, no date b).

The number of people living in the wards of Walker and Byker who describe their ethnicity as from a minority group is less than the averages of both Newcastle upon Tyne and England. In the 2011 census, in Walker this was around 8% (UK Census Data, no date a) and in Byker it was around 10% (UK Census Data, no date b).

Unemployment in both wards is higher than in other areas of Newcastle. The unemployment rate in 2011 in Walker was recorded as just over 10% (UK Census Data, no date a) and unemployment in Byker was slightly less at 9% (UK Census Data, no date b). Both were higher than the Newcastle average of 5% (UK Census Data, no date c) and the England average of 4.4% (UK Census Data, no date d).

Rates of breastfeeding at ward level are difficult to obtain. However, Van Der Eijk, Robinson and Black (2016, p 23) commented on the 2014 rates, noting that that there were “known inequalities between different parts of the city, with prevalence at 6-8 weeks ranging from

17% in Walker (Newcastle's most deprived ward) to 90% in North Jesmond (Newcastle's least deprived ward)". Van Der Eijk, Robinson and Black (2016, p. 1) acknowledge that "although rates of breastfeeding have increased in Newcastle, breastfeeding rates are far lower in more deprived wards".

These statistics help to illustrate some of the public health issues that can be found in the wards of Walker and Byker. Breastfeeding statistics show significantly lower rates at 6/8 weeks, than neighbouring areas and the city of Newcastle upon Tyne as a whole. This reveals the significant breastfeeding inequality present and highlights the need for research into infant feeding in the Walker and Byker wards.

1.7 Thesis Outline

This thesis is presented in nine chapters. A brief overview of each chapter is provided below.

Chapter 2: Literature Review

The literature review begins with a discussion around choice and infant feeding before moving on to how infant feeding is linked to identity. It then considers how the overarching dominant and counter narratives of infant feeding, discussed in the introduction, play out in private and family spaces, as well as in community space, public space and finally in the context of professional and policy space.

Chapter 3: Methodology

This chapter provides a justification for the biographical narrative methodological approach adopted for the study. It begins by stating the overall aim and research questions. Then discussion flows around the interpretivist paradigm, the socially constructed nature of reality and the importance of my positionality. A discussion around the biographical narrative approach is then presented. The chapter concludes with a discussion of ethical considerations.

Chapter 4: Method

Chapter 4 provides a description of the methods used during the research process. It details the work carried out to prepare for the interviews before moving on to the process of the interviews

themselves. The chapter includes a detailed description of the analytical strategy, which takes into account my positionality.

The Findings and Discussion are presented together in the next four chapters. In keeping with a storied approach, they have been structured in terms of the elements of a play: the Cast, the Setting and the Plot.

Chapter 5: The Cast: Family Narratives

This chapter focuses on the role that close family members play in the participants' narratives. The way the mothers included grandmothers and fathers in their stories are analysed here. This includes attention to how family members influenced (or did not influence) the mothers' feeding practices, as well as the ways they are referenced in the telling of the mothers' stories. The final part of the chapter reflects on the relative absence of fathers in the mothers' stories.

Chapter 6: The Cast: Wider Narratives

In this chapter, three additional elements of the mother's stories are analysed, namely health professionals, infant formula and family finances. In terms of health professionals, issues covered include inconsistencies and unhelpful advice. Infant formula was a key element in some of the stories. Here issues are discussed around brands, marketing and formula feeding rules. The chapter ends with a

discussion around the families' finances and the impact this may have on infant feeding practice.

Chapter 7: The Setting

In this chapter, perceived differences in the attitudes around feeding babies in different areas of the city are analysed. This includes a specific focus on breastfeeding in public and perceived local geographical differences.

Chapter 8: The Plot

This chapter explores the way each of the mother's stories helped them achieve and demonstrate their social aim, of being viewed as a good mother, and suggests that the way infant feeding stories are told may have an impact on the initiation of breastfeeding in communities. A discussion around breastfeeding 'horror stories' ends this chapter.

Chapter 9 Conclusion

This chapter concludes the thesis, drawing from the previous chapters. It responds to the original research questions, discusses research limitations, highlights the original contribution to knowledge and includes key recommendations for policy makers.

Chapter 2: Literature Review

2.1 Introduction

There are many factors which have been found to influence women's feeding practices, which are complex, interlinked and are the focus of this review. For the purposes of this literature review, issues around infant feeding have been considered, as far as possible, in the context of living in an area where breastfeeding was not the norm. The review begins with details surrounding the search strategy itself. Following this, the range of issues which have been found to influence infant feeding practice is considered. An ecological model (Bronfenbrenner, 1979) has been used as a frame of reference for this chapter to help understand the layers of influence around individual mothers and their children. These individual layers of influence are considered in turn.

2.2 The Literature Review Process

A traditional narrative literature review was carried out to summarise existing research findings and identify gaps in knowledge. Petticrew and Roberts (2006, p. 19) describe a narrative review as “the process of synthesizing primary studies and exploring heterogeneity descriptively, rather than statistically.” For the purposes of this research, a narrative review was thought to be more useful than a very focussed systematic review. Denscombe (2017, p. 150) suggests that systematic reviews “are valuable when tackling specific questions” and where “the “evidence” must lend itself to measurement, comparison and evaluation” which would not have

been appropriate for the broad nature of this review. This literature review analysed prior research to identify gaps in current knowledge, creating a narrative around the key themes. Bronfenbrenner’s (1979) ecological systems theory is used as a frame of reference to support understanding of the layers of influence around individual mothers and their children

Material included in the review was assessed to make sure it was relevant to the study and to ensure it was of sufficient quality. In terms of quality, peer reviewed journal articles were selected and additionally assessed in line with criteria adapted from Denscombe’s (2017, p. 153) suggestions for reviewing literature sources, as detailed in Table 2.1 below.

Table 2.1 Criteria used to Assess the Quality of the Literature

Issue Considered	Criteria Set
Year of Publication	Material from 2000 onwards was considered, although most was more up to date than this. Seminal work has also been included which predates this.
Funding sources	Funders were checked to avoid any conflict of interest.
Location of Research	Areas classed as deprived in the UK were the main focus of this literature review. Other areas of the UK were also included along with research from countries which were considered to be equivalent to England in terms of economy.
Type of Study	Peer reviewed studies were sourced.

Adapted from Denscombe (2017, p. 153)

The literature review began with a search of the Northumbria University database NORA. Other databases were also searched including Google Scholar, the Hospital Collection, Family Health, and Health and Medical Complete. Articles were excluded as not relevant if they were found to be about a specific health issue which included many articles surrounding breastfeeding, HIV and Aids. Articles were also discounted if they were focused on research connected to preterm babies, and from countries which were not considered to be equivalent to England in terms of economy. Other articles which were discounted focused on breastfeeding in the military since they address breastfeeding within a very contextually specific setting and animal feeding. The following search terms were used at the beginning of the research process: breastfeeding, stories, narrative, support, social network, low income. Each of these terms were considered and alternative words used to make sure relevant articles were included in the review.

This initial literature review was supplemented by further searches as the research was undertaken, in order to keep the work up to date. Later searches include the terms 'decision making' and 'parenting'. This included a search of Northumbria University's new Library Search data base. Articles were also sourced from reference lists of relevant articles, as well as from colleagues who forwarded links to relevant material.

A search of current policy documents was also undertaken. This included relevant NHS and NICE guidance. These documents were found via internet searching as well as citations in academic articles and other policy documents. A review of breastfeeding material in a range of newspapers was also carried out which have been used to illustrate some of the types of stories circulated by the press around the subject of breastfeeding in public. A range of newspaper websites were searched including *The Guardian*, *The Daily Mail* and *The Telegraph* to represent a broad spectrum of perspectives from the British press.

2.3 Ecological Systems Theory

Ecological systems theory (Bronfenbrenner, 1979) can help us to make sense of the complex nature of infant feeding and has been used as a frame of reference to structure this literature review. The theory helps us to understand the layers of influence around an individual and is more generally used to aid understanding of issues of child development (Gray, 2015; Maconochie and Fitzgerald, 2018; Young, 2021). Each of the layers, or systems, around an individual recognizes influencing factors that can shape and impact behaviour (Snyder *et al.*, 2021). These systems are known as the microsystem, mesosystem, ecosystem, macrosystem and chronosystem. Bengough *et al.*, (2021, p.1) highlight that “feeding decisions are situated within a woman’s personal situation” which means the use of an ecological approach to understand the various influences on an individual is a

useful tool for public health teams. Figure 2.1 shows the way the theory is typically presented in a diagrammatic form.

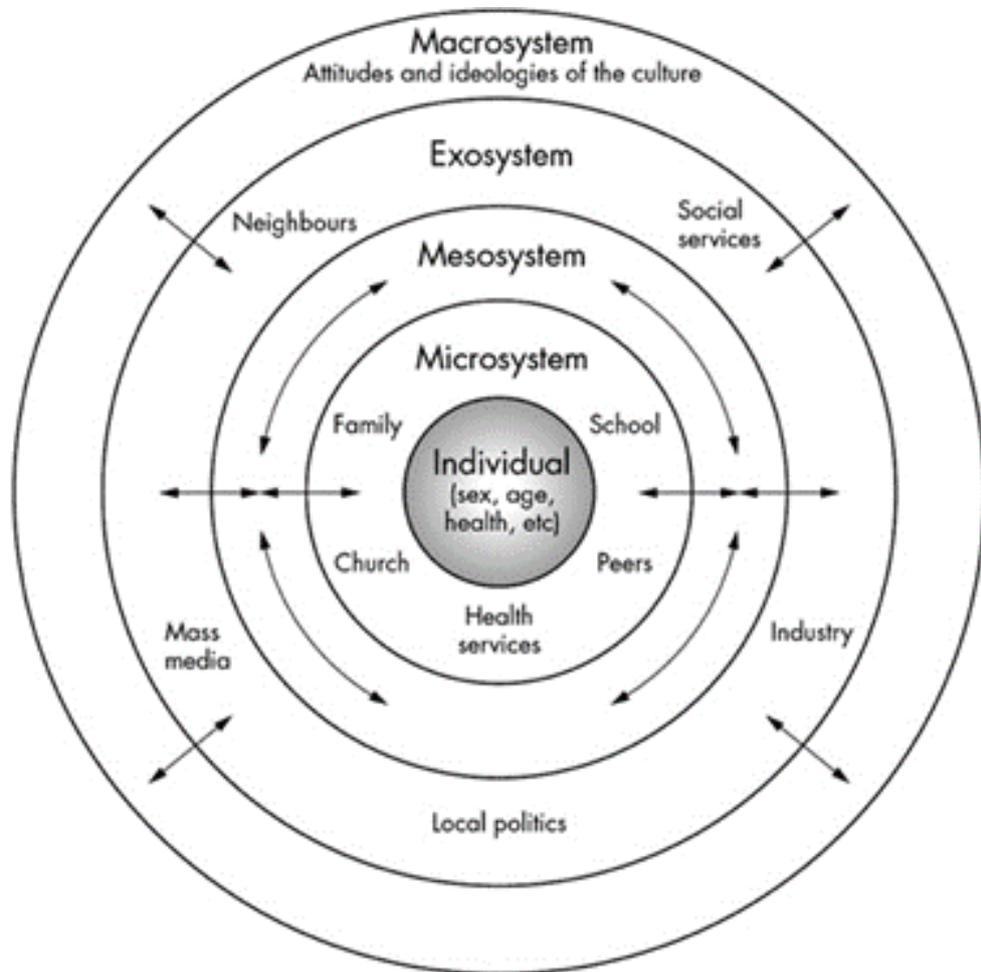


Figure 2.1 Bronfenbrenner's Ecological Systems Model (Sourced from McLaren and Hawe 2005, p.16)

This theory has been used previously in infant feeding research projects to support methodological choices as well as to structure discussion (MacKean and Spragins, 2012; Bueno-Gutierrez, and Chantry, 2015; Dunn, Kalich, Fedrizzi, and Phillips, 2015). Snyder *et al.*, (2021, p. 1) made use of the ecological systems theory “to examine supports and barriers to breastfeeding across environmental systems” in Nebraska, USA. The researchers interviewed 49 people

who represented different systems, including mothers, childcare staff, hospital management and health department leads. They found factors which supported the mother’s practice, as well as barriers and challenges to breastfeeding within every system. The theory helps us to understand that infant feeding choices are not only down to individual woman, but that other factors have a significant part to play. Jackson, Safari, and Hallam, (2022) used an ecological framework to present the results of their research on breastfeeding continuation. Figure 2.3 demonstrates the way findings were categorised into each system.

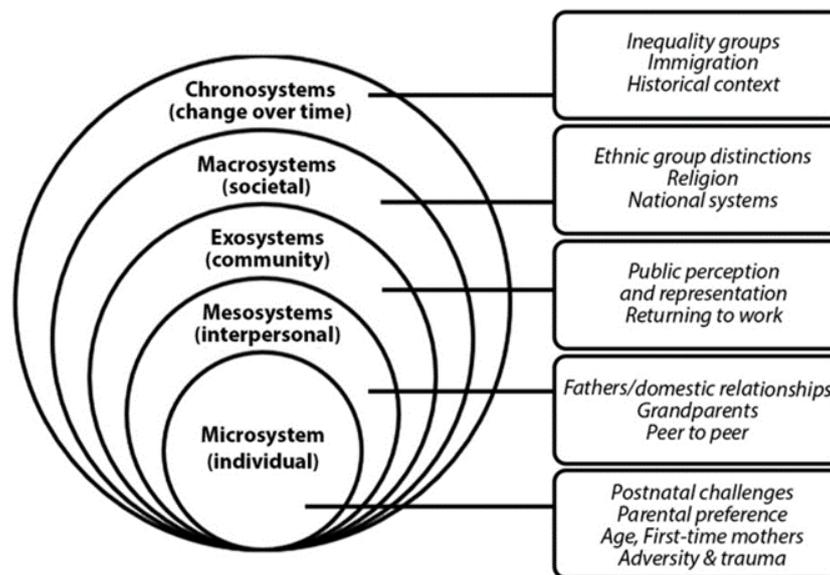


Figure 2.2 Jackson, Safari, and Hallam’s (2022) Ecological Model
Sourced from Jackson, Safari, and Hallam, (2022)

MacKean and Spragins (2012) used a simplified version of the ecological systems theory to categorise influences based on the individual mother and baby, the family, healthcare systems, community and society (Figure 2.3) below:

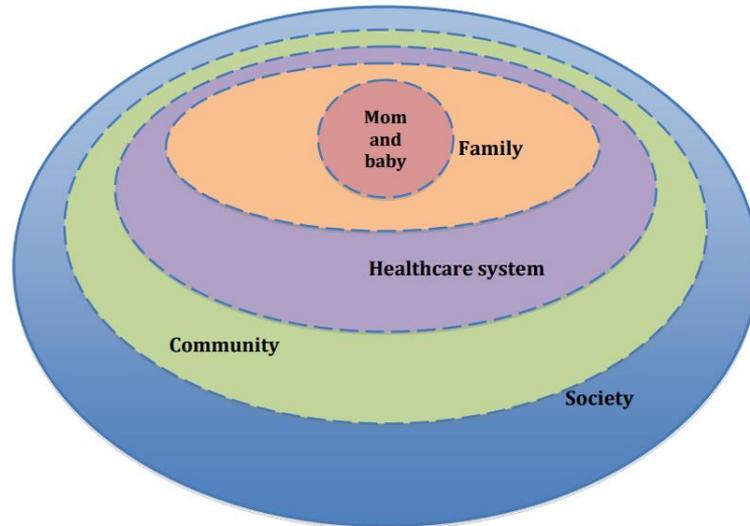


Figure 2.3 MacKean and Spragins' (2012) Ecological Model
(Sourced from MacKean and Spragins, 2012, p. 5)

Synder *et al.*, (2021) also simplified the layers of influence in their study to include individual, interpersonal, community, organisational and policy. The other main difference between the model used is the absence of a mesosystem and chronosystem.

For the purposes of organising this literature review and making sense of previous research in terms of infant feeding, Figure 2.4 below shows how factors have been categorised and how the chapter is structured.

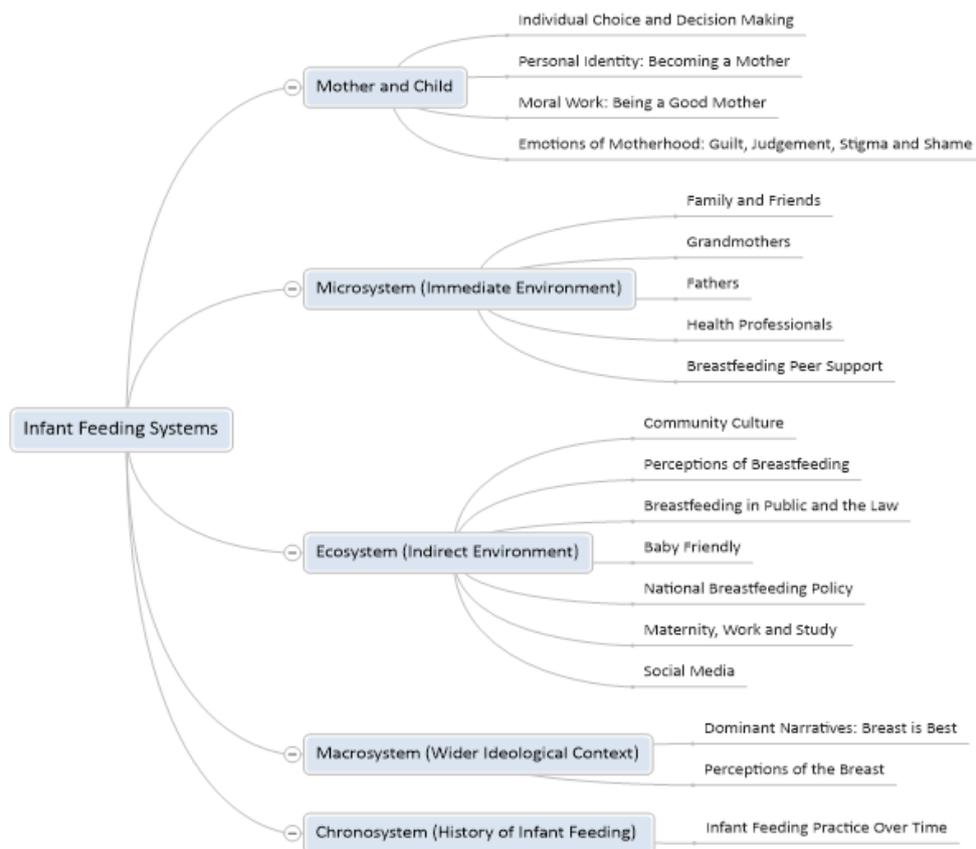


Figure 2.4 Infant Feeding Systems

2.4 Mother and Child

The mother and child, rather than an individual, are at the heart of an infant feeding ecological system (MacKean and Spragins, 2012). This literature review revealed specific individual factors that influence a mother's practice; namely perceptions of choice and decision making regarding of infant feeding method, personal identity in the transition to motherhood, living up to what society suggests is a good mother and negotiating a range of personal emotions such as guilt, judgement, stigma and shame.

2.4.1 Individual Choice and Decision Making

An individual's 'choice' to breastfeed or use infant formula is at the heart of this research. In *The Politics of Breastfeeding*, Palmer (2009, p. 2) questions why "the right to breastfeed [is] fought for so vehemently by some women and rejected so forcefully by others".

This literature review details many social, cultural and political influencers that are present when women make these choices, however it is first argued that the infant feeding choice may not be a conscious choice at all (Hoddinott, *et al.*, 2012; McInnes, *et al.*, 2013).

In their research with mothers living in disadvantaged areas of Scotland, McInnes *et al.*, (2013) describe the complexities of the infant feeding decision. They pinpoint accelerators and decelerators such as family support, health visitor involvement and pain, which they suggest inform the choices women make. They observed that "some women had difficulty articulating the thought processes around decision making suggesting that autonomic, non-cognitive decision making was occurring" (McInnes *et al.*, 2013, p. 12). This suggests that women may not actually make a conscious choice at all. From the same research project, Hoddinott *et al.*, (2012, p. 2) argue that infant feeding interventions, "mostly assume a cogitative model of decision making where pros and cons are weighed up", when in fact some infant feeding practice may actually be automatic (Strack and Deutsch, 2004). Similarly, Scott, Mostyn and Members of the Greater Glasgow Breastfeeding Initiative Management Team (2003, p. 272)

found evidence of a similar phenomenon where mothers stated that no one they knew would even consider breastfeeding or that breastfeeding was never perceived as an option. This discussion is important in terms of public health strategy which aims to encourage women to breastfeed, as there may not be a decision to be made.

Hoddinott *et al.*, (2012) go on to argue that infant feeding advice given may be too black and white, and there are specific times during pregnancy when advice is best received. They do not present infant feeding as a binary choice between breast or bottle but as a nuanced act considering the mothers' values and wider context. They suggest there can often be a "mismatch" between the ideals women and the health service may have and the reality of the situation. For example, they highlight the fact some women are so keen to be discharged from hospital they do so before breastfeeding is established. The immediate benefits of ending breastfeeding sooner than planned can also override longer term goals. Ultimately Hoddinott *et al.*, (2012, p. 12) argue that mothers should be able "to make individual choices informed by personal values and circumstances".

It is suggested from Earle's (2000; 2002) research carried out in Coventry, UK in the late 1990s that the infant feeding decision may be made preconception or in the very early weeks of pregnancy and prior to or irrespective of contact with a health professional (Earle, 2000; 2002). Earle (2000, p. 328) emphasises the role of the father in the

women's decision-making process and suggests that mothers may formula feed to secure some "time out" from baby or to ensure "paternal involvement". Earle (2000) also suggests that women do not include health professionals in their decision making and that health professionals "need to target women far sooner if they wish to have an impact on the uptake of breast feeding in the UK" (2000, p. 328). However, if infant feeding practice does not occur due to a conscious choice (Hoddinott *et al.*, 2012; McInnes *et al.*, 2013) then promoting breastfeeding via health professionals is clearly not enough to improve breastfeeding initiation rates.

Exposing very young children to the normal feeding practice of breastfeeding during their schooling and embedding infant feeding into the curriculum may be one way for public health practitioners to influence behaviour. Research from Northern Ireland (Greene, Stewart-Knox and Wright, 2002) suggests that information about breastfeeding should be part of the school curriculum. Indeed, 76% of their teenage participants agreed this was a good idea. Foss (2012) suggests that making breastfeeding more visible in the media and on television would also help to normalise breastfeeding.

The role of the father and health professionals are considered further later in this chapter and throughout the thesis.

The words 'choice' and 'decision' are used in the language that surrounds infant feeding. Many research studies begin with a question similar to the one used by Radzyminski and Callister (2016, p. 20) who asked women in Columbia, USA, "Tell me why you decided to breastfeed or formula feed?" which forces the women into revealing and retrospectively justifying her choice when she may not have consciously made one. It is difficult not to include reference to the words choice or decision when writing about infant feeding as such a lot of research frames infant feeding practice as a choice. In fact, Earle (2000, p. 325) asked her participants "whether [they] had decided to breast or bottle feed".

It could be suggested that infant formula manufacturers use these words as part of their strategy to sell infant formula. Aptamil for example, explain what you need to do "whether you *decide to move on* from breastfeeding..." (Aptamil, 2021, my italics). Here, the company position the 'choice' mothers have to allow mothers to employ agency, encouraging them to gain control of their new experience as a mother. Formula manufacturers emphasise mothers' agency regarding decisions, whereas women sometimes reject this sense of agency when suggesting they had no choice but to formula feed due to issues with supply or inability to feed. This is important to keep in mind as other factors that are known to influence infant feeding practice are considered. Once a choice has been made to start to formula feeding then it may be difficult for mothers to change

their practice on both an emotional and practical level. Women can and do re-establish breastfeeding once they have begun to formula feed, but this may not always be successful (Association of Breastfeeding Mothers, 2022; La Leche League International, 2022a).

Sears Allers (2017, p. 115) draws parallels between infant formula manufacturers and tobacco companies. For years, products were advertised based on freedom of choice, Sears Allers claims the companies manufactured a debate, creating “doubt” around the product. Scientists were employed to support marketing campaigns and defend their products, providing evidence that tobacco was “not bad”, thus denouncing the paternalistic and patronising approach of public health officials. Sears Allers (2017) suggests that these tactics are very similar to those used by infant formula manufacturers and argues that “the plan to create doubt that breast milk is actually better than formula is a business strategy”.

2.4.2 Personal Identity: Becoming a Mother

The transition to becoming a mother is an important period in a woman’s life (Miller, 2007; Thomson *et al.*, 2011; Hollway, 2015).

Responsibilities are increased, and it is normal to experience broken sleep (Ball, 2019). This transition includes a change in identity. Lawler (2015, p. 9) explains how identity is difficult to define:

“It can be used to refer to a range of phenomena. My sense of myself, others’ perceptions of me, my reactions to others’ perceptions, the social categories that attach themselves to me

and to which I attach myself – all may be referred to as identity”.

The way a person tells stories about themselves supports the construction of their identity. In *The Presentation of Self in Everyday Life*, Goffman (1959) suggests that during social encounters, people play parts, in a similar way to actors in a play. He argues that an individual “implicitly requests his observers to take seriously the impression that is fostered before them” (Goffman, 1959, p. 28). Goffman refers to the part played out in public view as a person’s “Front” (Goffman, 1959, p. 32). This Front, according to Goffman includes the setting, a person’s appearance, and their manner. It could be argued that the stories a person tells are part of this Front, and that these stories then become embodied. As Bruner (2004, p. 694) argued, “in the end we *become* the autobiographical narratives by which we “tell about” our lives”.

For new mothers, this identity change includes responding to the dominant Breast is Best narrative, counter narratives from infant formula manufactures and other narratives from the media. In terms of infant feeding mothers must negotiate their way through these infant feeding narratives, at what can be considered a vulnerable time. However, these narratives form a small part of the narratives the mother needs to respond to, with others including that of an emergent identity as mother. Marshall, Godfrey and Renfrew (2007, p. 2148)

suggest that becoming a mother and breastfeeding does “not occur in a social or historical vacuum”.

In research with first time mothers in the UK, Miller (2007) found that the women told stories of pregnancy and early motherhood while negotiating several dominant narratives (described as discourses) of childbirth. These discourses were originally identified by Cosslett (1994) and include the medical and the natural childbirth discourses which Miller (2007, p. 338) suggests “underpin stereotypes of the good mother”. Within these discourses, mothers anticipate birth and mothering to be natural and guided by experts. Cosslett (1994) also suggests a third discourse of motherhood, the unofficial popular discourse, which consists of “old wives’ tales” (p. 4) and “ghoulish horror stories” (p. 4). Bartlett (2002, p.43) too suggests that women’s own “often epic and tragic” stories of breastfeeding are a source of information for mothers that counter the dominant medical narratives. Miller (2007, p. 353) suggests that “there is no escaping the discourses that circumscribe mothering”.

A women’s identity as mother is also influenced by her consumption choices. Miller (2009) suggests that the “stuff” we choose to buy and keep hold of in our lives, tells a story to others about who we are, and supports us to express our identity. Finch (2007, p. 77) argues that we use objects to “display family”, suggesting that artefacts are used to display the relationships we have with our family to others. Thompson

et al., (2011) have considered these issues specifically around new parents and examines the way parents prepare for an “idealised future child”. Parents prepare for their baby’s arrival by purchasing a whole range of paraphernalia that they believe they need to care for their future child. Thompson *et al.*, (2011) describe the way that this preparation is different according to class and financial circumstance. Some are described as “buying products which fit with the kind of mother they seek to become” with younger mothers choosing the most expensive brands to help display their parenting abilities (Thompson *et al.*, 2011, p. 211). Luzia (2011) argues that these idealised ideas and plans parents have about what parenting is going to be like and what items are needed do not really work out, as babies come with their own ideas and agency and family life is negotiated. The “stuff” (Miller, 2009) parents buy to display they are good parents (Finch, 2007) may never be needed or used.

The return to pre-pregnancy identity can be a concern for some mothers. The literature review revealed that some women do not breastfeed as they are keen to re-establish their pre-pregnancy identities following pregnancy (Earle, 2002; Andrew and Harvey, 2011). Earle (2002) found that some of the women who formula fed did so as they were keen to be seen as separate from the baby, as an individual person rather than as a mother. Women who formula fed wanted to re-establish their previous identities and breastfeeding was felt to be “out of place” (Earle, 2002, p. 18). Similarly, Andrew and

Harvey (2011, p. 48) found that some woman thought breastfeeding would restrict their independence and self-identity, this included being able to go back to work and others who did not embrace being a mother as part of their identity. Hoddinott *et al.* (2012, p. 10) found that some women based their infant feeding decisions on a desire for “me time” and the desire to “get into a routine”. This time to oneself is also mentioned by Palmer (2009, p. 140) who suggests there is a pressure from others to “get back to normal” and “giving a child free access to the breast” does not fit with this. To allow for “time out” from the baby and pressures of motherhood, mothers are often keen to involve the father in the baby’s care (Earle 2002, p. 210).

2.4.3 Moral Work: Being a Good Mother

The importance women place on being seen as a good mother has been the focus of previous research (Murphy, 1999; Marshall, Godfrey and Renfrew, 2007; Miller, 2007; Furedi, 2008; Brouwer, Drummond and Willis, 2012; Thomson, Ebisch-Burton and Flacking, 2015). In response to the Breast is Best narrative, being a good mother is, rightly or wrongly, linked to breastfeeding. Earle (2002, p. 208) argues that the Breast is Best narrative “has been successful in improving women’s knowledge and understanding of the benefits of breastfeeding” for all women regardless of their feeding intention or practice. Hoddinott *et al.*, (2012) suggest that breastfeeding is often part of the intense mothering ideal, which “is a gendered model that advises mothers to expend a tremendous amount of time, energy, and

money in raising their children” (Hays 1996, no page, cited by Ennis, 2014, p. 1).

Gopnik (2016, p. 3) suggests that parenting has become a “goal-directed verb” and that a parent’s role is to produce the “right kind of child who will become the right kind of adult”. Gopnik (2016) suggests two parenting styles, the gardener and the carpenter. The gardener nurtures the child and follows the child’s lead as they grow, while the carpenter shapes the child into the ideal adult expected of the parent. Ramaekers and Suissa (2012, p. 34) suggest another style, that of the expert parent, who parents through the lens of expert discourse, providing “the kind of (scientific) ‘attention’ she is expected to exercise in order to be a ‘good parent’ (according to the dominant discourse)”. Furedi (2008) argues that parents appear to be blamed now what is wrong with society and there is more of a moral obligation on parents to produce good, honest citizens of their children.

Ryan, Bissell and Alexander (2010) carried out research with 49 women in the UK who had breastfed or were still breastfeeding. They describe the first part of their interview process as “relatively unstructured” (Ryan, Bissell and Alexander, 2010, p. 953) where women were asked to tell their stories. The women’s stories were categorised into four main categories of moral work. The first category was identified as “Biographical Preservation”, where the mothers were able to protect their former identity. The second category was to

“Biographical Repair”, where the mothers repaired their identity in their stories, often when they moved from breastfeeding to infant formula. In this situation the women reframed the situation, suggesting the move was for the best. “Altruism” was the third category of moral work found in the interviews where the desire to support others, often to allow the father to feed the baby with a bottle was found. The final category, “Political Action”, allowed the women to demonstrate that their actions involved raising awareness and changing the attitudes of others about breastfeeding. Each of these story types helped the mothers to rationalise their actions to both themselves as well as the interviewer.

2.4.4 Emotions of Motherhood: Guilt, Judgement, Stigma and Shame

The transition to motherhood is a significant period in a woman’s life (Miller, 2007; Thomson *et al.*, 2011; Hollway, 2015), which involves a change in her identity. The dominant Breast is Best narrative can be seen to have an impact on a women’s practice as well as their mental health (Earle, 2002; Hoddinott *et al.*, 2012; Thomson, Ebisch-Burton and Flacking, 2015). Being a good mother is an ideal many women try to live up to and the way they feed their baby is part of the way they can demonstrate their morality (Murphy, 2004). For some, a desire to return to their pre pregnancy identity is a priority which is difficult to negotiate around the Breast is Best narrative (Earle, 2002; Andrew and Harvey, 2011). The feelings of guilt, judgement, shame and

stigma appear to come hand in hand with mothering and infant feeding practice (Brown, 2019a).

Women report feeling guilty for not breastfeeding (Lee, 2008; Taylor and Wallace, 2012; Jackson *et al.*, 2021) as well as for not breastfeeding for as long as they intended (Brown, 2019a). Guilt is defined as having “done a ‘bad thing’ or not having done a good thing” (Niedenthal *et al.*, 1994 cited in Thomson, Ebisch-Burton and Flacking, 2015, p. 34). Women often report feeling like a failure when breastfeeding does not go to plan, whether that is in the early days (Earle, 2002; Lee, 2008) or months into their breastfeeding journey (Maushart, 1999, p. 149). They can feel judged by other mothers (Hunt and Thompson, 2016; Grant, Mannay and Marzella, 2018) as well as health professionals (Dykes, Moran, Burt, and Edwards, 2003). This perceived maternal failure (Taylor and Wallace, 2012) is powerful and these emotions can last a long time (Brown, 2019a). Earle (2002, p. 208) argues that the Breast is Best narrative is partly to blame for feelings of stigma and shame, suggesting that women who do not breastfeed feel compelled to defend their formula feeding practice.

Lee and Furedi (2005, p. 1) in their research with mothers who had formula fed from birth found that they were aware that formula feeding was “regarded as second best, and they invariably [felt] the need to justify their decision”. Thomson, Ebisch-Burton and Flacking (2015)

report that women who formula feed report feeling marginalised and may not ask for support due to their vulnerability and feelings of shame. Lee and Furedi (2005, p. 4) further suggest that women who formula feed may take a “posture of defiance, articulated through the claim that ‘mother knows best’”.

In the UK there are a lot of mothers who do not breastfeed, or do not for as long as they had intended. This means that many mothers are at risk of feeling guilt, judgement, stigma, shame, or a combination of these negative emotions.

Even before the baby is born women are seen to be protecting their identity. In a longitudinal study in Nottingham, England, Murphy (2004) interviewed pregnant women. She found that 30 of the 36 participants interviewed were planning to breastfeed. However, 17 of these women anticipated difficulties with breastfeeding and that for one reason or another anticipated that they might not succeed and may need to revert to the “suboptimal” infant formula. Murphy (2004, p. 129) draws upon the term “motive talk” and the work of Wright Mills (1940 cited in Murphy, 2004, p. 129) and claims that “the availability of an acceptable vocabulary of motives” made it easier for the mothers to justify the switch to infant formula, even before the babies were born. Similarly, research carried out in the North-East of England by Bailey, Pain and Aarvold (2004) suggest there is a “give it a go” breastfeeding culture which allows the mothers to breastfeed for a

short time and then 'fail' legitimately without losing face or damaging their reputation.

The promotion of breastfeeding has been criticised for adding to the stigma and shame felt by mothers who do not breastfeed (Taylor and Wallace, 2012). Taylor and Wallace (2012) consider the way breastfeeding promotion should be carried out to avoid causing women to feel guilty for not breastfeeding or ending breastfeeding sooner than they had planned. They suggest that campaigns which have focussed on risks of formula feeding rather than the benefits of breastfeeding have caused some mothers to feel shame rather than guilt. They suggest that campaigns should focus on the mother, they should be honest and consider lived experiences rather than simply promoting a medical narrative.

Thomson Ebisch-Burton and Flacking's (2015) work with women in North-West England revealed more about the emotion of shame for breastfeeding and non-breastfeeding mothers, defining this as:

“. . . both agent and object of observation and disapproval, as shortcomings of the defective self are exposed before an internalized observing 'other'. Finally shame leads to a desire to escape and hide – to sink into the floor and disappear.”
(Tangney et al., 1996, p. 1257 cited in Thomson, Ebisch-Burton and Flacking, 2015, p. 34)

They found that women experiencing shame “through feelings of fear, humiliation, inferiority and inadequacy” (Thomson, Ebisch-Burton and Flacking, 2015, p.37) can withdraw from society. Hanell (2017)

stresses the importance of this emotion suggesting it can lead mothers to feel like failed mothers and can also prevent women to continue to breastfeed when they are faced with challenge. Jackson, De Pascalis, Harrold and Fallon's (2021) systematic literature review revealed that shame has not been the focus of research as much as other emotions such as guilt, stigma and feeling judged. They suggest that the terms guilt and shame need to be clearly defined in future research to "improve research homogeneity" (Jackson, De Pascalis, Harrold and Fallon, 2021, p. 25).

2.5 Microsystem (Immediate Environment)

The micro system is the layer of influence closest to the mother and baby (McLaren and Hawe 2005; Maconochie and Fitzgerald, 2018). This includes family and friends and health professionals. Specific focus on the role of grandmothers and fathers with infant feeding is abundant in the literature.

Social support is suggested as one of the factors which positively influence breastfeeding outcomes (Meedya, Fahy and Kable, 2010), such as length of exclusive breastfeeding. If a mother has good social support, then it is believed that she will breastfeed for longer.

However, this may imply that women who formula feed do not have good social support or a supportive family which may not be the case.

An individual's interactions with their 'significant others' are known to play a crucial role in the development of their self and identity (Cooley, 1902; Mead, 1967) and is important in exploring how women's views about infant feeding may have been influenced by their 'significant others'. The term 'significant others' in this instance, is broader than the more commonly used definition of 'romantic partner'. It is used here to represent a person's spouse, partner, close family member or a close friend. Marshall, Godfrey and Renfrew (2007, p. 2148) suggest that "social networks provide women with a framework within which to make sense of their experiences".

2.5.1 Family and Friends

Women are influenced by their families (Brown, 2019b, p. 115), but this does not always match the public health narrative. The support received relies on the previous experience of the supporter. Friends and family members will naturally draw from their own experience when offering support and advice to new mothers and their families. This can be problematic if a woman who has only ever formula fed with a regimented routine is trying to support a woman who is exclusively breastfeeding on demand (Dykes and Griffiths, 1998). Moore *et al.*, (2012, p. 1666) found, in an online survey about weaning children onto solid food, that younger and less educated mothers were strongly influenced by their families. This group of mothers weaned their children onto solid food much earlier than advised by health professionals. Moore *et al.*, (2012) found that family members

commonly suggested early weaning based on experience of previous generations. This group of women were still receiving support from their families through their own weaning narratives. These stories and the support they received was not in line with the current public health messages around infant feeding.

In their research with women in the North-East of England, McFadden and Toole (2006, p. 160) found evidence of negative breastfeeding stories influencing decision making, suggesting that:

“family and friends were cited most frequently as being influential in the women’s decision of infant feeding method. Examples emerged of relatives or friends describing their own negative experiences of breastfeeding to persuade the women to choose bottle-feeding.”

These examples demonstrate that women can and do influence each other in terms of infant feeding practice. Women who feel they have successfully breastfed can support other women to breastfeed successfully. Alternatively, women who feel they have unsuccessful breastfeeding experiences often advise others that breastfeeding is difficult, and may try to persuade them to formula feed, in a supportive way.

2.5.2 Grandmothers

Grandmothers are significant others who often play a part in a woman’s infant feeding practice. Dykes and Griffiths (1998) suggest that “a woman’s mother is a major role model, inevitably influencing her parenting style”. McConville (1994, p. 86) refers to the role they

can play as, “the granny factor”. McFadden and Toole (2006) suggest that grandparents of breastfed babies can feel excluded from the baby’s care. McConville (1994, p. 87) suggests that grandmothers who formula fed their children feel that the new generation of breastfeeding mothers can be seen to be “having a dig at the old”. Often grandmothers try to help by giving advice on their own experiences of four hourly formula or breastfeeding which stands in contrast with current breastfeeding recommendations (Dykes and Griffiths, 1998; Lupton and Whelan, 1998), their formula feeding narratives not matching with the very different skills needed to be able to breastfeed. Grassley and Eschiti, (2008) suggest that conversations should take place with grandmothers to help support breastfeeding mothers. They suggest that any such intervention need to be based on the grandmothers’ own knowledge and cultural beliefs about breastfeeding. However, “A Grandmothers’ Tea” project in the US which addressed these issues (Grassley, Spencer and Law, 2012) found that following the intervention there was little difference in attitude between the grandmothers who took part and others who were part of a control group.

Cisco (2017) suggests that grandmothers provide less childcare in more economically advantaged families. This suggests that in areas classed as deprived (such as that studied here), more grandparents are looking after their grandchildren, providing a greater opportunity for grandparents to influence their daughters’ practice.

2.5.3 Fathers

Fathers are often included in the infant feeding debate and research suggests they have a strong influence on infant feeding decisions (McFadden and Toole, 2006; Brown and Davies 2014). Earle (2002) found that for the women who had formula fed, involving the father in the babies' care was very important and positioned in one of two ways. The first allowed fathers to take their share of caring for the baby and allowed women some "time out" (Earle, 2002 p. 210). Secondly, fathers taking their share of early baby care could help out during unsocial hours. Earle argues this 'shared parenting' is promoted in contemporary parenting manuals, however Murphy (1999, p. 201) suggests that this makes women "responsible for their partners' bonding with their babies". Palmer (2009, p. 86) suggests that "the reality is that few fathers actually do take the whole responsibility of infant care and most artificial feeding is still done by mothers". Earle (2000, p. 328) acknowledges that "it is not clear whether fathers wished to be involved" and refers to the work of Murphy (1999) who suggests that women may justify their decisions to formula feed as a way to involve the father more with the baby. It has also been suggested that fathers are not actively involved in infant feeding decision making processes. In a small telephone-based study with fathers and mothers in the south-east of England, Datta and Wellings (2012) found that fathers believed that the method of feeding was up to the mother, it was not discussed, and a conscious decision together was not made. They found that the fathers' role was

to support, both practically and emotionally “to make life easier” for the mother. Earle and Hadley (2018) also came to a similar conclusion in a systematic review of the literature suggesting that “although men can play an important role in supporting women, they do not have a significant role in infant feeding decisions”.

Brown and Davies (2014) found that fathers wanted to be part of the breastfeeding relationship but did not feel included from the start with things like antenatal breastfeeding education and call for more fathers to be invited to participate in such learning. Baldwin (2020) suggests that services need to improve their engagement with fathers by including them in the planning of all stages of health care.

2.5.4 Health Professionals

The literature review revealed that women commonly criticise health staff and public health policy and it is reported that health professionals give inconsistent messages and advice (Simmons, 2003; McFadden and Toole, 2006). This was found in the North-East of England, where women perceived that health professionals gave “conflicting information” (McFadden and Toole, 2006, p. 161). Public health campaigns have also been criticised by mothers who say classes and health professionals do not prepare them for the realities of breastfeeding (Hoddinott *et al.*, 2012). The campaigns can then create an expectation which does not live up to the reality of the experience or put women off breastfeeding in the first place. In

addition to this when advice is given by professionals, women do not always follow it. Hunt and Thomson (2016) suggest that some mothers perceive their health professionals have a set of breastfeeding 'rules' that must be followed and when these rules are broken the mothers deem themselves as failures and may avoid health professionals as a result. Burns *et al.*, (2013) suggest that midwives who "constructed breastfeeding as a relationship between mother and infant" rather than prioritising breastfeeding or constructing it as natural, build mothers' confidence and have better communication with her. McInness *et al.*, (2013) found that women 'broke the rules' and avoided their health professionals and in the same study it was found that mothers would not always tell their health visitor the truth about their feeding practice (Hoddinott *et al.*, 2012, p.10). Hoddinott *et al.*, (2012) suggest that health professionals would ideally be trained to fully support women to exclusively breastfed for six months and beyond however in reality this does not happen. They suggest that "not all staff have the necessary skills and breastfeeding care is highly variable and determined to some extent by luck" (Hoddinott *et al.*, 2012, p. 5).

Previous studies suggest that health professionals have little influence on women's infant feeding decisions, and that the experience and values of the health professionals as individuals is an important factor to consider. Dykes (1995 cited in Dykes and Griffiths, 1998, p. 79) warns that:

“it needs to be remembered that the attitudes, values and beliefs of health professional will inevitably be influenced by their own socialisation process and this must be addressed in any breastfeeding education provided for them”

Hoddinott and Pill (1999) suggest that health professionals could use stories in their practice to listen to pregnant women talking about breastfeeding. From this they would be able to identify those who have been exposed to breastfeeding and are therefore more likely to initiate breastfeeding and those who have not.

Thomson, Ebisch-Burton and Flacking (2015, p. 40) suggest that women may feel shamed when they are not provided with adequate support from their health professionals. They focus on the word ‘support’ and suggest that for some women this is interpreted as having a deficiency which they need to be supported with or an inability to cope. Ironically, this can be a barrier to successful infant feeding. Thomson, Ebisch-Burton and Flacking (2015, p. 43) argue therefore for a needs-led health service and for health professionals “to get to know mothers on a personal level to get to know them and their babies needs”.

2.5.5 Breastfeeding Peer Support

Peer support programmes offer support to women who are facing challenges with breastfeeding, rather than with their initial decision making (The Lancet, 2016). This lay support is known to be beneficial for some mothers (Thompson and Tricky, 2013; McFadden *et al.*,

2017) providing up to date information and support from a less formal source. In the past, women could rely on their mothers and female friends and relatives to pass down information and offer practical support about breastfeeding. Muller *et al.*, (2009) suggest the “wisdom and experience” of previous generations was valuable. However, with the decline of breastfeeding across the developed world, many women are unable to turn to friends and family for support. As early as the 1950s, a number of charity groups were set up by mothers to fill this gap and offer mother to mother support, although research shows that mothers value peer support that is supported by professional input (Thompson and Tricky, 2013). These charities have grown and include La Leche League (La Leche League GB, no date) National Childbirth Trust (NCT 2022), Association of Breastfeeding Mothers (2022) and Breastfeeding Network (2014). Now more formal ‘peer support’ groups are offered by the charities, with training available to mothers who would like to volunteer as a peer supporter to support others. Dyson *et al.*, (2006, p. 4) define peer support as the:

“...support offered by women who have themselves breastfed, are usually from similar socio-economic backgrounds and locality to the women they are supporting and who have received minimal training to support breastfeeding women. Peer supporters may provide breastfeeding support services voluntarily or receive basic remuneration and/or expenses.”

Peer support can be offered at meetings, play groups and over the telephone. Some peer supporters are also present at ante natal workshops and in hospital. Thomson *et al.*, (2012) discuss the way peer supporters in the North-West of England gave incentives to women as part of their intervention. They found that the incentives did

not influence the women however the relationships that were developed because of the scheme benefitted both mothers and peer supporters.

Peer support groups can be a valuable resource for a community. They encourage and support women to breastfeed (Arlotti *et al.*, 1998; Wade, Haining and Day, 2009; Thomson and Trickey, 2013) but also provide learning opportunities for the mothers. Women who volunteer to be peer supporters, also, often gain other skills themselves such as self-confidence (Wade, Haining and Day 2009). They may use this voluntary role as a stepping-stone onto further learning and employment (Raine, 2003, p. 468). Hunt, Thomson, Whittaker and Dykes (2021) demonstrate how peer support services can also help to develop mothers' social networks and signpost to other resources.

Peer support provision is however patchy across England. Often the areas needing most support lack volunteers due to the low numbers of breastfeeding mothers in the area. Peer supporters are usually recruited from the same local area as the mothers they will support (Thomson and Trickey, 2013). However, Hunt, Thomson, Whittaker and Dykes (2022) suggest peer supporters in disadvantaged areas may have a different background to the mothers they support. Many of the organisations ask for volunteers to have breastfed for a certain period of time, for La Leche league this is 12 months (La Leche League International, 2022b). However, if a very small percentage of

mothers in an area breastfeed until their baby is 6 weeks old, never mind 12 months, then there will be a shortage of mothers in the area who are qualified to volunteer, making recruitment very difficult indeed. Recruiting mothers from other areas may not be as effective as peer support works best when people share common experiences and backgrounds (Hunt, Thomson, Whittaker and Dykes, 2022). Hunt and Thompson (2016) carried out research into why mothers in South-West England may not attend breastfeeding peer support groups. They found that perceptions of judgement and concerns that peer supporters would follow the same strict 'rules' as their health professionals put mothers off attending. Other criticism has also been directed at peer support disparities in relation to race. Sears Allers (2017, p. 151) suggests that in the United States provision from La Leche league is designed and located in ways to support white mothers, leaving Black mothers (who tend to have lower rates of breastfeeding in the US) with little or no support.

Hunt, Thomson, Whittaker and Dykes (2021) considered how breastfeeding peer support works in a case study focusing on two breastfeeding peer support services in a socio-economically deprived area of North-West England. They found that although peer support in these areas did allow women access to services, the support offered did not always consider the specific needs of the community. Opportunities to target specific geographical locations were missed due to priorities around data sharing. A lack of knowledge about the

surrounding context of the women's lives resulted in a lack of context led delivery with the result of some mothers not being targeted at crucial points in their breastfeeding journey. Hunt, Thomson, Whittaker and Dykes (2021) suggest that the use of the social ecological approach (McLaren and Hawe, 2005) looking at micro, meso and macro issues could "increase equity by helping ensure resources reach those living in deprivation". Hunt, Thomson, Whittaker and Dykes (2021, p.10) also suggest that this ecological view also allows peer supporters a wider role in addressing "wider contextual issues".

Research into improving peer support services continues. Genograms were trialled as part of the "Assets-based Infant Feeding Help Before and After birth (ABA)" peer support project (Clarke *et al.*, 2020; Ingram *et al.*, 2020; Thomson, *et al.*, 2020) to help peer supporters make sense of the context in which each individual mother was living. Although this tool was difficult for some peer supporters to implement, a positive outcome was that this process highlighted additional support available to the mothers and it helped to develop a trusting relationship between the mother and peer supporter.

2.6 Ecosystem (Indirect Environment)

The ecosystem includes larger systems that influence a mother's infant feeding practice. Literature around the community itself and how breastfeeding, and breastfeeding in public is perceived is included in

this system. Local public health practice has also been included in this system; namely the Baby Friendly Initiative (UNICEF, no date a) and other practice influenced by national policy. The ecosystem includes social media which plays an increasing part in the lives of families and did so more significantly during the Covid-19 pandemic.

A supportive community can make the world of difference for parents who may base their parenting practice on social norms. Women are more likely to breastfeed if they were breastfed themselves (McFadden and Toole, 2006; Brown, Raynor and Lee, 2009; Di Manno, MacDonald and Knight, 2015) or have been exposed to breastfeeding (Hoddinott and Pill, 1999). Stories about breastfeeding being difficult and inconvenient are commonplace and mothers often listen and respond to these lay health stories rather than listening to and acting upon the medical narratives coming from health professionals. Peer support is designed to fit the gap between the public health narrative and lay health narratives but this is patchy and subject to criticism in terms of reaching those who need it most.

McInness and Hoddinott (2012, p. 12) describe how “infant feeding narratives influence social networks which span family generations”. These breastfeeding stories can be both positive and negative influences and cascade through social networks and families. Lavender, McFadden and Baker (2006, p. 151) found evidence of

stories of negative experiences having an influence in their research in the North-West of England, stating:

“...family members who had failed to breastfeed their own babies actively discouraged it. When women were having difficulty feeding, some members used these problems to justify their own previous failings. For example, one of the women’s sisters said; “if she’s anything like me she won’t be able to feed for long. I’ve told her she might as well put the baby on the bottle”.”

Furthermore, Hoddinott and Pill (1999, p. 33) suggest an “apprentice with a breastfeeding mother” from “her social network” as a way to bridge the gap of knowledge. This can be difficult to access in an area with low rates of breastfeeding.

2.6.1 Community Culture

Women are more likely to breastfeed if they have been exposed to breastfeeding (Hoddinott and Pill, 1999). Fitzpatrick, Fitzpatrick and Darling, (1994) found this in research in the Republic of Ireland where women were found to be influenced by the practice of close friends and relatives. Greene, Stewart-Knox and Wright (2002) also found similar results in their research with teenagers in Northern Ireland. Dykes and Griffiths (1998, p. 79) suggest “women in our society commonly have little visual experience of breastfeeding”. Dykes and Griffiths (1998, p. 77) argue that:

“many children and young adults in our society are never or rarely exposed to breastfeeding. Most will however be exposed to bottle-feeding images in public, via the media and even through play with items such as toy dolls with accompanying bottles and dummies.”

If individuals commonly see feeding with infant formula and not breastfeeding, then this helps to reinforce a formula feeding culture. Parents in the study carried out by Hoddinott *et al.*, (2012, p. 2) who were formula fed and healthy used this to show their choices did not make them a bad mother. The mothers argued that they knew someone who was formula fed and is healthy to justify that formula feeding is just as good as breastfeeding. This is a significant factor in an area where feeding with infant formula is the norm where there are fewer chances of seeing the act of breastfeeding than in an area where breastfeeding is common. This could become a self-sustaining influence and inform intergenerational practice. On the other hand, norms can be changed. For example, Brown, Raynor and Lee (2009, p. 57) found that a number of breastfeeding women in their study, recruited in the Swansea area as well as online, described how their breastfeeding experiences “had a positive effect on those around them... Others then chose to breast feed their babies, even if they had artificially fed in the past”.

It is known that women are more likely to breastfeed if they were breastfed themselves (McFadden and Toole, 2006; Brown, Raynor and Lee, 2009; Di Manno, MacDonald and Knight, 2015). McFadden and Toole, (2006, p. 156) carried out research in an area of the North-East of England described as having “high levels of socio-economic deprivation”. The breastfeeding mothers in their study were found to have been breastfed themselves or had seen their brothers and

sisters being breastfed. In a study with 12 mothers in Berkshire, UK, Andrew and Harvey (2011) found that their participants also followed the method of feeding their mothers had used. Demographic details were not collected for this study, so it is not known if it was carried out in an area of deprivation or an area with low rates of breastfeeding, but it does suggest that women follow the feeding practice of their own mothers. In areas where breastfeeding is not common, this is a particular challenge for public health teams. Greene, Stewart-Knox and Wright (2002) carried out research with teenagers in Northern Ireland, where rates are lower than most of the rest of the UK. They found that the teenagers who had been formula fed as children were much more disapproving of breastfeeding in public than their breastfed counterparts. This further illustrates the suggestion by Earle (2000; 2002) that women's infant feeding practice is decided prior to a woman becoming pregnant and influenced by some factors beyond her control. The material reviewed demonstrates that public health strategies aiming to increase breastfeeding rates must always be mindful of the rates of breastfeeding from the previous generation, particularly in areas where breastfeeding is not the norm.

This cultural explanation is problematic as it may attach blame to the local community themselves for the formula feeding culture which public health workers may class as poor health behaviour. Hall Smith (2018) suggests breastfeeding practice is shaped by a number of injustices including poverty, status and class. She argues that to make

breastfeeding available to everyone then we should focus on social justice to:

“understand and appreciate the ways these factors shape infant feeding decisions and practices in communities and to be open to ideas that there may be no one set of best practices, no one right way of breastfeeding, and no one standard for breastfeeding success.”

Primary socialisation (Denzin, 2010) provides some explanation as to why young girls grow up to learn the culture and social norms of their environment. This may explain why women follow the infant feeding practice of their own mothers. However, Peregrino *et al.* (2018, p. 12) argue that the initiation of breastfeeding:

“appears to be indirectly influenced by neighbourhood deprivation. In poor quality neighbourhoods, for instance, there may not be the support systems in place to encourage mothers to initiate breastfeeding, and perhaps socialisation with family and friends for whom formula feeding is the norm could discourage breastfeeding.”

They argue that factors such as deprivation and poor neighbourhoods may be to blame for the lower rates of breastfeeding, which takes into account the wider context in which the families are living. The Social Determinants of Health (Institute of Health Equality, 2022) “is a term used to describe the social and environmental conditions in which people are born, grow, live, work, and age, which shape and drive health outcomes”. This can help us to understand how factors outside of health policy, such as education, employment, housing and the physical environment can create “avoidable health inequalities” (Institute of Health Equality, 2022). For women who live in areas of deprivation where rates of breastfeeding are low there may be little

breastfeeding support but the Social Determinants of Health may suggest that this is down to poverty (Dahlgren and Whitehead, 2006) rather than lack of any form of support from family and community members. Marshall, Godfrey and Renfrew (2007, p. 2158) call for “broader societal changes, including revised national policy and law, for example to address employment issues that constrain women’s ability to breastfeed and work in paid employment”.

2.6.2 Perceptions of Breastfeeding

The ‘inconvenience’ of breastfeeding is another reason often cited by women for using infant formula from birth. In particular, going back to work, is not seen as compatible with breastfeeding. Andrew and Harvey (2011, p. 55) found that mothers who breastfed and formula fed described their method as being the ‘most convenient’. Breast milk was thought to be “on tap” and infant formula was thought to allow mothers, rather than the baby, to control the routine (Andrew and Harvey (2011, p. 55). However, a significant amount of the whole group, suggested that breastfeeding results in the loss of independence. The need to avoid breastfeeding in public, as well as going back to work proved challenging for the mothers. Both of these issues are significant and are discussed in more detail later in the chapter.

Previous research suggests that some women do not initiate breastfeeding as they believe breastfeeding is difficult and formula

feeding is easy (Murphy, 2004). A perceived lack of a good milk supply (Hector, *et al.*, 2005; Peacock-Chambers, *et al.*, 2017) is known to be a common reason why women do not begin breastfeeding or end breastfeeding sooner than they had planned. Palmer (2009, p. 26) suggests that “insufficient milk’ is the most common reason women give for abandoning breastfeeding while in reality “...poor attachment and restricted feeding are the commonest cause of problems and failure” (Palmer, 2009, p. 30). Andrew and Harvey (2011) interviewed 12 mothers in the UK with babies under 18 weeks. Just one of the participants formula fed from birth and said she did so, because she lacked confidence in her milk supply and was worried that she would not be able to feed a hungry baby. She is quoted as saying, “he’s easier with the bottle ‘cos I would never be able to feed him as much as he wants to eat” (Andrew and Harvey, 2011, p. 53). McFadden and Toole (2006, p. 161) found that mothers were concerned about “frequent feeding... not getting enough milk...latching on...soreness and sleeping difficulties”.

It is suggested that these lay health beliefs from the community about breastfeeding difficulty play a part in the perception that breastfeeding is difficult (McFadden and Toole (2006). Public health messages appear not to be getting through to individuals, however Armstrong and Murphy (2012) suggest that the situation is much more complex than this. Murphy’s (2004) earlier research demonstrates that mothers are aware of the Breast is Best narrative and the moral implications

around this but are able to justify their formula feeding practice without losing face. Murphy (2004) considers the way women begin to justify their formula feeding use before the birth of the baby. She argues that “mothers account, in advance, for the possibility that they may eventually feed their babies in ways they consider suboptimal.”

2.6.3 Breastfeeding in Public and the Law

Mothers’ concerns about breastfeeding in public is often quoted as being a barrier to the initiation and continuation of breastfeeding (Sheeshka *et al.*, 2001; McFadden and Toole, 2006; Meedya *et al.*, 2010; Amir, 2014). This is important because breastfeeding in public allows breastfeeding to be visible, it supports the social norm that breastfeeding is an accepted way to feed babies and encourages others to do the same (Earle 2002, p. 209). It is also an issue of equality. The issue of breastfeeding in public is complex and includes consideration of many of the previous points made. Babies require frequent feeding, therefore if a mother feels uncomfortable in taking her baby with her then this can lead to ending breastfeeding (Li *et al.*, 2008). Normalizing breastfeeding by making it more visible within communities and society would help to encourage more women to breastfeed. This would improve breastfeeding rates in communities where rates are low.

In the UK, breastfeeding mothers are protected, and it is against the law to ask a breastfeeding woman to leave a public space (Maternity

Action, 2021). In England and Wales, the *Equality Act 2010*, states that it is “sex discrimination to treat a woman unfavourably because she is breastfeeding”. In Scotland, an act of law specifically protects the rights of women to breastfeed in public (Breastfeeding etc. (Scotland) Act, 2005). The *Equality Act 2010* is particularly useful for women who return to work in allowing them to continue to breastfeed their children, however it has its limitations, for example it does not place a duty on organisations to give women paid breaks. Despite the laws in place, breastfeeding in public spaces is often headline news (Morris *et al.*, 2016; Bresnahan *et al.*, 2020), suggesting that as a society, the UK is not as accepting of breastfeeding mothers as these laws suggest it should be. Media attention is drawn to issues around breastfeeding in public on a regular basis, with women reporting to have been thrown out of restaurants, stores and other places such as swimming pools when breastfeeding (Daily Mail Reporter 2010; 2013; Philipson, 2013; Narain, 2013; Morgan, 2021). Members of the public respond to these challenges with the use of mass breastfeeding protests (Tomlinson 2012; Newton, 2014) creating different but equally polarising or problematic headlines.

It is suggested that the public may not always be aware of the laws in place to protect the rights of breastfeeding mothers (Amir, 2014, p. 1) and many mothers anticipate disapproval or challenge (Scott, Mostyn and Members of the Greater Glasgow Breastfeeding Initiative Management Team, 2003; McFadden and Toole, 2006). A study in

the North-East of England exploring women's views on breastfeeding in general (McFadden and Toole, 2006, p. 156) found that breastfeeding in public was commonly discussed in focus groups with 35 mothers. The women said that when they breastfed in public, they "felt uncomfortable because of the perceived reaction of others" (McFadden and Toole, 2006, p. 159) and some said they responded to this by feeding in corners or public toilets. One woman in the study described how she would try to time her child's feeds to coincide with her trips away from the home, so she was always able to feed at home. Andrew and Harvey (2011, p. 55) found that the breastfeeding mothers' "primary concern was that other people would disapprove of them" when they breastfed in public. Similarly, in Ontario, Canada, Sheeshka *et al.*, (2001, p. 31) found that breastfeeding women felt "vulnerable" and "anticipated some undesirable attention" when breastfeeding in public. This study included observations of women breastfeeding as well as formula feeding in various locations across the city. The mothers reported how they would "often role play in their minds how they might handle negative attention" (Sheeshka *et al.*, 2001, p. 37). However, in practice they found that they received no more attention than their bottle-feeding counterparts. How often women are challenged when breastfeeding is not known. McFadden and Toole (2006) did find some evidence of women being challenged in their study. One mother had been asked to "sit out of sight in a bar" (2006, p. 159) while another had "been asked to leave a café". Sheeshka *et al.* (2001) also reported one incident where a male

customer complained to a waiter about being able to see a mother breastfeeding her child. This isolated incident occurred amongst 60 hours of observations of women feeding their babies, which demonstrates that women are not routinely challenged. Thomson, Ebisch-Burton and Flacking, (2015) found that women who experienced shame in breastfeeding, due to perceived inadequacies or shortcomings would withdraw from others or wait until they had mastered breastfeeding before doing it in public.

Most breastfed babies feed often. NHS Guidance reassures parents that frequent feeding is normal (Public Health England, 2022). As discussed, women who breastfeed can find the thought of leaving their homes difficult (Andrew and Harvey, 2011). To encourage women to shop and take part in leisure activities, many stores and other facilities provide dedicated rooms for mothers to breastfeed in. These rooms often described as 'Parent's Rooms' can be found in towns and cities across the UK with the help of Apps such as FeedFinder (Simpson *et al.*, 2016). However, despite these rooms being welcomed by many as a quiet space for parents to care for their babies (Sheehan, Gribble and Schmied, 2019), it is argued that the rooms send the message that breastfeeding is something that should be done in private (Boyer, 2012). Boyer's (2012) research also suggests women feel obliged to use such rooms rather than have confidence to breastfeed in public. It is important that women have a choice, and that private spaces are available, however it is important

that women are aware that they can breastfeed their babies in public and are protected to do so.

2.6.4 Baby Friendly Initiative

The Baby Friendly Initiative is a worldwide programme of the World Health Organisation and UNICEF (UNICEF, no date a). “It was launched in 1992 to encourage maternity hospitals to implement the Ten Steps to Successful Breastfeeding” (World Health Organisation, 2022b) and to practice in accordance with the International Code of Marketing of Breastmilk Substitutes (UNICEF, no date b). “The Baby Friendly Initiative provides support for health care facilities and for Universities training midwifery and health visiting students, to implement best practice” (World Health Organisation, 2022b). The National Institute of Health and Clinical Excellence (2006, p. 6) recommend that:

“all maternity facilities (whether in hospital or primary care) should implement an externally evaluated, structured programme that encourages breastfeeding, using the Baby Friendly Initiative”

The Baby Friendly Initiative has been implemented in countries around the world. Studies of the initiative show an increase in breastfeeding rates among women who give birth in accredited hospitals (Ingram, Johnson and Condon, 2011). The initiative supports mothers to breastfeed by raising awareness, with both mothers, their families and hospital staff and by normalising breastfeeding. Byrom *et al.*, (2021) studied the changing culture in one hospital maternity

service in the North of England from 2010 to 2017 and found that Baby Friendly policies enhanced infant care although they recognised that this was challenged when working in a busy hospital environment with many demands on health staff.

Maternity facilities are required to adhere to the “Ten Steps to Successful Breastfeeding” (World Health Organisation (2022b) to achieve Baby Friendly Status. Aryeetey and Dykes (2018) have critiqued recent changes to Baby Friendly guidelines which now include more of a focus on health professionals supporting families to build close and loving relationships. They note a distinct change in focus which incorporates relational aspects of breastfeeding. This guidance also, for the first time, includes a recommendation for health professionals to “counsel mothers on the use and risks of feeding bottles, teats, and pacifiers” World Health Organisation (2022b) which is very different from the original version which recommended “give no artificial teats or pacifier to breastfed infants” (World Health Organisation, 1989, cited in Aryeetey and Dykes, 2018). This may go some way towards addressing concerns of health professionals having a set of “rules” that must be followed (Hunt and Thomson, 2016).

2.6.5 National Breastfeeding Policy

Despite the poor breastfeeding rates across England, there is no National Breastfeeding Strategy. What the UK has, however, is a raft

of smaller measures written into many larger national policies and guidance. These include the laws mentioned earlier (see section 2.7.1) in order to protect the rights of women to breastfeed in public (Breastfeeding etc. (Scotland) Act, 2005; *Equality Act 2010*).

Comparisons with Norway, a close neighbour of the UK are helpful when considering the UK position. Norway has breastfeeding initiation rates of 98% (Ovelsly *et al.*, 2008, cited in Andrews and Knaak, 2013; Andrews, 2022) and at 6 months 80% of babies receive breast milk. Rates of breastfeeding in Norway were low in the mid-20th Century. In the 1960s only 20% of mothers were breastfeeding at 3 months (Grovslien and Gronn, 2009). The increase in breastfeeding to the figures we see today has been attributed to many factors including national policies which have been strong since the 1970s. In 1981 Brundtland became Norway's first woman Prime Minister and held office for 10 years over three terms (New York Times, 2003).

Brundtland was originally a GP who had studied the decline of breastfeeding at Harvard University and her interest in breastfeeding appears to have influenced policy and practice across the country significantly. Norway introduced greater regulation of infant formula milk under food and drug laws (Grovslien and Gronn, 2009, cited in University of Sydney, 2011 p. 70). The country was an early adopter of the Baby Friendly Initiative. In 1999 a National Breastfeeding Co-ordinator role was established at the National Breastfeeding Centre at Oslo University (The University of Sydney, 2011, p. 72). This is now known as the National Breastfeeding Resource Centre. National

policies such as the *Action Plan for Better Nutrition (2007-2011)* with its main objective of increasing the rates of exclusive breastfeeding, continue to keep breastfeeding a priority for the Government (The University of Sydney, 2011, p.71). The country's focus is to increase the number of women who are exclusive breastfeeding at 6 months (Mason, Rawe and Wright, 2013 p. 12).

A national breastfeeding helpline and breastfeeding awareness week are two practical examples of support which have had varied success. The Department of Health provide some funding for the National Breastfeeding Helpline. It is staffed by volunteers from The Breastfeeding Network and Association of Breastfeeding Mothers (The Breastfeeding Network, 2021). In a review Thomson and Crossland (2013, p. 1) concluded that:

“callers valued the opportunity for accessible, targeted, non-judgmental and convenient support. Whilst the telephone support did not necessarily influence women's breastfeeding decisions, the support they received left them feeling reassured, confident and more determined to continue breastfeeding.”

This service is a valuable resource for breastfeeding women, however in their review, Thomson and Crossland (2013) do suggest further publicity is required to make the service more well-known.

A National Breastfeeding Awareness week has been promoting breastfeeding since 1993. The Government provided branded publicity material which was used by local health professionals and community services to promote breastfeeding. However, from 2011

the Coalition Government, who came into power in May 2010, removed funding for this initiative and the campaign no longer receives central funds or co-ordination from the Department of Health (Boseley, 2011; Boffey, 2013). The 2021 theme was focussed on the support provided from friends and family. The National Breastfeeding Awareness week has helped to promote breastfeeding. However, its impact has always been limited, due to the small amount of funding it received from central government (Boseley, 2011; Davis, 2018). The impact of any breastfeeding awareness event is shadowed by the millions spent on formula advertising each year. Small scale awareness campaigns continue to be held, however without a national campaign behind it the results may be limited. Silverton (2013), the Royal College of Midwives' director of midwifery claims that:

“Breastfeeding is no longer a public health issue. Under the previous Government there was a ten year infant feeding strategy, but there is no such framework and foundation now. There is now a lack of health promotion about breastfeeding. There is no longer a national breastfeeding co-ordinator to co-ordinate the country's strategy or national strategy, while Wales and Scotland have strategies. Indeed, this government is 'hands off' regarding breastfeeding.”

Rates of breastfeeding are increasing across the UK. However, Simpson, *et al.*, (2019) suggest this is due to the changing demographics of mothers. They argue that as first-time mothers are getting older, they move into the group of women who demographically would be more likely to breastfeed. Simpson *et al.*, (2019, p. 12) suggest that there has been:

“a persistence of sociodemographic inequalities in breastfeeding initiation between groups of mothers in GB from 1985 to 2010. These inequalities were hidden among the increasing rate of breastfeeding initiation at the population level. This increasing rate was most likely driven by the increasing prevalence in the childbearing population of those groups of mothers who are consistently most likely to breastfeed. Consequently, the needs of mothers who are least likely to initiate breastfeeding—younger mothers, those with less education, those from lower socioeconomic groups and those of white ethnicity—may have gone unmet by general population-based approaches to support breastfeeding.”

This means that in areas such as where I lived, worked and now research, women who have no intention to breastfeed may be missed as targets of public health campaigns and are subsequently unable to make an informed decision or choice about how to feed their babies. It is therefore important that alongside research and health campaigns focussed on increasing breastfeeding duration, research and breastfeeding interventions are focused in geographical areas where mothers are least likely to breastfeed to address this breastfeeding inequality. The First 1001 Critical Days Best Start for Life programme (HM Government, 2021, p. 67) brings the promise of a renewed emphasis on early years services including Family Hubs designed to support and provide information for families.

2.6.6 Maternity, Work and Study

According to Mason, Rawe and Wright (2013, p. viii), there are three areas which need to be considered in terms of national policy to support a “woman’s ability to breastfeed:

1. Maternity leave
2. Financial protection to help maintain the family's income while the mother is not working
3. Workplace provisions to allow breastfeeding to continue once a mother returns to work”

Mothers in the UK are entitled to 52 weeks maternity leave with statutory maternity pay being paid for 39 weeks (HM Government, 2022a). The first nine weeks of this is paid at 90% of the woman's pay with the rest being “£151.97 or 90% of...average weekly earnings (whichever is lower)” (HM Government, 2022a). Women may also receive additional payments from their employer, depending on the type and size of the organisation. The amount of maternity pay received therefore depends on the women's circumstances, for example self-employed sole traders do not receive any statutory maternity pay (Citizens Advice, 2022). Maternity leave supports women to breastfeed, however the amount of maternity leave provided across individual countries varies, Mason, Rawe and Wright (2013, p. viii) suggest that most low-income countries do not come close to the suggested, “18 weeks' leave with at least two-thirds pay”, Grovslie and Gronn (2009, p. 206) report on the practices that have helped to increase rates of breastfeeding in Norway:

“maternity leave has increased gradually as the breastfeeding rate has increased. Today a mother can stay home for 12 months with 80% of her usual income or for 10 months with 100% income. Mothers also have the right to take time off to breastfeed when they go back to work.”

Maternity leave provision in Norway is clearly better than that provided in the UK. New Shared Parental Leave policies which allow both children's parents to take leave have recently come into force in the UK (HM Government, 2022b). Research suggests that this could have a negative impact on exclusive breastfeeding if employers are not fully equipped to support mothers when they return to work (Gheyoh Ndzi, 2019).

As discussed earlier, maternity leave may not completely replace a mother's salary. Mason, Rawe and Wright (2013, p. 23) suggest that:

“Financial support from the state that helps a mother to maintain the family's income level during the early months of her child's life can alleviate some of the pressure to return to work immediately. This support normally comes in the form of maternity pay or benefits but can also take the form of state grants to enable breastfeeding.”

Pregnant women and families with children under four may qualify for funding through a means tested scheme known as Healthy Start. This scheme provides £4.25 per week (£8.50 if the child is under one) and can be used to purchase milk, plain fresh or frozen vegetables and infant formula milk. This milk must be based on cow's milk and suitable from birth. Free vitamins for women and children are also included as part of the scheme. Healthy start replaced the Welfare Food Scheme in November 2006, following trials in Devon and Cornwall. The Welfare Food Scheme had been introduced in 1940, during World War 2 due to food shortages. One of the reasons given for the change was that the Welfare Food Scheme was seen as a

disadvantage to breastfeeding. As part of the scheme, infant formula was distributed from NHS clinics and it was thought this could give mixed messages about feeding choices. Take up for the Welfare Food Scheme was however almost 100% as mothers were issued with voucher automatically (Citizens Advice Bureau, 2006). The Healthy Start scheme is much superior to the previous scheme as it does not normalise formula feeding the way the Welfare Food Scheme did. However, the paperwork that families must complete may be seen as a barrier to some and it could have an impact on its uptake.

Going back to work is often cited as being a reason why many women stop breastfeeding (Kimbrow, 2006). The Health and Safety Executive suggest that employers provide a “private, healthy and safe environment for mothers to express and store milk” although this is not law. However, employers are required, by law, to provide somewhere for breastfeeding and pregnant mothers to rest and that “the rest area should include somewhere for them to lie down” (Health and Safety Executive, no date). Many employers do provide additional facilities for breastfeeding mothers. Hawkins *et al.*, (2007, p. 893) found that employees with employers who “offered family-friendly or flexible work arrangements were more likely to” breastfeed for longer. Mason, Rawe and Wright (2013) suggest that

“once a mother returns to work, there must be policies in place that require employers to provide paid breaks and private places where women can breastfeed or express milk so that they are able to continue breastfeeding.”

In Norway, employees of the public service are entitled to paid breastfeeding breaks of up to two hours per day, other Norwegian women are allowed to take breaks for “half an hour twice a day to breastfeed” however this is unpaid (University of Sydney, 2011). Policies like this in England would most certainly help women to continue to breastfeed once they have returned to work.

Returning to or continuing with Higher Education raises challenges for mothers who breastfeed. West *et al.* (2017) suggest that although a lot of research has focused on breastfeeding at work, there is a lack of research surrounding breastfeeding in Higher Education. Burns and Triandafilidis (2019) found that breastfeeding mothers who returned to both work and study found difficulty in negotiating their roles of both good mother and good worker. This is also described by Moreau and Kerner (2015) who suggest one way mothers reconcile this dual identity is by considering that their studies will lead them to ‘better parent’ status in the future.

West *et al.* (2017) identified that one of the major barriers to breastfeeding at university included a lack of designated space to breastfeed or express breast milk, which resulted in some participants using formula once returning to their studies and the mothers feeling isolated and vulnerable. Hentges and Pilot (2021) found that even when specific rooms were made available for breastfeeding mothers at university, gaining access to locked rooms and searching for keys

made this experience more difficult than it could have been. Students from a Canadian university reflected on being able to bring infants into class (West et al., 2017) however the student mothers felt uncomfortable and anxious about disrupting their peers. Onsite childcare facilities are suggested to support breastfeeding mothers who work or study in Higher Education (Burns and Triandafilidis, 2019).

2.6.7 Social Media

The use of social media as a form of breastfeeding support has been found to be positive in terms of mental health with women reporting that it can help to increase confidence (Black, McLaughlin and Giles, 2020) support emotional wellbeing (Morse and Brown, 2022) and provide reassurance in contrast to the judgement and isolation they perceive from other parts of society (Jackson and Hallam, 2021). However, social media usage has also been associated with more negative emotions and mothers have reported feeling judged when they began to use infant formula (Regan and Brown, 2019, p. 2) and being excluded from groups due to “polarised debate” (Regan and Brown, 2019, p. 7; Morse and Brown, 2022).

The data collection for this research was carried out in 2014 and 2015 so it is important to put the use of social media into context at this time and further discussion around the role of social media today can be found in Chapter 9. Facebook (2022) was being used in 2015 but

newer social media sites like Instagram were just becoming established and TikTok did not exist (Statista, 2022; Schwedel, 2018). One social media site that was popular at the time and continues to be is mumsnet (2022) who claim to be “the UK’s biggest network for parents, with around 7 million visitors a month”. Boyer (2018) used mumsnet as one of four sites of data collection for her research, and although the focus of this was to consider the role of breastfeeding in public she argues that “community bulletin-boards” like mumsnet are important for mothers to learn and discuss shared experiences. Her findings suggest mothers find mumsnet a supportive environment where conversations were shaped by the reaction of others. Pederson (2021) suggests that mumsnet is a place where feminist and political ideas can be discussed, including issues that can be seen to be difficult and controversial in other spaces, including issues around breastfeeding in public. She argues that “mumsnet has been attacked by some for allowing such conversations to happen and praised by others for its commitment to a policy of freedom of speech” (Pederson 2021).

2.7 Macrosystem (Wider Ideological Context)

Maconochie and Fitzgerald suggest that the macrosystem, “is embedded in the cultural values and [includes] the impact of government policies” (2018). In terms of infant feeding, this layer of influence contains the dominant narratives discussed in Chapter 1, including Breast is Best. Alongside this are perceptions of the breast

itself as being sexualised, and the way breast milk is perceived as being a dirty fluid. Issues around attitudes towards feeding older children are also included in this system.

2.7.1 Dominant Narratives: Breast is Best

The dominant narrative of Breast is Best (Palmer, 2009) has been discussed in detail in the introduction to this thesis. This narrative suggest that breastfeeding is the best and preferred way for babies to be fed and has been validated by a range of people across society (Lee, 2008). The dominant Breast is Best narrative divides women into two binary groups of breast and formula feeders when previous discussion shows that the situation is much more complex. The continued use of Breast is Best divides mothers into groups who are seen to be doing their 'best' by breastfeeding and others who may be incorrectly perceived as falling short in their responsibilities.

2.7.2 Perceptions of the Breast

Breasts and breast milk are perceived by society in a way that is different to their primary biological purpose. Breasts are seen as sexual objects (Dettwyler, 1995; Lavender, McFadden and Baker, 2006, p. 152; Brouwer, Drummond and Willis, Amir, 2014) and the product of the breast, breast milk is seen as a dirty fluid, or a waste product (McFadden and Toole, 2006; Battersby, 2007; Amir, 2014).

These narratives sit alongside other narratives which dictate how long

it is appropriate to breastfeed (McConville, 1994; Dowling and Pontin, 2017; Andrews, 2022).

One of the reasons breastfeeding in public is seen as taboo is because of the sexualisation of breasts in UK society, and as many women, as well as men, think the primary, if not the only function of the human breast is for sexual pleasure (Dettwyler, 1995; Lavender, McFadden and Baker, 2006, p. 152; Brouwer, Drummond and Willis, 2012; Amir, 2014). Dettwyler (1995, p. 174) suggests that it is assumed that “breastfeeding feeding, like sex, is appropriate only when done in private”. Dettwyler (1995, p. 202) argues that the involvement of breasts in human sexual behaviour is not wrong, but it is a “learned behaviour” and one that is learned in a particular cultural context. Brown (2021a, p. 242) suggests that:

“it is likely that some women have been so socially conditioned to view their own body in terms of sexual attraction that they feel that others using their body must be performing a sexual act”

This socially constructed, dual purpose of the breast for both sex and for feeding babies can therefore create challenges for women who need to feed their babies away from the privacy of their own home.

The act of breastfeeding has been described by some as embarrassing and disgusting (Hoddinott and Pill, 1999), with this suggested as discouraging its uptake. In Northern Ireland, Greene, Stewart-Knox and Wright (2002, p. 60) found that 56% of their 419

teenage participants said they would feel embarrassed if they “saw a woman breastfeeding in a public place.” Furthermore, 75% of the teenagers said they would “pretend not to see” (Greene, Stewart-Knox and Wright, 2002, p. 60). Earle (2002, p, 212), who interviewed first time mothers in the West Midlands, aged between 16 and 30, revealed that some of the mothers there also saw breastfeeding as “embarrassing, disgusting and inconvenient”. Although these mothers still agreed that Breast is Best (Earle, 2002) these comments suggest that the way breasts have been sexualised may continue to have consequences for breastfeeding rates of future generations.

Breast milk itself has also been referred to as a “dirty” bodily fluid (Battersby, 2007, p. 102) which makes it difficult for some to deal with when in the company of others. Amir (2014, p. 1) suggests there is a conflict between breast milk being seen as a waste product like “genital secretions and vomit” or as “pure (like tears)”. McFadden and Toole (2006, p. 163) also discuss the notion that breast milk can be seen as a “disgusting” bodily fluid, with the father of one of the women in their study referring to it as “muck”. Battersby (2007, p. 103) describes how sometimes women’s breasts may leak unexpectedly and may stain their clothing, suggesting that:

“this situation may cause distress and embarrassment to the women because she and others may perceived her body as out of control, and observers may feel disgusted by the visible evidence”

This is not a new issue; in 1989 Kitzinger suggested that “breast milk has long been associated with excretion. It is thought of as an unclean fluid” (Kitzinger, 1989 cited in McConville, 2004, p. 82). The suggestion that breast milk may be seen as an out of control, unclean body fluid, or matter which is out of place (Douglas, 2005) may provide some explanation as to why women who breastfeed are often signposted to toilets to feed their babies (Morse, 1990; Stearns, 1999; Bartlett, 2002; McFadden and Toole, 2006; Grant, 2016; Morris *et al.*, 2016; Whiley, Stutterheim and Grandy, 2020) and why breastfeeding rooms are often co-located with public toilets (Boyer, 2012).

The length of time women are seen to be feeding their children is another important issue that fits in the macrosystem. The UK follows the advice of the World Health Organisation and the United Nations Children's Fund (WHO and UNICEF) (2003) in that it is recommended that children are breastfed until they are two years old:

“... infants should be exclusively breastfed for the first six months of life to achieve optimum growth, development and health. Thereafter to meet their evolving nutritional requirements, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age and beyond”

McConville (1994, p. 85) suggests that it is mothers who feed their older children who face the most disapproval from society. Remple (2004, p. 306) found that women “perceived less approval for breastfeeding the longer they breastfed”. Dowling and Pontin (2017, p. 67) found that women who breastfed older children were happy to do

so but carefully considered the way they were positioned and avoided eye contact as they became increasingly aware of the “potential reaction” of others. Drawing from the work of Douglas (2005), Andrews (2022, p. 55) suggests that breastmilk “changes symbolic character – from pure to impure – when the child reaches a certain age”.

2.8 Chronosystem (History of Infant Feeding)

The chronosystem was added to the ecological systems theory later than the original systems. Maconochie and Fitzgerald (2018) suggest that this system considers the “impact of patterns or time events in a child’s life”. This literature review revealed research about how historical infant feeding practice has an influence on families.

2.8.1 Infant Feeding Practice Over Time

Research suggests that women who have been breastfed are more likely to breastfeed their own children (Fitzpatrick, Fitzpatrick and Darling, 1994; Negin *et al.*, 2016). In the past, women could rely on their mothers and female friends and relatives to pass down the “wisdom and experience” (Muller *et al.*, 2009) of previous generations and offer practical support about breastfeeding. As discussed earlier, grandmothers and have a significant role to play in providing support for breastfeeding, however this can prove difficult if they have not breastfed or have little knowledge of breastfeeding practice.

Previous research has identified the way advice from grandparents, based on their experience from the past is not always helpful as childcare advice has changed and grandparents may be unaware of current recommendations (Dykes and Griffiths, 1998; Lupton and Whelan, 1998). Previous research also suggests that grandmothers can become frustrated with changing parenting practice (Lupton and Whelan, 1998; Grassley and Eschiti, 2011) when it feels as though their tried and tested practice is dismissed.

2.9 Chapter Summary

This chapter has demonstrated the complex nature of issues around infant feeding, beginning with the individual mother and child, and questioning whether or not women make a conscious choice (Hoddinott *et al.*, 2012; McInnes *et al.*, 2013). The ecological view (Bronfenbrenner, 1979) captures the range of spaces which influence health behaviour. The literature suggests that women often make choices about infant feeding practice either during pregnancy or before they are pregnant, and that choice may be unconscious (Hoddinott *et al.*, 2012; McInnes *et al.*, 2013) and determined by local culture rather than as a response to public health campaigns. Further research would be useful in order that health professionals can understand more about the families they are working with, to support relationships and ultimately support women to make decisions that are right for them at the time (Hunt, Thomson, Whittaker and Dykes (2021). This may be breastfeeding or feeding with infant formula.

Public health teams also need to be aware of the influence of local culture and injustices including poverty, status and class (Hall Smith, 2018) in order for their campaigns to reach women in the more deprived areas of the UK to respond to this breastfeeding inequality. Before considering the factors that may influence a woman's infant feeding practice, it is useful to begin with the women herself.

Despite the *Equality Act 2010*, protecting the rights of breastfeeding mothers and babies, breastfeeding in public spaces continues to be a debated issue (Sheeshka *et al.*, 2001; McFadden and Toole, 2006; Meedyia *et al.*, 2010; Amir, 2014). Research shows that women can feel apprehensive about breastfeeding their babies away from home (McFadden and Toole, 2006), particularly if the child is older (Remple, 2004). Some of this anticipation can be attributed to the way breasts are represented as sexual objects in society (Dettwyler, 1995; Lavender, McFadden and Baker, 2006; Dykes, 2007; Brouwer, Drummond and Willis, 2012; Amir, 2014) as well as the portrayal of breast milk as a dirty fluid (McFadden and Toole, 2006; Battersby, 2007). Amir (2014, p. 3) argues that making breastfeeding more visible would have a positive impact on breastfeeding initiation and continuation rates. Research shows however that this remains difficult as women experiencing shame “through feelings of fear, humiliation, inferiority and inadequacy” (Thomson, Ebisch-Burton and Flacking, 2015, p.37) can withdraw from society.

Breastfeeding policy and practice in the UK is a mixed picture. Many of the influences are positive, such as the Healthy Start Scheme (HM Government, 2017), the International Code of Breastmilk Substitutes (UNICEF, no date b) and the Baby Friendly Initiative (UNICEF, no date a). However, many do not go far enough and could benefit from revision to make a real difference to breastfeeding rates across England. The Health and Safety Executive laws (Health and Safety Executive, no date) intended to support breastfeeding mothers are weak and a more specific law around breastfeeding in public that replaces the less well known *Equality Act 2010*, would also help to increase the number of women who breastfeed for longer.

Brown (2021) stresses that additional support for all mothers would support an increase in the rates of breastfeeding. She calls for more practical and emotional support for mothers whether they breastfeed or not. As can be seen by the example of breastfeeding practices in Norway (Andrews, 2022) more could be done to make a difference to the rates in England. However, rates have been low for a long time so this is not an easy task to undertake. The First 1001 Critical Days Best Start for Life programme (HM Government, 2021, p. 46) call for breastfeeding support groups and peer networks to be part of the Universal offer which may help to address some of the breastfeeding inequalities.

The review of the literature identifies areas that are worthy of study, and which have not been answered fully by previous research. This includes a focus on women who formula feed in areas where rates of breastfeeding are low as they are not well represented in literature. The issues around choice and decision making are also an interesting focus as well as the design of the research to prevent any further feelings of shame, judgment and guilt in mothers (Lee, 2008; Taylor and Wallace, 2012; Jackson *et al.*, 2021; Brown 2021a). An exploration of how infant feeding narratives are present in women's lives and what impact these narratives have on women's decisions within local communities is required.

Chapter 3: Methodology

3.1 Introduction

This chapter provides a justification for the methodological approach adopted for the study. It begins by stating the overall aim and research questions. Then, the decisions made in terms of ontology, epistemology and methodology are considered. A discussion around the use of stories, which underpins this work, is presented, before moving on to consider why a biographical narrative methodology was chosen to explore infant feeding in this particular area of the UK. The chapter concludes with a discussion of ethical considerations.

3.2 Research Aim and Research Questions

The aim of this research was to explore the infant feeding practices of women who live in an area of the North-East of England with low rates of breastfeeding, to better understand their experiences. It addressed the following research questions:

- 1, What stories are women telling about their infant feeding practice?
- 2, How are infant feeding stories passed through generations and across friendship groups?
- 3, How do infant feeding stories influence the initiation and experience of breastfeeding?

3.3 Interpretivist Paradigm

This research has been carried out through an interpretivist paradigm.

A paradigm, or worldview, provides a lens through which research is undertaken and includes ontological, epistemological, and methodological views (Crotty, 1998).

3.4 Ontology

Ontology is the study of reality or the study of being (Gilbert, 2008, p. 138; Gray, 2014, p. 19). It is an important part of the research paradigm as within this, researchers are required to consider what reality is and how it is understood for their specific research context. Ontologically, interpretivists view the world as holding no objective truth or set of universal laws which are waiting to be discovered (Gilbert, 2008, p. 138). Instead, the interpretivist approach “looks for culturally derived and historically situated interpretations of the social life-world” (Crotty, 1998, p. 67). It is focused on “how the social world is interpreted by those involved in it” (Robson, 2011, p. 24) and suggests there are multiple realities that depend on individuals’ experiences, beliefs and understanding. In my research, a culturally situated approach aimed to understand how women who live in an area described as disadvantaged in the North-East of England make sense of their infant feeding decisions and experiences.

3.5 Epistemology

Epistemology is the study of knowledge. It is concerned with what knowledge is, how we know things and how we gain knowledge (Gilbert, 2008, p. 138). Epistemologically, the Interpretivist paradigm assumes “that meanings are produced and exchanged in interpretative processes” (Flick, 2015, p. 24). Interpretivism began with the work of Max Weber who suggests that “in the human sciences we are concerned with *Verstehen* (understanding)” (Crotty, 1998, p. 67). Weber suggests that researchers should focus on interpreting the cultural meaning behind norms, symbols and values. Interpretivism involves learning about what participants think and interpreting contextual cultural meanings within each social group. The social world is understood to be complex and multi-faceted, with layers of meaning. This research has been carried out based on an understanding of the socially constructed nature of reality. Schütze (1962, p. 5) suggests that:

“Strictly speaking there are no such things as facts pure and simple. All facts are from the outset selected from a universal context by the activities of our mind. There are, therefore, always interpreted facts, either facts looked at as detached from their context by an artificial abstraction or facts considered in their particular setting. In either case they carry along their interpretational inner and outer horizon.”

This interpretivist approach incorporates the concept of social construction. Flick (2015, p. 25) argues that “the contents of knowledge are constructed in a process of active production. Facts only become relevant through their meaning and interpretation” (Flick, 2015, p. 25). Interpretivists explore the subjective meaning making of

individuals. Meaning is centrally important to interpretivism as it is considered that meaning is made through language and context. This makes interpretivism an appropriate choice in research with people and culture which is concerned with the role of stories in a specific geographical context.

In contrast to interpretivism, a positivistic paradigm assumes that there is only one, objectively verifiable, observable, or measurable reality (Silverman, 2000, p. 5). Positivism was the “dominant epistemological paradigm in social science until the 1960s” (Gray, 2014). With a positivist view, facts are treated as objectively true and understood through scientific research, with the aim of producing generalisable knowledge (Silverman, 2000, p. 10). Interpretivists analytically interpret meanings of findings, whereas positivists believe that researchers discover or observe objective truths. Approaching this research from a positivistic paradigm would have resulted in the women’s stories being discredited as subjective and therefore deemed to be unreliable. Taking an interpretivist approach means that there is an understanding that there is no objective knowledge waiting to be discovered and that participants’ subjective views are valued.

A common reason mothers provide for giving up breastfeeding is that they could not produce enough milk for their babies (McFadden and Toole, 2006). Positivist research would suggest that this is subjective, likely to be untrue and nothing more than a cultural myth. While we could still argue that this is the case; for the purposes of this

interpretivist research this is not an issue. Whether the mother's story is objectively or scientifically true or not is of little concern. Either way, this is the meaning she has made of the situation, and this is the story she may pass to her friends and family. As Riessman (1993, p. 15) suggests, "although the goal may be to tell the whole truth, our narratives about others narratives are our wordly creations". The stories that women believe to be true are the stories which may be passed to others and may influence their own and others' decision making.

The interpretive paradigm also appreciates that researchers influence the research process, so findings are co-constructed (Salmon and Riessman (2013, p. 199). It is important for researchers to be aware of this and to consider their own positionality. An approach which allowed me to pay attention to this positionality was important. The benefit of this approach was that it enabled me to reflect on how the mothers constructed their stories, supporting their preferred identities in relation to me as their audience.

3.6 My Positionality

Following the discussion around my positionality in the introduction to this thesis, there were two key issues I considered in terms of my positionality at the recruitment stage. They were, not sharing my own personal story and avoiding being perceived as a health professional.

I did not share my own infant feeding story with the participants until the end of each interview. I felt that sharing my own infant feeding story with the women may influence the story they told me. The “Hawthorne Effect” (Payne and Payne, 2004) was a factor in this consideration as I was keen to avoid encouraging women to tell me what they thought I wanted to hear. At times, I found it difficult not to speak personally to each mother before the interview about my own experiences. On one occasion I recruited all three members of a group to the research. I had to explicitly inform the group that I was not allowed to discuss my personal experiences with them as they began to ask more and more questions. They did however accept and understand my explanation. Avoiding telling my story at this point also avoided the participants relying on my story as a “narrative type” (Frank, 2013) and providing a framework for their own story or inadvertently introducing issues around the dominant and counter narratives which may or may not have an impact on their lives.

The second issue I was conscious of was to make sure the participants did not mistake me for a health professional. I was aware from my previous employment that some mothers did not disclose certain things to their health visitors, their official stories being different to their private accounts (Cornwell, 1984) so I was keen to make sure the participants did not believe me to be a health professional. Here, I was very much aware of my role as a “Consumer” (Plummer, 1995, p. 21) of each story. Riessman (1993, p. 11) would suggest that this is

important as a story “might have taken a different form if someone else were the listener”. I was particularly concerned about the validity of the data, and that being perceived as a health professional may restrict participants’ retelling of the story, in that they may exaggerate breastfeeding duration or withhold stories about potential issues with health professionals. McFadden and Toole (2006, p. 165) were also aware of this and acknowledged that in their study one of the researchers was known to some of the women and recognised that the participants may have been “aware of her enthusiasm for breastfeeding”. I replaced my NHS breastfeeding lanyard for another which was plain with no logo.

I am also aware that avoiding being seen as a health practitioner may not necessarily have totally neutralised my position and therefore participants may have adapted or exaggerated their stories in other ways given their perception of me as closer to themselves. As described earlier, getting to an absolute objective truth of the stories is not the purpose of this research. This study is interested in the ways that the women’s stories were used to construct subjective meaning out of their experiences, and how these stories functioned to reinforce certain beliefs and practices within the local community.

A method I had considered using in the early stages of the research planning was the use of genograms in a similar way to those used by Darwent (2015) and Darwent, McInnes and Swanson (2016) to help

focus conversations on the intergenerational nature of infant feeding practice. However, it was also considered that the use of genograms as the first activity in the research process could impact upon the relationship between myself as the researcher and the participant and create some issues with power dynamics. As a researcher, I had very limited knowledge of the participants prior to the interview. It was a concern that creating a family tree together would almost force the participant to include and discuss family members which could bring back difficult memories. Creating a family tree may inadvertently cause a participant to feel shame or embarrassment. Alternatively, the participants could spend time talking about individuals who were not particularly significant in their feeding story. With the use of a biographical narrative approach, participants choose what and who they talk about and as will be discussed further later in the thesis, this generated important and unique insights into the relative absence of some family members (namely fathers) in breastfeeding stories.

Upon reflection, I feel that by considering my position, I am actually selecting my own "Front" (Goffman, 1959, p. 32). Goffman might suggest I am impersonating a person of lower status than myself, which he claims is an acceptable thing to do, while claiming a higher status is not (Goffman, 1959, p. 42). This may be seen as being inauthentic and perhaps deceitful. The truth is that I felt and still feel positioned between two identities. The first being a woman from a working-class background and the second a University academic. The

Front I chose at the time of the interview was the one I was, and still am, most comfortable with; that of a working-class woman from the local area. I believe that using this Front helped the participants to feel more comfortable during the interview process. On one occasion, Amy voiced this, by including me on her side of a debate about Government “policy makers”:

‘so I think that’s just stupid, the people who are writing this are probably, they’re probably rich and have got nannies and stuff to make up the bottles for them their not living in the real world and understanding normal people like us if we’ve got another three kids running around, and then you’ve got one toddler drawing on your wall and you’ve got someone upstairs you know trying to drink the toilet water.’ (Amy)

Amy was the first participant to tell me her story and her words reassured me that I had made good methodological choices. Other participants such as Becky used quite a lot of phrases that seemed to draw me alongside her position and into her argument.

Becky: but just you know [health professionals] don’t give first time mothers the credit isn’t it? the just brush you off straight away
Justine: right, ok, so they brushed you off?
Becky: argh yeah
Justine: what did you think, did you have other ideas? did you know?
Becky: I, I had a feeling you know when something is not right and I’m a [childcare professional] as well so I’ve fed kids before
Justine: right, right
Becky: I know when things aren’t normal do you know what I mean
Justine: mhh, mhh
Becky: or not the norm should I say and erm (2sec) but yeah the just, the looks that you get (4sec)
Justine: ok
Becky: you’ve just got to beat the system don’t you when you’re a first time mother

Becky's talk included lots of moments in which she appeared to reassure herself that we were indeed, like-minded.

3.7 Stories and Narrative

A narrative interpretative approach focussing on women's stories felt like an obvious choice for this research from the beginning. Plummer in 1995, described the emerging interest in the use of stories and narratives as a cross-disciplinary research methodology, referring to a much quoted "narrative moment" in time (Plummer, 1995, p. 18). We make sense of the world through stories, and they help individuals create identities (Frank, 2013). We also communicate with each other through stories (White, 1980; Polkinghorne, 1988; Bruner, 2004). It therefore makes sense to research human experience through stories. A wide range of issues, across many disciplines, have been researched with the use of a narrative approach, such as health, diaspora and culture (Riessman, 1993, p. 1; Plummer, 1995, p. 18; Rosenthal, 2007). Harrington (2008, p. 24) defines a story as "living, local and specific" and narrative as "templates" that "provide us with the tropes and plotlines that help us understand the larger import of specific stories we hear, read, or see in action". This distinction has been applied to this thesis.

It is suggested that "telling stories about past events seems to be a universal human activity..." (Riessman, 1993, p. 3). Carter (1995, p. 200) suggests that "feeding stories exist not only because women can

readily recall events which are important to them, but because they need a feeding story to tell, polish up and tell again". The moral imperative around breastfeeding creates a need for women to give accounts of their identities and infant feeding practices. Infant feeding stories are believed to be used by women to defend themselves and explain themselves as women and mothers (Carter, 1995, p. 200). The stories may be used to justify mothers' actions. Mothers may reconstruct events to "claim their identity" (Riessman, 1993, p. 2) and "restore equilibrium" (Ryan, Bissell and Alexander, 2010, p. 952) returning their status to that of the moral position they held prior to infant feeding experiences which may have damaged their identity.

To begin to consider the way stories help shape and construct meaning, it is important to examine how stories are constructed. The material presented here has been used to support the analysis of the data, particularly in Chapter 8. Labov and Waletzky (1967) considered the linguistic features of African American Vernacular English in New York in the 1960s. From this work, they argued that stories could be broken down into clauses, which have particular functions. They argued that these clauses (Table 3.1) are ordered within a story, in a particular and familiar sequence. Labov defines a narrative as two or more of these clauses, which follow each other in a narrative sequence (Labov, 1972, p. 360). This definition emphasises the temporal ordering of events and that events happen over time.

Table 3.1 Narrative Sequence

Narrative Element	Definition
Abstract (A)	A summary: what the narrative is going to be about.
Orientation (O)	Any relevant background, such as time, place, situation or participants.
Complicating Action (CA)	The sequence of events: something which disturbs the normal.
Evaluation (E)	The significance and meaning given to the narrative.
Resolution (R)	What finally happened.
Coda (C)	The end of the narrative, which returns the perspective to the present.

Adapted from Labov and Waletzky (1967).

In his 1995 work, *The Wounded Storyteller*, Frank suggests that stories of ill health fit into pre-existing narrative types, and that people follow pre-existing culturally preferred plot lines. In this work, Frank identified three main narrative types, namely restitution, chaos and quest (Frank, 2010; 2013). The restitution narrative comprises a story with a beginning, a middle and an end, very much like the order of Labov and Waletzky's (1967) Narrative Sequence. Frank's restitution narrative (2010; 2013) consists of an individual who can bring a significant Complicating Action of ill health or disease to a positive, restorative conclusion. This restores the person's identity to that of a well person or even improves their identity to that of a survivor or hero. In Frank's (2013, p. 97) chaos narrative, stories are told without order or a "coherent sequence". Frank suggests these stories are hard to hear due to their lack of order so therefore can cause anxiety to the consumer. The quest narrative raises the profile of the producer of the story to that of a hero (Frank, 2013, p. 134) a person who has "risen above illness" (Frank, 2013, p. 135).

In *The Wounded Storyteller*, Frank describes how, “the stories we tell about our lives are not necessarily those lives as they were lived, but these stories become our experiences of those lives” (Frank, 2013, p. 22). He describes the way people’s stories of ill health can change and start to incorporate some of the medical information heard during treatment, to produce a new version of the story which incorporates both the person’s story and the medical discourse. This means that a women’s infant feeding story may be different at different points in her life. Frank (2013, p. 22) warns researchers that “the social scientific notion of reliability...does not fit here”, and the ways that stories may change over time forms a potential object of study.

The meaning of stories can also change depending on the context in which they are told. Bergmann (1985 cited in Matt, 2004, p. 327) suggests that “every narrative ‘as it really was’ is a construction for specific purposes and for a specific audience, and never a mere reproduction”. A person telling a story about a situation may provide slightly different versions of events, depending on who the consumer of the story is (Plummer 1995, p. 23).

3.8 A Narrative Approach

There is no “one size fits all” approach to narrative research (Riessman, 1993, p. 54; Plummer, 1995; Frank, 2010). Riessman (2008, p. 186) suggests there “is no canon, that is formal rules or standardized technical procedure for validation” in narrative research.

Riessman (2008, p. 186) suggests that instead, “students in the social sciences have to make arrangements to persuade audiences about the trustworthiness of their data and interpretations”. The methods used in narrative research are different in terms of data collection as well as the way narrative interviews are analysed. Riessman (2008) categorises the way narrative research is analysed into four types: thematic; structural; dialogical or performative; and visual. Riessman suggests that a Thematic analysis (Riessman 2008, p. 73) is generally concerned with what a narrative communicates. Structural analysis (Riessman 2008, p. 77) considers how the story is told to “persuade” a listener that a sequence of events “really happened”. Dialogical or Performative analysis addresses not only the participants speech, but other components such as the environment and historical and cultural context (Riessman, 2008, p. 137). Finally, Visual analysis is used to analyse “words and images from different visual genres (photography, painting, collage, and video diary)” (Riessman, 2008, p. 141). The Biographical narrative analysis approach taken lends itself to the first three of these approaches, although as will be discussed in Section 4.11, it was difficult to analyse the “story told” (how the person chooses to tell their story) alongside other components of the “lived life” (what happened) (Riessman, 1993).

3.9 Biographical Narrative

Biographical narrative interviews as a method for data collection were first used in the 1970s by the German sociologist Schütze (1992) and

have increased in popularity since. Wengraf and Chamberlayne developed the Biographical Narrative Interpretative Method (BNIM) in the 1990s (Wengraf, 2014) which has become a popular method in research across a range of disciplines, taken forward by Wengraf. Using a biographical narrative research methodology involves eliciting the stories of participants and listening to their subjective experiences (Rosenthal, 2007). These subjective views are then analysed alongside the context in which they are told, to determine subjective meaning. This method “allows sociologists to uncover how people give subjective meaning to their life experiences” (Schütze, 1932 cited in Denzin, 1989 p. 14). Flick (2018, p. 282) suggests that using a biographical narrative approach gives control to the interviewee in such a way that they might mention “awkward topics and areas” that they may not have mentioned with other methods.

The methodology for my research has been supported by the work of Riessman (1993; 2008), Plummer (1995), Wengraf (2001; 2014), Rosenthal and Fisher-Rosenthal (2004), Rosenthal (2007) and Frank (2010; 2013). While a biographical narrative approach is often used to research a whole life story, it has also been used to focus on one particular part of a person’s life. Hollway and Jefferson (2000, p. 37) prefer an episodic narrative approach, a “free flow narrative” to find out about particular themes within a person’s life story. I chose not to follow any one biographical narrative methodology in its entirety. As part of the biographical narrative analysis process, researchers

compare the analysis of the participant's "lived life" to "the told story", in a "biographical case reconstruction" (Rosenthal and Fisher-Rosenthal, 2004; Rosenthal, 2007; Wengraf 2014) comparing the factual elements of the story with the storied elements around it. This proved to be problematic to carry out within a very focused episodic study around infant feeding, as the number of factual elements were limited. Five additional interviews were carried out with participants to obtain their life stories; however, the infant feeding section of each story was such a small part of their lives, that the case reconstruction proved ineffective. Furthermore, a case study approach was also rejected at this point to maintain participants' anonymity as it was believed that participants may have been known to one another.

The biographical narrative methodology allowed me to ask the participants just one initial question, "generative narrative" (Flick 2018, p. 177) and then listen to their stories without interruption. This methodology permitted me take into account my positionality (Merriam *et al.*, 2001) as well as the potentially contentious subject area known to evoke feeling of shame, judgment and guilt in mothers (Lee, 2008; Taylor and Wallace, 2012; Jackson *et al.*, 2021; Brown 2021a). This approach suited the study well as it appreciated the broader cultural narratives in the local area.

3.10 Responding to the Review of the Literature

The literature review revealed a lack of research with women who had formula fed from birth, with their stories almost missing from the body of research. It was clear that a sensitive approach to the recruitment of women who formula fed from birth was needed.

The literature review revealed that breastfeeding public health campaigns have a tendency to focus on the important issues of increasing the duration of breastfeeding. Peer support programmes also, often emphasise support for women who are facing challenges with breastfeeding, rather than with their initial decision making (The Lancet, 2016). The lack of focus on initiation of breastfeeding is perhaps reflective of the lack of attention in existing research to the experiences of women who have never breastfed and is particularly important for communities who live in an area where breastfeeding is not the norm, as their particular needs may not be recognised. A biographical narrative methodology helps this to be addressed through a non-judgemental approach and the planning and preparation involved before the interview. This includes careful consideration of the word choice for the one initial interview question which is quite unique to the biographical narrative approach.

The literature review revealed that breastfeeding in public can be problematic and is often cited as a reason why women do not breastfeed or stop feeding (Meedya *et al.*, 2010; Amir, 2014;). Again, it was considered that a biographical approach would be useful to help

consider whether breastfeeding in public was a concern for women living in the geographical area, or whether the previous data existed purely because researchers asked women about breastfeeding in public.

3.11 Limitations

This methodology involves participants being able to tell stories about their lives or aspects of their lives. It is acknowledged that a biographical narrative methodology is not suitable for every research study and every participant (Wengraf, 2014). Riessman (2008, p. 25) suggests that “some participants may not want to develop lengthy accounts of experiences with a stranger” and that “the assumption that there is a story wanting to be told can put pressure on participants”. Flick (2018, p. 285) also argues that not everyone can narrate to the same level. These issues were considered in great detail at the very initial stages of the research and as part of the ethics application. A number of my participants were concerned they would have nothing to say, and some said they did not think they would be able to talk for very long. I can be clearly heard responding to this in one of the interviews:

Justine: yeah that’s great you’ve done really well there it’s
 erm 20, 26 minutes
Amy: is it? argh
Justine: it’s great
Amy: I think I’ve just blabbered on
Justine: no it’s good

It was important to prepare the participant for a different type of interview before the interview took place. This enabled me to gain access to aspects of experience which might have been narrated less frequently or had been previously unheard. These actions are analysed in detail in the following chapter.

3.12 Ethical Considerations

Ethical considerations have been prioritised throughout the research process. I am aware of the responsibility I have towards the participants as well as Northumbria University in terms of keeping data confidential, not causing any harm and following University procedures. The Faculty of Health and Life Sciences Research Ethics Review Panel granted ethical approval for the study on 30th June 2014 with an amendment approved on 13th August 2015.

3.12.1 Compliance with the Data Protection Regulations

All information and data gathered during this research was collected and stored in line with the Data Protection Act (1998) which were the regulations in place at the time of the interviews. Data will be destroyed 3 years following the conclusion of the research. This is in line with Northumbria University's (2018) Records Management Policy. The data will only be used by the research team for purposes appropriate to the research question.

According to the Data Protection Act (1998), personal data includes any information, from which a living individual can be identified. The personal data that I have collected includes each participants' telephone number, their postcode, dates of birth, and the number of generations of their family that have lived in the local area. All data has been anonymised and pseudonyms will be used in publications and presentations. Telephone numbers were collected and have been stored on a list of participants, with participants' names and codes in order for interviews to be arranged. By collecting the postcode of the participant, I was able to find out which ward the participant lived in. The area in which the study took place is described in section 1.6. Initially, I had considered completely anonymising this area but realised that, in describing the area characteristics, this would make the location detectable. I have therefore focussed on keeping individual women anonymous while making the location known.

The participants' dates of birth are important as existing research has focused on different practices between younger and older mothers (Meedy, Fahy and Kable, 2010). To further minimise the risk of identification, the participants' month and year of birth only were requested. Although my research question does not focus on the age of the mother, I feel, this information is required as I have been able to compare my results with those of other research projects. This gives this personal data, "a clear purpose" (Data Protection Act, 1998).

Ethnicity was classed as “sensitive data” under the Data Protection Act (1998) and must only be held if absolutely necessary. I have asked each participant to tell me how they would describe their ethnicity at the end of each interview. I also asked participants to disclose how long their families (and previous generations of their families) had lived in the local area in order to ascertain where infant feeding stories had been previously told.

3.12.2 Anonymisation and Storage of Information

As soon as they were recruited to the study, participants details were anonymised using pseudonyms and participant codes. Only the research team (myself and my initial supervisors) have had any access to identifiable information. Details of participants and their corresponding codes were stored in a locked cabinet at Northumbria University’s Coach Lane campus and on the password protected University systems. Interviews and panel meetings (discussed in detail in section 4.10) were audio recorded and then the electronic sound file was transferred to the University system. This took place as soon as possible following the event and the recording was then deleted from the dictation machine. Recordings and notes taken during interviews which may also hold actual names and identifiable information were also stored securely in a locked cabinet at Coach Lane campus and on the password protected University OneDrive. This information will be destroyed 3 years after the end of the

research, in line with Northumbria University's (2018) Records Management Policy.

Research already presented has been anonymised. Any future presentations or publications arising from the research, will be anonymized and pseudonyms will continue to be used.

3.12.3 Audio Clips

Participants were asked as part of the informed consent process, prior to the interview, if they would agree to audio clips from their interviews being used in future presentations. They had the option to decline this request, but still carry on with the interview. Following each interview, I also asked each participant how much of their information they were happy for me to share in this manner and they were asked to complete a Post Interview Consent Form (Appendix B). The four options regarding the use of audio clips given were:

1. Participant has changed their mind and permission to use audio clips has been withdrawn
2. All audio clips can be used by the researcher in any future presentations
3. Audio clips may be used, but participants would like the researcher to contact them before they are used, to gain permission
4. Audio clips from certain sections of the interview can be used. Participants will be asked to describe the issues they do not want to be included.

All the participants were happy for me to use their audio clips in future presentations. One participant however, asked me not to use her

voice in any local presentations for personal reasons which I am unable to disclose. I recorded this request separately, away from the consent form, as the consent form contains the participants signature and could identify the individual alongside the potentially most identifiable part of the interview. The use of audio clips has already been extremely valuable in presenting this research at conferences and for teaching purposes.

3.12.4 Safety of Participants

Although not anticipated, I was prepared for participants becoming distressed during each interview, and ready to draw upon my experience of working with families in a community setting and tailor my response to the individual situation. I have a lot of experience of working with and talking to mothers who are emotionally distressed, however I was fully aware of my role as researcher only in these circumstances and was prepared to signpost participants should the need arise. Gray (2014, p. 406) suggests that if participants become, “anxious or upset during the course of an interview, the session should be immediately abandoned” to avoid any harm or damage to the participant. However, I was ready to follow the example of Corbin and Morse (2003, p. 343), who suggest that a sensitive interviewer will pause the interview “until the participant regains composure”. One participant did cry during her interview, but she insisted on carrying on with her story. At no time did any participant indicate that they would

like to end their interview. None of interviews left the “participant in a distressed state” (Corbin and Morse, 2003, p. 343).

If I felt like a participant would benefit from speaking to a health professional, such as their health visitor or GP, regarding their distress I was prepared to encourage the participant to contact the health professional either immediately (while I was with them) or at a later date. I was also ready, if necessary, to make arrangements to call the participant at a later date to check they had made an appointment or had received some professional support. A Participant Debrief Sheet was given (Appendix C) to participants at the end of each interview which specifically signposted them to their Health Visitor or GP services if they felt they needed to speak to someone about any of the issues they had discussed. This did not happen.

3.12.5 Safety of Researcher

A risk assessment was carried out prior to the interviews taking place (Appendix D). It was felt that my personal risk could be adequately controlled during the recruitment and interview process. I ensured that I carried a fully charged mobile phone at all times. My supervisor or another colleague was informed of my location when I was away from the University interviewing participants. This complies with Northumbria University’s (2019) Lone Working and Out of Hours Procedure policy. My supervisor was informed when I left the building or participant’s home. I also took part in two Northumbria University,

People Development training courses (Personal Safety and Lone Working and Risk Assessment) and drew upon my experience of lone working and carrying out risk assessments as part of my previous Community Development Worker role.

To balance researcher safety against the needs of data protection (Data Protection Act, 1998), participants' full details were never given to a third colleague. To comply with data protection regulations, if my supervisor was not available to check I had completed the interview safely, the colleague who took on this role, was provided with just the address I attended. This was the only way to ensure researcher safety while minimising the risk of participant identity being discovered.

3.12.6 Child Protection

Participants were made aware of my responsibility towards the protection of children and vulnerable adults. This was formalised by the inclusion of a question on the Informed Consent Form (Appendix E). In the event of a disclosure, then I would have been ready to follow the process set out in Northumbria University's (2020) Safeguarding policy, contacting the designated Safeguarding Children and Vulnerable Adults Co-ordinator.

3.13 Chapter Summary

This chapter has provided an overview of the methodological considerations made to support this research. A biographical narrative methodology was found to be well suited as it allows participants to

tell their stories and also minimises the risk of participants feeling judged for their method of infant feeding practice. The research was also designed to gain access to the views of women who had never breastfed. This chapter included additional discussion about my positionality at the recruitment stage, including careful preparation taken to avoid sharing my own infant feeding story and not to be seen as a health professional. Ethical considerations have been prioritised throughout the research process which has made the research safe for both participants and myself as researcher. Chapter 4 provides a detailed account of the methods used.

Chapter 4: Methods

4.1 Introduction

This chapter begins by exploring the choice of methods in conjunction with the methodological approach adopted for this research, before moving on to preparations made prior to the interviews and the process of the interviews themselves. The post interview actions are analysed next, followed by a discussion of the methods used for analysis.

As previously mentioned, there is not one clear approach to narrative or biographical narrative research (Plummer, 1995; Riessman, 2008; Frank, 2010). By using a combination of methods, I have considered both the structure of the story as well as the role the stories play in the community in addition to their impact on infant feeding attitudes and practices. Therefore, although one methodology, such as BNIM (Wengraf, 2014), has not been followed in its entirety, this thesis demonstrates that, as suggested by Riessman (2008, p. 186) I have “followed a methodical path, guided by ethical considerations and theory, to story [my] findings”.

4.2 Methodological Choices

Prior to a decision being made to follow a biographical narrative methodology a number of other approaches and methods were explored. The creation and use of genograms (McGoldrick, Petry and Gerson, 2008; Darwent, 2015; Darwent, McInnes and Swanson,

2016) as a method was initially considered to help focus conversations on the intergenerational nature of infant feeding practice. This approach was also considered as I am very familiar with the use of genograms and experienced in genealogy. However, this approach was felt to be too structured and would not have allowed for the open narrative approach required to address gaps in the literature around how women construct stories and identities in relation to their breastfeeding practices. Hollway (2015) and Hollway and Jefferson (2000) use a free flow narrative approach which may have been useful for this study. In free flow narrative, participants are asked a small number of questions. However, a biographical narrative methodology was selected which allowed me to ask the participants just one initial question and then listen to their stories without interruption. This methodology also allowed me to address issues in relation to my positionality (Merriam *et al.*, 2001) and the potentially provocative subject area, as the focus of the interview is centred around Active Listening (Moss, 2015, p. 6; Flick, 2018, p. 211) with minimal involvement from the researcher.

4.3 An Overview of the Approach Taken for Data Collection

A detailed description of the approach used for data collection is provided in this chapter. However, for ease of reference, a brief summary of specific steps taken is also provided in Table 4.1.

Table 4.1 An Overview of the Approach Taken

Research Stage	Description of Activity
Ethical Considerations and Approval	Consideration was made to comply with Northumbria University regulations, data protection regulations as well as ensuring participant and researcher safety
Recruitment and Sampling	Participants were recruited with the help of a gatekeeper from a local Children's Centre. Feeding method was not requested at recruitment however particular social groups were targeted.
Pre-Interview Preparation	Participants were made aware of the one question approach which was used as well as the way they would be allowed time during the interview to pause to collect their thoughts.
Preparing the Interview Question	The question was carefully designed to allow the women to lead the interview as well as aiming to avoid causing them to feel any shame or judgement for their practice.
Interview Stage One	In the first part of the interview, participants were asked to respond to one question; "please can you tell me the story of your experiences of feeding milk to your baby". They were allowed to talk uninterrupted until they had reached the end of their stories. During the interview I engaged in Active Listening and took notes, paying particular to when the theme of the story changed.
Interview Stage Two	During this stage the participants were asked for more information about the story told. This was carried out by referring to times when the themes of the story changed during part one. The participants were asked to expand on these parts of their stories.
Interview Asking Questions	At the end of the interview, participants were asked additional questions in a more familiar semi-structured interview style.
Reflection	Notes were made following the interviews to reflect on my thoughts, feelings and initial analysis of the stories.
Transcription and Data Analysis	The interviews were transcribed verbatim.
Panel Analysis	Anonymised data was analysed, line by line with the support of an academic panel. The panel were asked to hypothesise about what might happen next at points in the story where the text changed.
Second Interview	Second interviews were carried out with 5 of the 9 women. They were asked to tell their life story. This data was used to inform the discussion surrounding their first infant feeding story.
Final Analysis and Findings	Material was reviewed in categories and findings were selected in response to the research questions.

4.4 Recruitment and Sampling

Originally, a sample size of up to 40 participants was the aim. This was highlighted as being very optimistic at my Project Approval Panel meeting held 6 months into the research, and I was asked to review the feasibility of this plan. I kept an open approach to this during the interview period and stopped recruiting and interviewing when I had conducted 9 interviews. This had resulted in a significant amount of data (see section 4.10) which I had already started to analyse and had found richness and depth. As discussed below, I was also pleased to have recruited a range of women to the study, 3 who had breastfed and stopped, 3 who had not breastfed and 3 who were still breastfeeding.

With a particular interest in the experiences of women who formula feed, I was aware that methods used would need to be carefully considered in order to avoid inducing any feelings of guilt, judgement or shame among women participating in the study (Earle 2002; Brown, 2019a). Research that only included women who had formula fed would be easy for me to arrange, since I live in a community of formula feeders. However, recruiting women by asking those who had formula fed to take part may have immediately placed many women in a defensive position in a similar way to the woman who responded so fiercely to my “chosen to formula feed” statement (Section 1.2). I therefore decided to widen the participants to include mothers who had fed using any method, but recruit from specific areas where rates

were known to be particularly low. This way, there would be a good chance of including women who had formula fed in the study, without having to state there was a particular desire to include them.

To recruit women who had never breastfed I spoke to the Children's Centre staff and used their local knowledge to inform me which groups and activities they believed I should focus my recruitment strategy on. The staff were aware of particular areas where breastfeeding rates were the lowest. Although this was not entirely "purposeful selection" (Patton, 2014) it was certainly not "random selection" (Patton, 2014; Bell and Waters, 2018). Participants were selected with experience of the phenomena I was investigating, and I targeted the areas I recruited from. My aim was to recruit a maximum variation sample (Patton, 2014) of mothers with a range of infant feeding experiences, but I was particularly keen to include women who had never breastfed. The stories of mothers who breastfeed were nevertheless important to include, as they enabled me to be able to contrast them against the formula feeding stories.

Participants were recruited from activities being held at Sure Start Children's Centres. A series of gatekeepers gave permission to allow me to access the women attending groups and activities in the local area. This was a very straightforward process as I drew from my previous experience in a Children's Centre. I was aware of the sustained focus on increasing breastfeeding rates as a target for

Children's Centres (Eisenstadt, 2011) so I was very confident that the staff would be interested in the project. They were and offered me full access to all of the groups being delivered from the Centre and the use of rooms to interview mothers when needed.

Practically, co-ordination of my recruitment activities was arranged with the setting's receptionist and two Early Years Practitioners who worked directly with parents and families in the local area. These gatekeepers were vital in allowing me access to the mothers. They informed the groups in advance that I would be attending, and I feel that this helped me to gain trust with the participants very quickly.

I attended 'stay and play' baby groups as well as a baby massage group and found it very easy to recruit women to be interviewed. The gatekeepers supported me to introduce myself to the whole group on each occasion and I then spoke to women who appeared interested. I also participated in the groups when it was possible, for example, during the baby groups I took part in the group singing activities and I chatted to the parents about everyday issues. I have many years' experience of working with different groups of parents and children so this was a very natural setting for me. At the groups, women were given an Information Flyer (Appendix F) as well as a Participant Information Sheet (Appendix G) to help them make an informed choice about their participation in the research. I also gave the participants my mobile telephone number. One woman did contact me

to say she had changed her mind and no longer wanted to take part in the research. Although I was obviously disappointed that she would not be taking part, I was also pleased that she had felt comfortable enough to let me know and had respected me enough to do so.

Women were offered a time to come back to the centre to be interviewed. In keeping with existing recommendations (Boynton cited in Robson 2011, p. 202), time between initial meetings and interviews gave the participants the opportunity to consider their informed consent. The Participant Information Sheet (Appendix G) was written as clearly as possible using plain English to aid comprehension. As participants' literacy levels were not known, potential participants were offered the opportunity to discuss the information together. This, in effect, allowed me to read out the information to participants, checking for understanding and defining terms. I used this method with all documents I gave to participants.

The initial plan was to recruit women to the study if they had a child under one year. I felt that I needed to interview women within around a year of birth to get an up-to-date picture of the community and gain an understanding of infant feeding culture for new mothers at that time.

4.4.1 The Final Sample: Participant Characteristics

A summary of each of the participants is provided in Table 4.2. All the participants described their ethnicity as White British or White Irish. Included in this table is the number of generations of the participants family who had lived in the local area. This number includes the baby as one generation. This proved to be interesting data as the women who had not breastfed had a family history linked more to the local area, while those who had moved to the area tended to breastfeed for longer.

Table 4.2 Participant Characteristics

Name and Age	Generation in area	Children(s) age at 1 st interview	Breastfeeding History	Location	Interview Duration	Key Details
Amy Late 20s	5	11 months 9 years	Zero 2 days	Home	51 minutes	Lived in a formula feeding world Employed in M&S café. 'Chopped and changed formula'
Becky Late 20s	5	8 months	Zero	Centre Home	29 minutes 86 minutes	Formula feeding was her 'personal choice' Worked with children Partner from minority ethnic group Supported others to end breastfeeding
Claire Early 20s	4+	13 months	Zero	Centre	19 minutes	Was formula fed as a child. Wanted to formula feed as 'wanted to use pink bottles'. Grandmother supported with overnight care Formula changed several times due to reflux.
Danni Late 20s	2	9 months	4 weeks	Centre	46 minutes	Friends had babies earlier and breastfed them, but Danni had no contact with them Breastfeeding easy at first, then frequent feeding and pain. Mastitis, breast abscess and breast surgery
Emily Late 20s	2	9 months	16 months +	Home Home	90 minutes 150 minutes	Very critical of peer support she had received. Baby had tongue tie Paid to see a private lactation consultant
Faye Mid 30s	2	7 months 3 years	10 months 4 months	Home Cafe	42 mins 30 mins	In laws keen for her to formula feed so they could give baby a bottle

Table 4.2 Participant Characteristics (Continued)

Name and Age	Generation in area	Children(s) age at 1st interview	Breastfeeding History	Location	Interview Duration	Key Details
Gina Mid 20s	4 Grandfather of baby from neighbouring county	3 months	4 weeks	Home	39 minutes	Gave breastfeeding 'a go'. Little praise for health professionals Painful frequent feeding. Grandmother supported. Told not to use breast milk with antibiotics for toothache. Guilt for formula feeding. Health Visitor said "Happy baby, happy mother"
Helen Late 20s	2	4 months	10 weeks	Home Home	68 minutes 185 minutes	Grandmother has baby 2 days and nights per week while Helen works. Felt guilty for not breastfeeding but "had no choice". Little support and conflicting advice from health professionals
Izzy Early 30s	2	5 months 3 years	9 months 5 months	Home Home	68 minutes 102 Minutes	1 st child had tongue tie, 2nd child easier to feed, made her feel guilty about first child. Child brings back a lot of milk. Mother formula fed in 80s. Sister fed for 6 weeks. Works day around feeding as not comfortable feeding in public Discussed practical issues feeding a baby with a toddler to look after.

4.4.2 Developing Trust

Developing trust is an important part of the researcher-participant relationship (Fernandez *et al.*, 2021). Wearn (2020) describes some of the difficulties she faced in gaining access to women as part of her PhD on barriers to cervical screening uptake. She found it difficult to recruit as the women and groups she approached were mistrustful of her as an academic researcher, despite her positionality as a woman living in the same community as the groups she intended to study. I did not know the women I was introduced to at the Children's Centre groups so I considered how I might gain their trust. As discussed, I believe this was achieved with the help of the staff within the centres, and by drawing upon my previous experience as a Community Development Worker. However, on one occasion the boundary between myself as researcher and one potential participant became blurred. During a baby group, a mother asked me to hold her child and as an inexperienced researcher I was unsure about what to do. The mother had twin babies and both babies began to cry at the same time. In that moment, I was not sure what action would be appropriate for me to take, however as part of the recruitment process I was intending to gain trust from the group, and this therefore presented me with a dilemma, as captured in my reflective diary:

“A mother with twins was nearby and after a few minutes she handed me one of the children. Arrgghh!!! This is nothing I haven't done before – I've worked with families for over 8 years and am very used to this, but I was conscious that my role as a researcher shouldn't really include holding babies.”

Instinctively, I did take the baby from her, as I wanted to support her. However, my professional role at this point in time was as a researcher, not to support the families there. On reflection, however, I feel this demonstrates the level of trust that this group of women had developed for me in a very short space of time, which was less than half an hour in this case. It also highlights there is often a need to break rigid research roles when working with groups, particularly to establish trust. At the end of this group, I shared my thoughts with one of the Children's Centre staff. She acknowledged the difficult position I had been in and between us we could not decide whether my actions had been correct. To refuse to hold the child would have damaged the relationship I was trying to build with the group, but technically I know I should not have held the child in my role of University researcher.

4.4.3 Feeding Status of Participant

It was important to me in terms of the potential relationship between myself as a researcher and each participant, that I did not ask whether women were breastfeeding or formula feeding at the point of recruitment. Asking the woman's feeding method at this point may have influenced their perceptions of me as they may have felt judged due to their feeding practice (Taylor and Wallace, 2012; Brown, 2019a). In eight out of the nine interviews I was genuinely unaware of the feeding method being used until the mother told me during the interview. It is interesting that the mothers did not volunteer this before the interviews given the potential for women to feel judged based on

their feeding method (Taylor and Wallace, 2012; Brown, 2019a) and the identified need for women to defend their practice (Murphy, 2004). I feel this was down to the careful thought given to my positionality.

4.5 Pre-Interview Preparation: Place and Time

Interviews were planned to take place in a Children's Centre but this did not go as intended. Although the staff at the Children's Centre were very accommodating and I appreciated the free use of this facility, it became very difficult to book rooms as the centre was very busy. The only time available for me to interview was usually between around 3pm and 5pm, which was not the best time for new mothers and babies. Also, during interviews at the Children's Centre we were aware of other people walking along the corridor and I wonder if this may have had an impact on the women's stories.

Other difficulties arose when arranging interviews. On one occasion I was contacted by the centre to cancel an interview as their room had been double booked. This was challenging as it raised some ethical questions. I did not have the mother's telephone number to be able to contact her to rearrange and I would not have been able to disclose to the centre staff the name of the mother I was interviewing. To solve this problem, the manager offered me the use of her office. However, despite our last-minute arrangements the mother did not turn up for interview. I offered for the interviews to take place at the centre and if this was not suitable, I asked about using the participant's own home.

Only three of the nine initial interviews were held at the centre. Interviewing mothers in their homes appeared to work very well as they seemed much more comfortable. This may have also supported my more neutral positionality, rather than that of a researcher in a more formal location.

Participants were initially interviewed for a period of 20-90 minutes. They were made aware of their ability to stop the interview at any time, to decline questions and to only pass on information they were comfortable sharing. The Informed Consent Form (Appendix E) and necessary discussions around this should have made this absolutely clear to participants, although I also reminded participants of this if they appeared at all unhappy or distressed. The participants therefore made up their own minds about what stories they shared and what may or may not have had the potential to cause distress.

Denscombe (2017) suggests that researchers should agree the length of time an interview will take place with a participant. This can usually be estimated based on the number of questions an interviewer plans to ask. Riessman (2008, p. 26) argues however that "if brief answers to discrete questions are expected, participants learn to keep their answers brief". However, with the use of just one question and a participant with the ability to lead the conversation there cannot be an agreed or estimated time with biographical narrative interviews. A person's story may be very long, or very short. As a researcher

interviewing mothers with young babies, this could have been particularly difficult. Time periods were open, but inevitable breaks were taken to enable participants to care for their babies. For example, one mother prepared a snack and fed it to her baby during a break. This did not appear to have an impact on the quality of the interview. It was a shame that some of the mothers felt the need to apologise for interrupting the interview, however I reassured them by reminding them the babies were the most important part of this study and we would not be there without them.

4.6 The Interview Question

In this research, I asked women about one particular area of their lives, namely infant feeding. Traditionally, biographical narrative methodology has been used for broader whole life research and the interview question would ask for the person's life story. However, this life story can still be directed towards a particular theme. Hermanns (1995, p. 1983 cited in Flick 2009, p. 177) suggests that "the interviewer's task is to make the informant tell the story of the areas of interest in question as a consistent story of all relevant events from its beginning to end". Rosenthal (2007, p. 51) initially used a more thematic question in her work in Germany, concerned that participants, "would not know what they should talk about and what they should leave out". Later, however she found that it was more beneficial to ask for a broader "whole life story" and stopped narrowing down to a specific "thematic focus" (Rosenthal, 2007, p. 49)

as she suggests this “makes it much easier for the biographer to talk”. However, as the period of infant feeding in a women’s whole life is a comparatively short period, the chances of women talking at length about their infant feeding experience as part of a whole life story were thought to be slim, so I narrowed my initial question down to cover the issue of infant feeding.

Hollway (2015) and Hollway and Jefferson (2000) have used an episodic narrative methodology in their work with women. Following similar principles to biographical narrative, this method allows the researcher to ask a number of questions about different topics or episodes. This was considered but it was felt that asking just one question narrowed down the chance of making the participants feel judged. The one initial question approach used in biographical narrative research (Wengraf, 2014; Flick, 2015, p. 143) allowed for a non-judgemental approach. Other methods have been used such as storyboards to elicit narratives of newlywed couples in quite a structured way (Veroff *et al.*, 1993, cited in Riessman, 1993, p. 54). Riessman (1993, p. 55) herself, prefers less structure and asks 5- 7 broad questions followed by probing questions such as “can you tell me more”.

With the biographical narrative methodology I selected, the researcher initially asks one question (Wengraf, 2001, p. 113; Rosenthal, 2007, p. 51; Flick 2009, p. 178). It is critically important to get this question

correct as using the wrong words could lead the participant to start talking about issues that are not relevant to the research study (Flick, 2018, p. 286). The “generative narrative question” (Flick 2018, p. 177; 280) I used was:

‘Please can you tell me the story of your experiences of feeding milk to your baby. You may like to include your thoughts about milk feeding during your pregnancy. Take the time that you need, I will listen and take notes. So please can you tell me the story of feeding milk to your baby.’ (Justine)

Rosenthal suggests that an open question is required. It must be broad but sufficiently specific and include an explicit request for a narration (Flick 2009, p. 178). Hence the request for a story in my question. Riessman (2008, p. 24) found that “changing the wording of initial questions to simple, more open and straightforward ones elicited long narratives”. Rosenthal (2007) describes her experiences as a novice researcher using a biographical narrative methodology for the first time. She reports that she used a closed question in her interview which then took the participant off on a trajectory she was not expecting. However, Riessman (1993, p. 54) suggested that sometimes even closed questions can produce narrative “because the impulse to narrate is so natural”. Riessman (2008, p. 24) suggests that storytelling happens “at the most unexpected” times during interviews, even in answer to “fixed-response questions”. Riessman suggests that these “digressions” from the questions provide “narrative opportunities” and that there is little guidance or space for such moments with traditional survey interviewing practice. Riessman (2008, p. 25, *my emphasis*) describes the way she encouraged

women to begin at the beginning of their stories by carefully constructing the interview question. In interviews as part of her infertility study she asked, “how did you *first become aware* that you were having difficulties with childbearing?”. I signposted my participants to their pregnancy as a possible beginning.

Using biographical narrative methodology allows the participant to tell their story free from question or interruption. This is aimed at preventing the researcher from taking on the role of the “Coaxer” (Plummer, 1995, p. 21) as could be argued may happen during more traditional semi-structured interviews. Plummer (1995, p. 21) suggests that the Coaxer can “change the nature of stories that are told”.

Salmon and Riessman (2013, p. 199) suggest that all narratives are co-constructed, and that even if the audience is not physically present there is always a co-construction. This gives weight to the one question approach used in my research, with the traditional conversation etiquette, such as turn taking (Riessman, 2008) not being followed. Jones (2003, p. 2) suggests that change “to narrative enquiry shifts the very presence of the researcher from knowledge-privileged investigator to a reflective position of passive participant/audience member in the storytelling process”. Of course, this may not be true of all narrative research. The aim of a biographical narrative interview is to elicit a single subjective story from the participant. By allowing the participant to tell their story, free from interruption, the aim is for them to do so without influence from

the researcher. In the case of my research, the focus is upon the meaning behind the women's infant feeding practice. One initial interview question is asked and then the researcher listens to the participant's story.

4.6.1 Word Choice

Word choice is very important when constructing the question. Single words can be loaded with meaning which may cause participants to feel a particular way. The semantics around the words 'choice' and 'decision', discussed in Chapter 2 informed the interview question. I did not include the words choice or decision in the interview question to avoid potentially judging the women before I had even started. As noted previously, infant feeding decisions can provoke feeling of shame, guilt and judgement (Lee, 2008; Taylor and Wallace, 2012; Brown, 2019a; Jackson *et al.*, 2021). I was also careful not to include the word breastfeeding as to do so may have imposed my own subjective views onto the participant and the purposes of this research has always been to explore issues of infant feeding for all women in a locality. Instead, I used the more neutral phrase "feeding milk to your baby", as I could anticipate a negative response to a question such as:

'Please can you tell me the story of why you chose or did not choose to breastfeed your baby?'

Questions similar to this have been used in previous research.

Radzyninski and Callister (2016, p. 20) asked "tell me why you

decided to breastfeed or formula feed?” and Earle (2000, p. 325) asked her participants “whether [they] had decided to breast or bottle feed”. These questions may have been adequate for the purposes of these studies but I was aiming to be as non-judgmental as possible with my question. Scott *et al.*, (2015, p. 78, emphasis added) added an extra complication to one of their questions and asked mothers “Have you ever *tried* to breastfeed in public”. It could be argued that this is a leading question, possibly suggesting that it is something which could fail, or is not expected to be very successful and also has quite moralising undertones suggesting that women should have at least tried to breastfeed.

4.6.2 Researcher Preparation

A practice interview is recommended for a researcher using this method for the first time and this was found to be very useful. I interviewed my father who had spent a considerable period of time in hospital as a child. I had been researching this as part of my interest in genealogy and had recently gained access to some of his childhood medical records. This practice interview allowed me to trial the skills I depended on during the interviews with the mothers. It revealed to me the power of the method as he was allowed to speak without interruption and I found out many new things about a period in his life which I believed I was already familiar with. I spoke to him about the process following the interview and we discussed the importance of preparing the participant for long uninterrupted pauses, which are

discussed below, and which he said, 'felt a bit strange but okay'. I felt ready to complete my first interview.

4.6.3 Participant Preparation

Participants were prepared in advance for the biographical narrative technique used in the interview, both verbally and via the Participant Information Sheet (Appendix G). They were advised that the interview could take around an hour, although I also spoke to them about how the nature of the interview meant this could be longer. All were happy with this and most had a cut-off point in mind such as the need to pick an older child up from school or a partner coming home from work, that we both worked towards. The participants were also informed about the Active Listening (Moss, 2015, p. 6; Flick, 2018, p. 211) process I would be using within the interview and that there may be long pauses and periods of silence. These issues are discussed at length in the next section which focuses on the actual interview process itself.

4.6.4 The Interview Process

The biographical narrative interviews were split into three stages. For the purposes of this research, the three stages took place on the same day as it was felt that asking participants to take part in more than one session at such a busy time of their lives might be too much of a commitment. I wanted to elicit as much data as possible from each participant on the day. A semi-structured interview schedule

(Figure 4.1) was prepared, just in case the one question, biographical narrative approach was not successful in eliciting a story, however these questions were never used. Questions were asked in the third stage of the interview and were included on the semi-structured interview schedule (Figure 4.2) as discussed in Section 4.6.10 below.

Project Title: ‘An exploration of socio-cultural factors relating to infant feeding, in an area with low breastfeeding rates.’

Named Researcher: Justine Gallagher; justine.gallagher@northumbria.ac.uk

Participant number	
Postcode	
Date of birth (month/year) =	
Date of birth of children (month/year) =	
Ethnicity	
How many generations of your family have lived in this area? (Baby = generation 1)	

Your Family and Friends

- Tell me about your family and friends
 - o Who do you live with?
 - o How often do you see each other? Do they live close by?
 - o Have you always lived close by?
 - o Describe your relationships? Close? Distant?
 - o Who would you class as your ‘significant others’?

Your ‘Infant Feeding Story’

- Tell me about your infant feeding experiences
 - o How did you prepare for feeding your baby when you were pregnant?
 - o Did your feeding experience go to plan?
 - o What help and support were you given at first?
 - o What help and support are you given now?
 - o Describe the feeding process, sterilization / washing bottles / expressing / timings
 - o Why have you chosen the brand you have? Have you always used the same brand?
 - o Have your circumstances changed since you child was born? Gone back to work? How did that impact on the way you fed your baby?

Other People’s Stories

- Thinking about the ‘significant’ people you mentioned earlier – please tell me what you know about their feeding experiences
- Do you know how you were fed? (if mother is not one of significant others) what does your mother think about infant feeding?

Figure 4.1 Semi-Structure Interview Schedule (Part 1)

What do you know about breastfeeding?

- Advantages / disadvantages
- How do you know this? Who has told you this? Where is this information from?

What do you know about formula feeding?

- Advantages / disadvantages
- How do you know this? Who has told you this? Where have you got this information from?

Future children / advising others

- If you had another baby, would you do anything differently regarding the way you feed your baby?
- If a friend was pregnant, what advice would you give her regarding feeding her baby?

Further Research

- Would you be happy to take part in further research? Interview? Focus group?

Figure 4.2 Semi-Structured Interview Schedule (Part 2)

4.6.5 Stage One

In the first stage of the interview, I asked the participant my well prepared, “generative narrative question” (Flick 2018, p. 177; 280) and then listened to their stories without interruption. Preparing the participant for a biographical narrative interview is extremely important. The interview “violates” the role that is expected in a traditional semi-structured interview (Riessman, 2008, p. 24; Flick, 2015, p. 143) particularly in terms of the “turn taking” expected during conversation (Riessman, 2008, p. 24). Participants are asked to tell their stories and are not interrupted but encouraged to continue with “minimal prompts” (Hayes, 2002, p. 61) or Response Tokens (Rapley, 2007, p. 20) such as words like okay, yeah, and mhh. The interview itself has the potential to feel one sided and a bit artificial. This could make the participant feel uncomfortable if they have not been pre-

warned. It can also be difficult to not obey the rules of normal conversation etiquette.

4.6.6 Active Listening

I followed an Active Listening (Hayes, 2002; Moss, 2015, p. 6; Flick, 2015; 2018) approach during each interview. Active Listening involves being attentive and paying attention to the word spoken but also to the “tone and emphasis” (Gray, 2014, p. 397). Egan (1998 cited in Hayes, 2002) believes it is important within the Active Listening process for the speaker to know that the listener is fully engaged. Riessman (2008, p. 26) suggests that we must “learn to listen attentively”, referring to the work of Andrews (2007, p. 15) who suggests this is “hard work, demanding as it does an abandonment of the self in a quest to enter the world of another; and it takes time”. Flick (2015, p. 143; 2018, p. 281) suggests that once the participant begins to narrate during a biographical narrative interview, they should not “impede the interviewee’s storytelling with questions or directive or evaluating interventions”.

Hayes (2002, p. 63) suggests that “learning the art of silence responsiveness has been described as the key to good listening”. In my research, I tried not to interrupt any pauses in the talk. Often researchers will jump in to try to repair the conversation or rescue a participant who stumbles with their words or may appear lost.

However, it is important to allow enough time for the participant to be

able to continue with their own story. It was very useful to have told participants that these pauses would happen and that I would not interrupt but allow the participants time to gather their thoughts. The example below, presented in “physical line units”⁴ (Wengraf, 2001, p. 214) from Faye’s story shows three pauses in a short period of text. The pauses may appear short in written format but in an interview situation 9 seconds and 13 seconds feels like a very long time. In this example, I did not interrupt Faye’s thinking and allowed her to continue with her story.

Faye: it’s all part of being a parent, feeling guilty
Justine: yeah
Faye: anyway (9sec) and with [child] as well it said she wasn’t putting on enough weight and they wanted her waking up through the night
Justine: right, right
Faye: two extremes
Justine: ok
Faye: (9sec) that’s the other thing that’s different about breastfeed you don’t know what they are getting
Justine: yeah
Faye: so it’s hard to judge so with the bottle there is a bit more of a routine to your day
Justine: yeah
Faye: so (13sec) but erm I never went to any of the breastfeeding groups or anything like that
Justine: right, right
Faye: maybe I should have done stuff like that but er, especially with [child] I just didn’t have the time to go

Allowing these periods of silences is difficult. In the example that follows below, a pause of 17 seconds is noted in Danni’s story. Again,

⁴ Extracts from the interviews have been presented verbatim in a typical qualitative format to aid flow of understanding, however when it is important to see how my comments may have influenced the narrative, as in this case, the quotes are included in the format suggested by Wengraf (2001, p. 214).

17 seconds is a very long and quite uncomfortable period of silence in an interview situation, and I broke it:

Danni: erm but she's doing fine being bottle fed but I do sometimes feel that people look down on you as well if you bottle feed and yes people don't always know your story do they? So [laughs]
Justine: no, no not at all (17sec) so people don't often know your story
Danni: no
Justine: how does that feel?
Danni: a lot of the time I feel a bit like I think (2sec) there's a lot of pressure on you isn't there and you always feel like people are judging you and there're probably not
Justine: ok

At the point of breaking the silence, I repeated Danni's words to help her regain her momentum with the story. Bell (cited in Riessman, 1993, p. 34) used this technique, repeating the words of the participants in her work with women with health problems due to drugs taken by their mothers during pregnancy. Danni did continue with her story, but I wonder if my prompt, and particularly the "How does that feel?" comment had changed its trajectory.

Not responding to participants, other than by indicating you are listening, can be very difficult. As seen in the two examples above, I generally fell into the pattern of using the neutral words "hmm" and "yeah" to indicate I was listening. Rapley (2007, p. 19) suggests that being neutral in any form of interview situation is impossible and that even a neutral sounding Response Token such as, ok, or a silence gives control to the interviewer. I became aware of this during the interview with Danni who spoke to me about her experiences of

surgery following mastitis, an infection of the breast (NHS, 2019), when I could not help but react by responding to her with the use of the word 'wow' when she spoke about her experiences of daily trips to the hospital:

Danni: the reasons that it upsets me is that I don't feel like, that you are given enough guidance
Justine: right, right
Danni: on things like that but yes she's been bottle fed since then and I, I can see why mums do it initially but (2sec) after, after everything was sorted and erm like everything had healed cause it took quite a while cause I had to have like my wound packed every day
Justine: wow
Danni: yeah it was awful [laughs] and I had to go backwards and forwards to the hospital
Justine: right
Danni: and after all that was sorted I kind of thought if I had another I would probably try and breastfeed again but everyone is like you're crazy don't [laugh]
Justine: [laugh]

On reflection, I should have stayed more neutral, but I was genuinely surprised by this twist in her story and could not help myself. In other interviews I realised that I used the word, really, as a Response Token. So, despite sticking to the use of hmm and yeah as much as possible I do wonder whether I have been perceived by the participants as neutral in all interviews.

4.6.7 Text Sort

I made notes during the interview to point out when the participant changed topic. A biographical narrative interview method also calls for

researchers to note any changes in the type of text during the interview so that researchers can take the participants back to these points in the second stage of the interview. This is known as paying “double attention” (Wengraf, 2001, p. 194). These different types of text used by Riessman (1993) were those found in Labov and Waletzky’s (1967; Table 3.1 in section 3.7) Narrative Sequence, namely the Abstract, Orientation, Complicating Action, Evaluation, Resolution and the Coda. Wengraf (2001, p. 241) describes a “DARNE Typology” and considers changes between the following types of text: Description, Argumentation, Report, Narrative and Evaluation.

In practice, I found this extremely difficult so started to make notes only when the participant changed the topic of her discussion. In narrative therapy, therapists are taught to take notes without looking at the paper in order for the researcher to continue to remain eye contact with the participant. I found it difficult to listen to the participant’s story, while taking notes about that as well as making notes about the changes in the text. In the example below Danni changed the topic of conversation:

Danni: erm my sister's recently had a baby, before me
 Justine: right
 Danni: and she just bottle fed
 Justine: right
 Danni: erm so that was what I'd seen but I wanted to
 breastfeed, I wanted to give it a go
 Justine: Right
 Danni: Erm, I knew like all the advantages of it, of, sort of
 like the health, like for the aids and even down to
 cost like not having to pay for formula and things
 like that

In this example, Danni spoke about her sister's baby who was bottle fed and then moved onto another topic; the fact that she wanted to breastfeed due to the health benefits.

4.6.8 Codas

The participant will come to a "Coda" (Labov and Waletzky, 1967; Riemann and Schütze, 1987, p. 184 cited in Flick, 2018, p. 324) within their interview, which signifies the end of a section of talk. This Coda could lead into another topic, or signify the actual end of an interview. For example, a participant may say, "well that's about all I can say on that". The interviewer should allow time after this for the participant to start talking again, rather than bringing the interview to a close. Table 4.3 shows the Codas used in the initial nine interviews.

Table 4.3 Participants' Codas

Name	Coda
Amy	<p>A: So I think it's good that people like you are coming out and doing this J: good, good A: and getting opinions of people from of all walks of like J: great A: Is there anything else you want us [me] to say?</p>
Becky	<p>B: he still wakes for a bottle during the night and his early morning one they are the ones that he really wants the rest of them he's just, he just has a play with them J: right (4sec) ok (4sec) I'm going to ask you some questions, ok?</p>
Claire	<p>C: It's just, it's hard to tell what they are getting when you are breastfeeding J: mhh, mhh (7sec) anything else? the thoughts, for better for you C: no that's it (laughs)</p>
Danni	<p>D: I think that's how, that's how I feel about it now just that just that it is easier and that I think the, that breastfeeding is the sort of thing where like I, I did want to do it but I think it's easier if you are around people who do it as well (6sec)</p>
Emily	<p>E: I can totally understand why people give up J: ok E: (12sec) I think that's all I can think of J: Thank you E: so if there's anything you want to start clarifying now and then I can, if it jogs my memory and I think J: yeah E: of anything else I can always mention it</p>
Faye	<p>F: me friend said she went to one she said everybody that was there was bottle feeding J: right, right F: so I thought that no, J: Not what she expected? Yeah F: {inaudible} after the breastfeeding, like [talks to baby] I don't know what else?</p>
Gina	<p>G: and I felt like I was getting more of a life back and she like I say was more content so she settled for longer so we were both kind of happier for it really J: right, right G: (11sec) and now she's a little chunky [to baby](laughs)</p>
Helen	<p>H: it depends on what my work I suppose you know J: yeah H: work and money dictate J: yeah, yeah H: in terms of that J: yeah H: (10sec) erm just trying to think if there's anything else (18sec) I don't I can't think of anything else</p>
Izzy	<p>I: there's no point in putting her in say pretty outfits (laughs) J: (laughs) I: 'cause you have to change them almost instantly so like by the end of the day she's in some of [first child's] old stuff J: right I: cause it's just like J: yeah (4sec) I: erm, I think that's, I don't know if you need anything else really (10sec)</p>

This demonstrates that the participants used their talk to tell me that their story was at an end. It is interesting to note that there are a number of pauses in this section of their talk too. These pauses appear to be longer in the later interviews and I believe that this is down to my experience with the method where I was more comfortable in allowing the silence. I would very much like to go back to Claire's interview and allow for a longer pause to see if that encouraged her to say more.

4.6.9 Stage Two

In the second part of the interview, I went back to each of the topics the participants had mentioned and asked them to share more information with me about each one. The text below shows the part of the interview when I returned to ask Danni about her sister.

Justine: Ok and then after you talked about your friends you talked about your sister who you said had bottle fed
Danni: yeah
Justine: Did she share anything with you about?
Danni: She just thought I was a bit stupid for wanting to breastfeed
Justine: really?
Danni: yeah
Justine: right
Danni: Erm when I'd asked her why she didn't, she told me that she didn't have a choice after her baby was born, because erm, she got taken away for stitches and they'd given her, given her baby a bottle while she was gone which I didn't, at the time I didn't think anything of but I have, since having my own baby I know that wouldn't happen

This additional context was useful in considering the infant feeding influences in Danni's family. At this point Danni completed the story she had briefly mentioned in the first stage of the interview. This is referred to as "narrative probing" (Flick, 2018, p. 280) which takes place to complete the "narrative fragments of the story told" (Flick, 2018, p, 280). I asked these questions sequentially; in the order they were presented in the original narration. Generally, revisiting each topic in the story was useful to gain additional information and to reinforce the existing story told.

4.6.10 Stage Three

In the third stage of my interviews, I asked some additional questions about infant feeding. This was more like a traditional semi-structured interview, though I continued with Active Listening (Hayes, 2002; Moss, 2015, p. 6; Flick, 2015; 2018). This stage was used to make sense of some of the stories, to clarify who was who and how it all fitted together. Flick (2018, p. 178) suggests that in this period researchers can ask participants to readdress fragments of stories told, or ask another generative narrative question (Flick, 2018, p. 280). I asked about participants friends and family as well as preparations they had made during pregnancy for the baby's arrival and about any support they had received in terms of their infant feeding practice. A Semi-Structured Interview Schedule (Figure 4.2) was used to help guide the questions at this stage.

4.7 Post-Interview

At the end of the interview, I made sure each participant was happy with the interview and did not leave feeling distressed. As discussed in the Methodology Chapter, one of the participants did get upset during the interview, so this was important. Ethically, participants should not be harmed as part of the research process, with this principle known as nonmaleficence. I believe that comments from the participants at the end of the interviews demonstrate that they had enjoyed the process as much as I had, and that the research had left a positive “footprint” (Graham, Grewal, and Lewis, 2007). Some suggested they were happy that they had taken part in useful research, and that they had the chance to share their views.

Soon after each interview I reflected on the interview and made some notes on my initial feelings and analysis of the mothers’ stories.

4.8 Second Interviews

I re-interviewed five of the nine participants to ask them to tell me their “life story”. This second interview took place around a year after the first. The other four participants were unable to take part generally due to work commitments. The shortest of these five interviews took just 30 minutes and was restricted by the fact that the participant was on her lunch break so we were located in a café near to her place of work. The longest interview took 3 hours and 5 minutes with a mean time of 1 hour and 50 minutes. The rest of these interviews took place in the

participant's home. Participants were sent an email inviting them to take part in a second interview (see Figure 4.3).

Your Infant Feeding Story

You will remember that I interviewed you a few months ago about your experiences of feeding milk to your baby. Thank you very much for sharing your story with me.

I am very pleased to tell you that I have now interviewed nine women from the local area. Everything that was said during the interviews has been typed up and I am starting to look at the information gathered in a lot more detail.

I am doing this in a particular way. It is known as the 'Biographical Narrative Interpretive Method'. To complete the next part of the research process, I would like to share the interviews, with my colleagues from Northumbria University and selected researchers from other North East Universities who will help me examine what has been said. This will be done by looking at the typed up copy of each interview. Your interview will be completely anonymised; all names and any specific details which could identify you that have been mentioned will be changed.

If you have any questions about this, then please contact me by either replying to this email (justine.gallagher@northumbria.ac.uk) or by telephoning me at the University on 0191 215 6706.

If you don't want me to share the interviews with my colleagues in this way, then that is absolutely fine, but please can you contact me before Monday 14th September 2015 to let me know.

Second Interview Request

I would also like to ask you if you would be happy for me to come out to your home to do a second interview. During this interview I will ask you to tell me your 'life story' and it will be done in the same way as the first interview. I will ask you to tell me your story and I will listen, take notes and I will not interrupt or ask any questions. This 'life story' information will be used to support what was said during the first interview.

If you are interested in being interviewed again, please can you let me know by replying to this email (justine.gallagher@northumbria.ac.uk) or by telephoning me at the University on 0191 215 6706.

I look forward to hearing from you soon.

Best Wishes
Justine Gallagher

Justine Gallagher
Graduate Tutor/ PhD Researcher, Faculty of Health & Life Sciences

Figure 4.3 Letter Sent to Participants via email 2

Within a biographical narrative methodology, the "story told" (how the person chooses to tell their story) is analysed alongside the "lived life" (what happened) (Riessman, 1993). In trying to analyse the transcripts in this way, it became apparent that further information

about the participant's life would be useful to aid analysis. For example, Faye spoke about the support she had received from her partner's family but not her own. It was not clear if her own family were in the local area which had an impact on the hypotheses being made.

Riessman (1993, p. 21) views the context of the story as important, in her work with divorce narratives she realised that they were impossible to interpret without reference to broader societal discourses and politics. Her participants had made assumptions about how marriage should be and constructed their stories in line with these tropes. In my research, four of the five women who were interviewed for a second time revealed financial pressures on the family. Each of the families were coping but significant financial issues were present including low income and other specific circumstances I am unable to disclose to keep the participants anonymous. The financial positions were not clear in the original interview, but it is important context for the infant feeding stories as the Social Determinants of Health (Institute of Health Equality, 2022) help us to understand how factors outside of health policy, such as poverty create "avoidable health inequalities" (Institute of Health Equality, 2022). Financial strains on the families were evident and are perhaps unsurprising given that the women interviewed were living in an area classed as disadvantaged.

4.9 Transcription

Interviews were transcribed verbatim, including notes on the length of pauses taken. While Robson (2011, p. 478) suggests that transcribing your own interviews is an “excellent way to familiarize yourself with the data”, this was however, time consuming. A total of 142,910 words were transcribed between both sets of interviews: 69,459 for the first and 73,451 for the second. In total, the first interviews had taken 7 hours and 32 minutes and the second interviews took 9 hours and 12 minutes. I also made some brief notes while transcribing to capture initial ideas. After transcription, I categorised some of the data following the example of Riessman (1993, p. 59), who identified each segment of text as per the categories found in Labov and Waletzky’s (1967: Table 3.1 in section 3.7) Narrative Sequence. This enabled me to consider the way the stories had been structured which supports the discussion in Chapter 8.

4.10 Panel Analysis

Following the method suggested by Wengraf (2001, p. 258) panels of two or three colleagues were drawn together to help analyse my data for each of the nine stories. At first these panel discussions were not audio taped; however, I soon realised the value of doing so and the final six meetings were recorded and transcribed. This resulted in a further 89,852 words of data. Handwritten notes were taken at the other meetings and have also been included in the data analysis. The

recordings of the six panel meetings are 11 hours and 11 minutes long. Each meeting took around 2 hours and 30 minutes.

4.10.1 Ethical Implications of Panel Analysis

The decision to include panel analysis and interview participants for a second time, was made after the approval of the initial ethics application and the initial interviews. An ethics amendment was submitted and approved by Northumbria Research Ethics Committee on 13th August 2015. Participants were contacted by email to request a second interview and to inform them of the panel analysis process. They were given the opportunity to opt out of this (see Figure 4.3). This means that all participants were fully aware of the process being used. To protect the anonymity of the participants all data presented at the panel were anonymised. Participants names, place names, occupations and employers were changed.

4.10.2 Panel Demographics

Participants in the panel meetings were in the main from a regional Narrative network, academic colleagues, and PhD students from local North-East universities. Wengraf (2001, p. 258) suggests that panels of at least two people should be used to carry out a Panel Analysis. He also suggests that the Panel members should be as different as possible in terms of background and knowledge to reduce the impact of one single subjectivity on the analysis. The panel allows the impact of my own subjectivity to be reduced which is important as the stories

people tell, can be told and heard in different ways. Two story “Consumers” who hear the same story at the same time may make sense of the story in different ways. Plummer (1995, p. 28) suggests that it is never certain how a story will be interpreted by a consumer. The panel members were similar in that they were all academics, however there were other differences between them. The panel was made up of a mix of ages, from 20s to 60s. There was a mix of nationalities with three European countries represented. There was also a mix of genders. Some of the panel members were colleagues who did not have a background in Childhood Studies, they had no children and no experience of feeding milk to babies. This raised some interesting hypotheses and subsequent discussion. They were intrigued to hear that woman who live in the local area, which is often described as deprived were more likely to feed their babies infant formula than to breastfeed and were confused about why poorer women may not breastfeed since this is free.

4.10.3 Panel Meeting Process

During the panel analysis, colleagues looked at transcripts of each interview on a line-by-line basis. It is suggested by Wengraf (2001) that panels should be presented with this data pre sectioned into text sort segments. I chose not to follow this, since as previously mentioned, I had found this a difficult activity to complete with a printed transcript. I also thought it might complicate the process, make the process longer than was necessary and inhibit the thoughts of my

colleagues. Dividing the sections into types of text can be difficult and subjective so their ideas about what each segment comprised of may have been different to mine. Jones (2003, p. 68) also found this difficult in his PhD research with informal carers, suggesting that “concentrating on the text structure appeared to restrict the reflecting teams’ possibilities of multiple, intuitive responses to the data”. We therefore looked at small sections of text within topic themes.

At the panel, colleagues were asked to go through the text, line by line to look for themes and to suggest hypothesis, based on what had been said, about what might happen next in the story. This strategy was taken from the BNIM developed from the work of Rosenthal and Fisher-Rosenthal (Wengraf, 2001), where the panel are said to be future blind to the narrative. Wengraf (2001, p. 259) suggests a minimum of three hypotheses are needed for each section or “datum” of text. The researcher’s role here is to lead the process, rather than be part of the panel. The researcher is the only person in the process who knows what happens next in the participant’s story. As the researcher, I found this tricky as it was difficult to remain neutral and allow the panel members to talk without giving clues to what might happen next. In the same way that saying, wow, might influence a participant during an interview (see Section 1.5) saying “wait until you hear what happens next” may influence a panel member and cause them to exaggerate their hypothesises and miss more simple explanations. The panel analysis sessions were taped and

transcribed, and every detail of the discussion was included in the analysis.

4.10.4 Strengths and Limitations of Panel Meetings

A strength of panel meetings is that they can deepen interpretations, minimise interpreter bias (Jones, 2003) and increase trustworthiness of the research. Wengraf (2014) suggests that it helps to prevent bias when researchers may have already made up their mind about the interpretation of the story. Panel meetings can help to save time for the principal researcher as the meetings provide an opportunity for a great deal of analysis in a short period of time (Corbally and O'Neill, 2014). Conversely, time can also be a limitation to the use of panel meetings. Arranging meetings with busy academic colleagues was a difficult part of this process, although once the meetings had started, most found they did not want to leave. Other issues with group analysis have been suggested, such as it can provoke tensions within group power relations (Phillips, Kristiansen, Vehvilinen and Gunnarson, 2013) and it being emotionally difficult (Cahill, 2008). Becky's story is presented below to demonstrate the method used.

4.10.5 Detail of Becky's Panel Meeting

Becky's infant feeding story was analysed line by line by a panel of three colleagues. Becky's panel meeting to consider her 29-minute infant feeding story took 2 hours and 36 minutes. Her life story was not analysed by the panel. Permission to do this had been given by

Becky, however I felt uneasy with this and there were some practical, more logistical reasons. The panel members, all busy academic staff, gave their time freely and I felt uncomfortable asking for more of their valuable time. The panel were not aware of how the story would develop and what was going to happen next. As an example, the first section of text considered by the panel included the interview question and is presented here:

Justine: Can you tell me the story about your experience of feeding milk to your baby, you can start wherever you like you might want to include your thoughts about milk feeding during your pregnancy, it's up to you erm, take the time that you need, I'll listen and I'll take notes, erm and then I'll ask you some questions once you've gone through your story ok? So tell me the story of your experiences of feeding milk to your baby

Becky: Well, when I was pregnant, well even before I was pregnant, I always knew I was going to bottle feed

Hypotheses made and themes discussed from this very short section, just 20 of Becky's words are detailed in Table 4.4:

Table 4.4 Hypotheses from Becky's Interview Segment

Number	Hypothesis
1	Infant feeding decision made before pregnancy
2	Came from a family where breastfeeding was not the
3	May be a social reason for not breastfeeding
4	There is a local formula feeding culture
5	Baby was planned or at least 'semi' planned
6	Decision was made based on 'bad' personal experience

4.11 Final Analysis and Developing Findings

At the end of the Panel Analysis sessions, I noted the key themes that had been repeated within the stories. Following the Panel Analysis of Becky's full interview, the themes presented in Figure 4.3 had been repeated several times:

- Decision Making
- Justification
- Local Formula Feeding Culture
- She was Strong
- Control (she liked to be in control)
- Partner from another country
- "I can't do it" [breastfeed]
- Lack of Respect / Trust in Health Professionals
- Medical Intervention
- Lack of Mention of Partner
- Breastfeeding in Public
- Close Knit Family
- Breastfeeding Horror Stories
- Good Mother
- Identified as a Supportive Friend

Figure 4.4 Themes Identified in Becky's Interview

It was difficult to follow the full biographical narrative process at this point. This was because the time period I was interested in represented such a small part of the women's lives. This made it difficult to compare the "lived life" to the "told story". Therefore, a decision was made to base the analysis on the panel conversations and a further data sort. The interview transcripts, my notes and discussion of the hypotheses from the Panel meetings were categorised according to themes on to a word document. This process resulted in a large document of 60,632 words covering a range of themes, from grandmothers, breastfeeding in public, Breast is Best to

alcohol and pain. The findings of my research are presented in response to the original research questions.

4.12 Chapter Summary

The chapter analyses the methods used as part of the biographical narrative approach, including a Panel Analysis. It includes an explanation of why comparisons with life lived and told story (Riessman, 1993) were difficult and gives insight into how the findings were presented.

The methods used were appropriate for this study of infant feeding in England, in an area which is often described as deprived. The biographical narrative approach using one question and following Active Listening was particularly useful so I could listen to the women's stories in the most neutral way possible. It is acknowledged however that my influence could never be erased completely. The next four chapters present an analysis of findings from the research.

4.13 Structure of Findings and Discussion

In the next four chapters, Chapters 5-8, the findings of this research are presented and discussed. In keeping with ideas of stories and narratives, the findings have been linked to elements involved in a play, namely the Cast, the Actors, the Setting and the Plot.

Chapter 5 introduces the first Cast members, the people or Actors closest to the women. This refers to family members with a focus on grandparents and the fathers of the babies.

Chapter 6 widens the Cast to include Health Professionals as Actors in the stories. Another two elements are included in this chapter, namely Infant Formula and the families' Finances.

Chapter 7 provided details about the Setting of the stories and considers the way the location of the stories has had an influence on infant feeding practice.

Finally, Chapter 8 considers how the women's stories have been constructed.

4.14 Summary of Themes

A summary of the themes presented in the following four findings chapters are included in Figure 4.5 below.

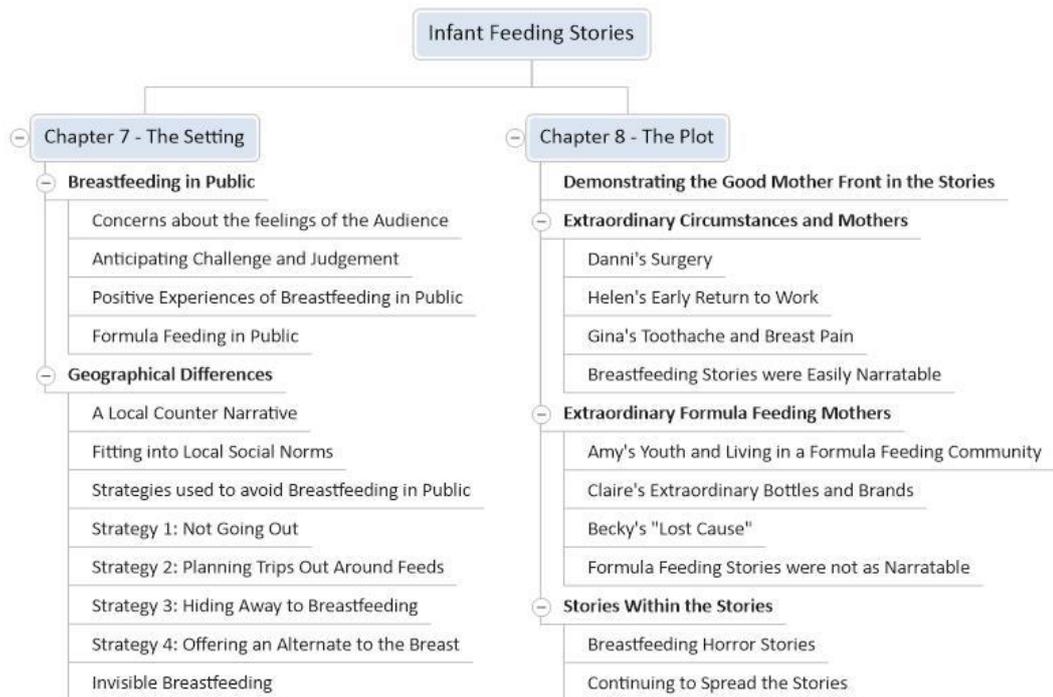
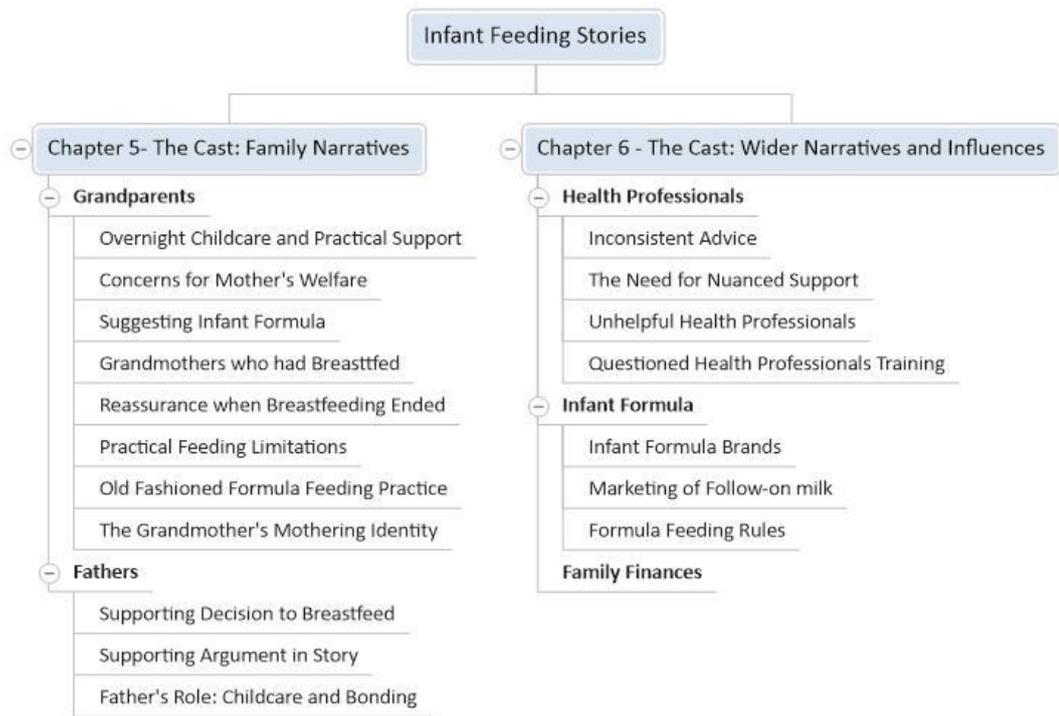


Figure 4.5 Summary of Themes

Chapter 5: The Cast: Family Narratives

5.1 Introduction

This chapter and the next, introduce the women's stories, the actors they included within them and the influence these actors have in infant feeding decision making. It demonstrates how the social context in which mothers live and their families play a significant role in the choices women make.

The role the babies' grandparents played in the women's stories is discussed first. Most commonly this was the maternal grandmother, although reference was also made to in-laws, grandfathers and step-grandfathers. In contrast to the frequent inclusion of grandmothers in the women's stories, fathers appeared to be missing. The way they were, or were not, included in the women's stories is analysed towards the end of the chapter.

5.2 Grandparents

Grandparents and more specifically grandmothers, were key actors in several of the women's stories. The overwhelming message was that they provided love, care and support to the mothers. The women highlighted a range of support offered by their parents. However, their support did not necessarily match to the public health messages around breastfeeding. Grandmothers are known to play an influential role in the parenting style of their children (Dykes and Griffiths, 1998; Thomson *et al.*, 2011; Hollway, 2015). McConville (1994, p. 86)

referred to support from grandmothers who may be “hostile to breastfeeding” as the “granny factor”. The mothers in my research did not explicitly tell me that the grandmothers were hostile to breastfeeding, but they did disclose ways that the grandmothers, as well as the grandfathers had encouraged them to end breastfeeding with good supportive intentions. Issues around the positive support provided by the grandparents is detailed in the following sections.

5.2.1 Overnight Childcare and Practical Support

Claire and Helen described how the support they received from their mothers included overnight care for their babies. For Claire, who formula fed from birth, this began immediately upon return from hospital. Claire lived with her mother when baby Sophia was first born. Claire’s mother Mary cared for Sophia for two nights a week, as well as other times when Claire “was tired”. Mary had offered this support for her other grandchildren until the babies became a “certain age”.

Helen, on the other hand, initially breastfeed her baby and began using infant formula when she made an early return to part time work. Helen’s mother provided childcare for the baby. However, because the families lived quite a distance away from each other, the only feasible way to arrange childcare was for the baby to stay overnight. Both Claire and Helen’s mothers were also included in their stories as actors who provided practical advice and solutions to perceived challenges. Grandparents are known to “establish their

connectiveness” and begin to develop relationships with the baby by buying items such as a cot or a pushchair (Thomson *et al.*, 2011, p. 218). Helen’s mother supported her by buying new bottles, from a factory shop in the North-East and mentioned this in the section of her story when she described their weekly childcare hand over routine:

‘it’s kind of like in a morning, w., I’ll take her erm I’ll take her and I meet Mam at the same spot in Newtown and erm take everything over to her and she’ll normally go into to Oldtown or something like that, so she says “would you mind like doing us up a bottle to take, to take erm ‘cause she’ll er she’ll take, take the bottle erm with her kind of thing and it’ll obviously cool down as, as and when she needs it type thing, and she’s bought like some new bottles and stuff for her and, and I went to Tommy Tippee the other day, argh it’s amazing the factory shop it’s like it’s so cheap, ‘cause she bought three coloured bottles and they were lovely and I was gonna buy them but then the clear ones were like 6 for £10 and I thought “oh my god that’s like really good” erm so yeah it’s working out really, really well.’ (Helen)

Similarly, Claire’s mother was also instrumental in providing practical support by purchasing the right bottles for her granddaughter. When a specific type of pink bottles Claire had purchased failed, it was Mary who suggested a change to Avent bottles. This very welcome practical support will no doubt have been a great benefit to Helen and Claire as new mothers. Two nights of uninterrupted sleep as a parent of a young baby would have been very useful. However, if Helen and Claire were breastfeeding it would have been extremely difficult, if not impossible for them to continue. Two nights per week away from her new-born baby would have made it extremely unlikely that Claire would be able to establish breastfeeding (Public Health England, 2022). For Helen, whose baby was slightly older, expressing milk had

been considered as an option, however, although she had more success with an electric pump than a manual one, she said she “was only managing to get... a bottle a day” which would not have been enough to cover the time they were apart.

In terms of public health, overnight care provided by the grandmothers was a breastfeeding disabler for Claire and Helen. However, this initial discussion of Claire and Helen’s stories begin to demonstrate the complexity involved with infant feeding which set the tone for the rest of this thesis. The decisions made by both mothers were influenced by wider issues in their families and society. These issues are included in the Social Determinants of Health as factors which can influence health outcomes (Institute of Health Equality, 2022). Claire made use of her mother’s offer of overnight care to follow the example set by her siblings and be a well-rested mother to her baby. This historical, intergenerational practice appeared to be important to the family however this would not have afforded breastfeeding. Helen had to return to work earlier than she would have liked for financial reasons and had no choice but to end breastfeeding so she could make use of her mother’s offer of free childcare. From a feminist perspective, balancing breastfeeding and financial independence can be challenging. Helen did not have a choice about returning to work in the way that someone who was more economically advantaged would have had. Cisco (2017) suggests that grandmothers provide less childcare in more economically advantaged families. This would

suggest that in the area where the research took place, which is often described as deprived, more childcare by grandparents is taking place. This may contribute to reduced rates of breastfeeding initiation and continuation.

In her research in Scotland, Darwent (2015, p. 237) found that overnight care caused a different type of issue, and that “grandmothers found breastfeeding to be a barrier to bonding with the grandchild as they were not able to feed the baby or have overnight stays”. Either way, the issue of overnight care appears to be a problem for women who breastfeed. Regular overnight care of very young babies may only be an option for women who do not breastfeed, and overnight care appears to please grandmothers who feel it supports their developing relationship with the baby. Women who breastfeed may need to negotiate grandparents desire to support carefully, in order not to upset their relationship.

Women who breastfeed successfully are often quoted as having good social support (Meedya *et al.*, 2010). This could suggest that women who formula feed their children may not have as good social support. Helen and Claire’s experience demonstrate that women who do not breastfeed can be provided with good social support; just not in the way that supports current public health messages. Here, both grandmothers played a supportive role in the care of the babies. However, the grandmother’s help, although very positive and

supportive turned out to be a breastfeeding disabler. It is suggested that this other type of support is not recognised in the literature where this deviates from public health messaging. This is important as this research recognises the valuable role grandmothers play in infant care and it highlights the need for grandparents to be involved in antenatal education where possible.

5.2.2 Concern for Mothers' Welfare

Several mothers included in their stories concerns that the baby's grandparents had for them, as new mothers, during the time they were breastfeeding. Faye's mother was concerned about how "tired" Faye was, Danni's parents and sister responded to her at a point where she describes herself to be "struggling". Gina's parents were concerned about how much pain she was "suffering". Gina revealed that her stepfather had "bumped into" her midwife and had used this as an opportunity to question her about Gina's pain and frequent feeding. Consequently, the grandparents provided a great deal of emotional support to the mothers, Gina commented that without the support of her mother who would often tell her to "just calm down" she "would have had a breakdown". This close family support was obviously very welcomed by the mothers. What was apparent is that the grandmothers were close at hand for the mothers, some lived together when their babies were first born. In terms of health determinants, having close social and community networks (Institute of Health Equality, 2022) is known to support good health. This

closeness may not have been possible in other areas where families are not always as geographically close.

5.2.3 Suggesting Infant Formula

Some of the grandparents suggested the breastfeeding mothers begin to use infant formula as they believed it would solve the perceived challenges the mothers were having with breastfeeding. Sometimes, the mothers responded to these suggestions and ended their breastfeeding journey. Faye reported that her mother told her to “*give her a bottle*”, Danni’s family suggested, “*why don’t you just bottle feed?*” and Gina’s stepfather is reported to have told her, “*just go to formula and we can help you she’s not going to be worse off for it*”. All of this is against the public health messaging but clearly comes from a place of care, love, and support. The move to infant formula would perhaps empower the grandmothers but it would also be something they could help their daughters with in a very practical way. Helen recreated a scene, using direct speech to give additional strength to the argument (Buttny, 1998; Hall *et al.*, 2014), where her parents offered her support and encouragement to switch to formula. The way she recreates this scene is interesting as in it, her parents are quite obviously reacting to an event that Helen does not describe specifically:

'erm but then obviously like well everybody was saying like my partner, my Mam and Dad they were saying "you're doing really well but we're just you know at least if you do give her a little bit of a bottle as well you'll know how much exactly she's getting" erm so I was like so a part of me gave in kind of thing in the end but also I knew I needed to start feeding her, erm in December time you know just before I went back to work so I thought, "well, ok this is the time (1sec), to do it".' (Helen)

Helen does not mention the conversations she must have had with her family to provoke such a response. This conversation, or merged collection of conversations, may have included concerns that the child not getting enough milk, Helen's imminent return to work, the fact that Helen told me she was finding breastfeeding a "a little bit... tedious" and was having difficulty fitting in things like "housework and stuff like that" and the fact that Helen was "not really a fan" of seeing "older babies attached to their Mam's breast".

To support the mother's decisions, the grandparents provided evidence to make the mothers feel better about stopping. Gina's stepfather referred to the fact that his two biological daughters were successfully formula fed:

'and he said "look at them" do you know what I mean there's no negative outcome, erm he went "so go for it", like he was really, really pushing the formula' (Gina)

'he was, he was just saying like, it even got to the point where he's like, "I think you're stupid" he went "you're putting yourself through so much pain" he went "I know you want to do the best for her" he went "but look at your sisters they're absolutely fine and they've been bottle fed, what, why are you so adamant", like he was a lot more pushy but in a supportive way.' (Gina)

This illustrates the way that support along with discouragement from breastfeeding co-existed in the stories and it also highlights that educating only mothers about breastfeeding is far from sufficient. Gina reported that this made her feel better about her decision to end breastfeeding. However, when Danni's family used the same strategy and used her niece as an example of how it is fine to bottle feed the reverse happened; Danni reported that she felt even more determined to breastfeed:

'they were all just a bit like, "just bottle feed it's fine" and I think, when I look back on it now I didn't want to give up I was being a bit more like, "because you're telling me to give up I'm not gonna", it was being a bit more of a (2sec) erm and I un, I know that it can be much easier to, well I would imagine it is sometimes much easier to bottle feed from the start but I don't regret trying.' (Danni)

Her families concern and support met with resistance from a woman who clearly felt she was doing the right thing and perhaps had a point to prove. Danni's decision to continue to breastfeed was being undermined by her family which has been highlighted in other research (Tarrant, Dodgson and Tsang Fei, 2002; Grassley and Nelms, 2008).

5.2.4 Grandmothers who had Breastfed

Grandmothers who had breastfed, and who it may be assumed would be least likely to encourage a switch to infant formula, also appeared to act against the public health narrative to support their daughters. The concern they felt for their daughters appeared stronger than the health message they had responded to as mothers themselves.

Faye's mother encouraged her to end breastfeeding and switch to infant formula:

'but even my mammy she was, "ah, just give her a bottle" [laughs] even though my mammy breastfed, me and me sister I think, I don't know why they think it it's just maybe you're too tired or something, [laughs] when you breastfeed, and Mammy thinks I'll have more of a life if I give her a bottle and stuff.'
(Faye)

Faye's mother was obviously concerned that her daughter was worn out from breastfeeding, perhaps thinking back to the time when she breastfed her own daughters. It is interesting that research suggests that women who have been breastfed are more likely to breastfeed their own children (Fitzpatrick, Fitzpatrick and Darling, 1994; Negin *et al.*, 2016) in part down to the support they receive from their mothers. The difference in this finding may be explained by considering breastfeeding as a health behaviour. There is a point at which the downsides for the mother, which are immediately visible and difficult to watch, outweigh the upsides for the baby, which are long term and much less tangible.

Gina, who was also breastfed, reported that her mother "had like breastfed me as long as she could and stuff". Gina's mother was therefore in a good place to provide emotional and practical support to her daughter however she was only introduced into Gina's story at a critical moment when breastfeeding became "extremely painful", "excruciating" and "exhausting" and when Gina felt she was "continuously feeding". However, Gina's mother and stepfather

supported Gina in ways which again do not fit with the public health narrative as their first priority despite Gina's mother's breastfeeding history:

'by this point me Mam had been out and bought erm shields, she'd bought formula just in case she erm bl., me Mam, me Mam was so like, she felt so bad for us (laughs) erm but I tried, so I tried the shields at that point and it kind of took the edge off the pain I mean it was still really, really painful, but it did kind of, take the edge off.' (Gina)

She gives more detail when asked during the final part of the interview:

'basically that night, the night before she went it was, obviously it was bad and anyway, I was up crying constantly and she came in the room erm and she was like, "I'll take her away for a bit", I says "you can't take her away she needs fed" and she was like, "You need to calm down, you need to get some rest I'll take her for an hour" and this was like in the early hours of the morning, me Mam had to go to work bless her, erm so she took her for like half an hour while I kind of got meself together and she was saying, "do you want do you want to try to have a sleep?" and I was saying, "I can't 'cause she's obviously hungry", I said "I can't" and she said, "I'll tell you what, I'll go to Asda now and I'll buy you the shields", so she went and I'm sure she bought us something else, the shields, some formula erm (1sec) just in case obviously and I can't remember if it was anything else but I (sighs), I just kind of felt I don't know just kind of relaxed that I had them there and it I did try the shield and it did take the edge off the pain so I was grateful, but anytime I was getting really, really upset, me Mam would be, "just calm down" and she would kind of just talk us through it and she was there for us (3sec) and I think if I didn't have her I would have had a break down (laughs) 'cause it was, it was, it was horrendous, so bad (sighs).' (Gina)

Gina described the way her mother had Gina's happiness at heart despite having breastfed herself:

'she was basically seeing me in pain constantly erm so she was kind of more for the breastfeeding but she, she really wanted me and her to be happy so she was like, "If it's going to make you happy just do it, just go for it".' (Gina)

Gina's mother supported her daughter by going to a supermarket in the middle of the night to buy nipple shields⁵. Gina's mother also bought formula "just in case". This is an important example of how grandmothers support their daughters and can have influence over their daughters' infant feeding practice in a way that can help a mother to make the decision to stop breastfeeding. Gina's mother and stepfather were quite obviously anxious about their daughter and questioned why she was continuing to breastfeed while suffering with so much pain and exhaustion.

5.2.5 Reassurance when Breastfeeding Ended

Grandparents also provided reassurance to the mothers who had ended breastfeeding. Helen began using infant formula upon her return to work and felt guilty for ending breastfeeding, however she mentioned that "people have been really reassuring and stuff and saying, "*ah well, don't be daft*" kind of thing, you know, "*look at her*" kind of thing, "*she's doing really well*". Helen's father was mentioned again during the final part of her interview, responding to her feelings of guilt:

'as me Dad says, "It's matterless now you, you know and you can't do anything about it".' (Helen)

⁵ The NHS (2019b) advises against the use of nipple shields:

"avoid using nipple shields (a thin, protective cover worn over your nipple as you breastfeed) or breast shells (a hard, protective cover worn inside your bra) – these will not improve your baby's attachment to the breast"

This is a very down to earth and straightforward response to his daughter's obvious distress, and perhaps the type of reassurance not expected from a health professional.

The grandparents played a supportive role in the care of the babies as well as the new mothers. However, their help, although very positive and supportive was often a breastfeeding disabler. This is a challenge for individual mothers with a desire to breastfeed for longer as well as health professionals, public health colleagues and others who are working to try to increase breastfeeding rates.

5.2.6 Practical Feeding Limitations

This research identified that the support the grandmothers could provide to their daughter and daughters-in-law was limited to their own infant feeding practice and knowledge. Research shows that breastfeeding mothers can feel unsupported by their own mothers who have formula fed (Lupton and Whelan, 1998; Grassley and Eschiti, 2011) and have no experience of breastfeeding. Several of the grandmothers had breastfed their daughters but still were unable to fully support their daughters and daughters-in-law due to a change in advice given about breastfeeding. However, in addition to this, the mothers were also unsupported in terms of feeding with infant formula as practice has changed. The grandmothers' support, although well intended, was not always helpful for both breastfeeding and formula feeding mothers.

5.2.7 Practices Passed down Generations

Parenting practice is passed down from one generation to the next (Thomson *et al.*, 2011). Amy was aware of this. She knew that children learn from their parents and that her limited amount of breastfeeding might be connected to the fact that the people in her social and community network, her mother, sisters, and friends had never breastfed:

'me mam was alcoholic and we were brought up with coming in with me mam sitting with a bottle of Bella, you know coming in from school and we grew up and erm we started drinking thinking it's the normal, so erm I think it does influence if ya mam does something you were brought up on it, you think it's normal and you tend to do it.' (Amy)

Faye's experience followed her mother's and she breastfeed both of her children. However breastfeeding advice and practice had changed in this time and this was problematic for Faye and her mother. Faye was born in the early 1980s when breastfeeding to a routine was encouraged by health professionals. These experts included Dr Spock, who despite being an advocate for breastfeeding recommended four hourly feeds (Hardyment, 2007). Four hourly breastfeeding practice is very different to the breastfeeding on demand which is promoted and practiced by many today. Faye said that her mother:

'always said she didn't understand why had to feed so much because she said when she was feeding me and me sister it was every 4 hours... She said all she ever did was 15 minutes on each side and that would be yours [sic] for 4 hours.' (Faye)

Previous research has identified the way advice from grandparents, based on their experience from the past is not always helpful as childcare advice has changed and grandparents may be unaware of current recommendations (Dykes and Griffiths, 1998; Lupton and Whelan, 1998).

Faye described the relationship she had with her in-laws who visited around twice a week. Faye described their love for their grandchildren and how they were very keen to take an active role in their lives. However, Faye found breastfeeding in front of them difficult. She believed that her in-laws were under the impression that she was feeding on demand to prevent them from holding and playing with the baby:

'they think you are just putting the baby on as, like, rather than doing anything else with the baby, you, like I know Steve's parents used to be like, "ah, you don't need to feed her again, just do something else with her", just like well if you put her on and it stops the crying and why not, but I think with them, then I think they find it difficult 'cause they think they should be holding her the whole time, rather than her feeding and stuff and you feel a bit (2sec), like, they don't get much time with her because I'm feeding, and er, they don't like me to take her off her to feed her and stuff erm you know they try and give her a bottle but, I don't, erm, just wanna stick with the feeding I think.'
(Faye)

Faye's mother-in-law breastfed her children, so it could easily be assumed that she would be more aware of the normal feeding pattern of breastfed babies and perhaps not in a routine, based mindset. But just like Faye's mother, it is likely that Faye's mother-in-law did not

feed on demand as it was not encouraged in the 1980s. Faye described what they would do if the baby was crying:

'and I like, if she was crying and then I tried to take her back to feed her again they were like "no let us you try something else" and I was just "let me feed her".' (Faye)

Perhaps the desire to be the actively involved grandparent, outweighed any feeding beliefs Faye's mother-in-law held. Faye was conscious that she has deprived them of the bottle-feeding experiences they were perhaps expecting, and this is an added stress for Faye who is in the early perhaps vulnerable stages of being a mother of two:

'it feels like I've deprived them of that a wee bit, they're very good with the, and stuff like, like and they're good grandparents it's just I don't know you sort of feel a bit bad for them when you feed.' (Faye)

In the second interview Faye revealed just how uncomfortable she could be when breastfeeding in front of her in-laws. She described the way that her mother-in-law would hold the baby's hand while she was feeding. Faye said she found this uncomfortable as at times this meant her mother-in-law was "touching [her] boob". Faye mentioned that breastfeeding allowed her to care for her own child. She asserted that she "had that control", which could suggest that one of the motivating factors for continuing breastfeeding was to prevent grandparents somehow coming to take over the care of the baby. Previous research suggests that grandparents of breastfed babies can feel excluded from the baby's care (McFadden and Toole, 2006). It is

interesting that Faye did not have the agency to be able to say something to her mother-in-law, to tell her she felt uncomfortable. Perhaps breastfeeding afforded Faye to help her feel in control of her own child as well as the bond they share. Faye revealed that she and her husband were “not bothered about going out” so there was no need for the children to sleep at their grandparent’s house and they only felt the pressure, to take over the care of the baby lift when Steve’s sister had a baby and the grandparents took on an active role in the care of the new baby.

5.2.8 Old Fashioned Formula Feeding Practice

As previously mentioned, limitations to practical support with formula feeding were also identified in the research. Izzy included a story about how formula feeding practice has changed and how contemporary grandmothers try to support their daughters using practices from previous generations (in this case, making up a batch of bottles up and storing them in the fridge):

I remember my mum and my mum was always kind of with my sister saying ah, you know, “you can always mix up a formula and then keep it in the fridge” and my sister like saying, “no you have to do it right at that time”, so it was kind of like that dispute of like you know, “Why are you making your life difficult [breastfeeding] when you could do this?”.’ (Izzy)

Previous research suggests that grandmothers can become frustrated with changing parenting practice (Lupton and Whelan, 1998; Grassley and Eschiti, 2011) when it feels as though their tried and tested practice is dismissed.

5.2.9 The Grandmothers' Mothering Identity

Izzy introduced another challenge to the support grandmothers can offer their breastfeeding daughters; some grandmothers may feel uncomfortable around breastfeeding. Izzy recalled that:

'my mum was instantly uncomfortable, I think she came to stay, er straight after Matthew was born and she was, I could tell that she was uncomfortable.' (Izzy)

'I think she's sometimes shocked by my decision erm but I don't think she's ever she's never she never kind of disputed it to breastfeed, I think it was just something that she, that she was never comfortable with doing. We don't really talk about it that much it seems like a strange conversation to have like, "why did you bottle feed me instead of breastfeed me" but that's the impression that I get.' (Izzy)

Izzy and her sister were formula fed. This uncomfortableness from one of a woman's closest, significant others, could have been enough to encourage Izzy to end breastfeeding, however she did not, and the second time around Izzy described how she was even more determined to breastfeed feed openly in front of her mother:

'my mum came to stay and this time I kind of made a mental, I, I made a, a decision that it was just kind of like I'm just going to feed downstairs and she's just going to have to deal with it (laughs) so I mean she was kind of all right about it then, but when I went to hers at Christmas it was kind of like, I was always being covered up by blankets and things (laughs) it was kind of like, I think she., , I don't know, so, I think, I think that there's always a little reason for it.' (Izzy)

The reasons for Izzy's mother's uncomfortable feelings may be partly influenced by her own stories of motherhood guilt. Izzy's mother's stories are told within Izzy's story and Izzy retold these stories which she had clearly heard several times before:

'she [Izzy's mother] always tells the story of where she erm, had me and then her midwife saw her in the pub in the evening so the midwife telling her off kind of thing so it wasn't any kind of er (laughs) erm, you know er, er, it was er you know, she wasn't doing what I was doing which was, which was staying in every night and erm, and doing that kind of thing.' (Izzy)

Izzy's mother must have felt her identity was challenged by the midwife in the pub. Her "Front" (Goffman, 1959, p. 32) was giving off the wrong type of message about her mothering identity. Another of Izzy's mother's stories challenged her mothering identity:

'my mum went back to work quite quickly so I guess that was the deciding factor I'm not sure I mean I was born in the early 80s so I'm not sure what, what the advice and practice was then, erm, er I think erm my sister was born in the late 70s so I think it was kind of like, when women were working and, and kind of you know, it was my mum, my mum was a teacher and it was very, very quick when she, when she went back to work to the shock of the neighbours kind of thing.' (Izzy)

It is true that, for Izzy's mother, breastfeeding would not have been seen as the normal way to feed a baby in England in the early 1980s. Again, in this section of text Izzy repeats a story she has heard her mother tell. Her mother had felt judged by her neighbours for returning to work, her mothering identity had been challenged again. Izzy's breastfeeding practice itself may have also challenged Izzy's mother's own mothering identity. For Izzy's mother to acknowledge breastfeeding as a good thing could make her historical practice of formula feeding look bad. She may have felt regret about not feeding her daughter and envy at her daughter's breastfeeding (Grassley and Eschiti, 2011, p. 138). Darwent (2015, p. 239) describes how this could challenge the relationship between a new grandmother and her daughter:

“in the absence of being able to discuss the reasons for their mothers decision, they had to find a story which helped them resolve the dissonance that while ‘the best mothers breastfeed’, their own mother did not breastfeed them. It appears that some participants’ are constructing empathetic explanations for their mother’s decision, from the few bits of information which some of them have, to allow them to continue to see their own mothers in a positive light, thus protecting their relationship.”

Izzy’s mother was ahead of her time in the early 1980s in returning to work so soon after having a baby. She had broken from the oppression of a previous generation by returning to employment as a new mother. For Izzy’s mother, formula feeding may have been a symbol of this freedom (Dykes, 2006), as it certainly enabled her to be able to return to work. Palmer (2016) argues:

“if you now ask your mother whether she breastfed you and she’s upset because she did not, please listen to her story. Forces way beyond her control made it very, very difficult to breastfeed. The same forces still do.”

McConville (1994, p. 87) argues that grandmothers who formula fed their children, feel that the new generation of breastfeeding mothers can be seen to be “having a dig at the old”. However, Izzy offset this in her story as she mentioned that she was aware of the forces which made breastfeeding not an option for her mother:

‘I don’t know in the 80s, I don’t know, if there if the., I think erm, I just, I don’t know, even though she might have tried with my sister and it not worked so as I say it’s just never really, I just kind of figured that it might have been just not that advised at the time, but it was all maybe there, there would have been new, new kind of formulas out or something which was kind of advertised I mean obviously they were able to advertise then weren’t they kind of like new formulas out which were advertising I don’t know (1sec) as good as breastfeeding, I don’t know when the new studies kind of came up with regards breastfeeding and all of this stuff to do with like ear infections

and language development and all that kind of stuff I'm, I'm not aware of when that kind of and maybe it was after that point.'
(Izzy)

Izzy also referred to the BBC TV show *Call the Midwife* (2012) to further explain that she understood breastfeeding practice has changed over the years. Having to deal with her mother's attitudes to her breastfeeding is an additional stress for Izzy, on top of her other challenges. Izzy had previously discussed the pressure new mothers feel to breastfeed and how she did not think that this was fair. What she reveals here is that, for her, some of that pressure did, in fact, come from her own mother.

It is argued that public health campaigns need to be aware of the influence that grandmothers can have over current infant feeding practice. Grassley and Eshchiti (2011, p. 134) suggest that;

“by asking grandmothers to tell their stories, health-care professionals may understand the personal and cultural context grandmothers bring to their support of new mothers and facilitate a place for grandmothers' voices to be heard.”

This research highlights the way grandmothers who had formula fed may need to navigate their own mothering identities and infant feeding stories when their daughters breastfeed.

5.2.10 Section Summary

Infant formula is part of history and so many grandmothers have experience of formula feeding babies, particularly in the area studied. They wanted the best for their daughters but found it hard to help as

they know the formula feeding narrative. Supporting their daughters meant for some, encouraging the end of breastfeeding and perhaps surprisingly this includes those grandmothers who had breastfed. The immediate wellbeing of their daughters taking priority over any long-term health advantages for both baby and mother.

This research also identified challenged for grandmothers themselves. It must be very difficult for grandmothers who have formula fed to hear messages about Breast is Best and fully support their breastfeeding daughters without experiencing this as a challenge to their own mothering identities. We know that feelings of guilt, shame and judgement last a long time (Brown, 2019a). Breastfeeding education to include grandmothers would be a positive step to support women who would like to breastfeed.

5.3 Fathers

One cast member who was missing from the stories was that of the babies' fathers. The fathers were rarely mentioned in the stories which is surprising as fathers are often mentioned in research as being a key support for breastfeeding women (Dykes and Griffiths, 1998; Earle, 2002; Meedy, Fahy and Kable, 2010; Brown and Lee, 2011; Hauck *et al.*, 2016; Cisco, 2017). Those who were included, were used to validate any decisions the women had made about formula feeding or to give strength to other arguments in their stories. They were actors positioned in the stories with a particular purpose of reinforcing the

mother's positive identities. Some of the women referred to the fathers when they discussed the reasons behind their formula feeding choices. For example, formula feeding allowed the fathers to bond with their children in a way breastfeeding would not have. This contributed to establishing their identity as a good mother for enabling this.

Despite having a partner who was at home at the time of the interview, Amy, who had two children, did not mention their father/s. The fathers of Claire and Gina's babies were not included either but perhaps this can be more easily explained by the fact that they were both single parents. Specific questions about the child's father were not asked for, but their absence is noteworthy.

5.3.1 Supporting Decision to Formula Feed

The mothers who did mention their baby's fathers, albeit in a limited way, did so in a manner which supported the way their stories were told. Helen, who started formula feeding when her baby was 4 months old, included her partner Sean in her story at the point of the Complicating Action (Labov and Waletzky, 1967; See Table 3.1 in section 3.7), when the decision to end breastfeeding was being made. By including Sean at this point, Helen attributed some of the decision making to him, as well as her parents. For Helen, the reality of being a mother was different to what she had expected. It is suggested that Sean picked up on her complaints about not getting things done and

breastfeeding being tedious, and he offered support. He tried to help her fix the difficult situation that she was in by suggesting the switch to formula. Helen displayed her anxiety to her partner who picked up on this and responded to it. Helen repeated this when asked about who reassured her during the final questioning section of the interview:

'My partner [reassured me], although like, he is, he is reassuring, he's the one who said, "Helen, I think you should put her on a bottle, a bit of a bottle now I think you should", because I think it was at night time and he could see how much, like how, how tired I was starting to get, because you know I was just sitting there kind of thing and obviously you do get tired when you're not moving around and doing stuff, erm and, and, and, and he has, he, but then he's been very much for me breastfeeding obviously because like afterwards he's like argh, erm you know I think he, he sees where I have been coming from in terms of why I wanted to breastfeed and things.'
(Helen)

Helen was supported by her partner and wider family to end breastfeeding.

5.3.2 Supporting Argument in Story

Fathers were also used in a limited way in the stories as a third party to support an argument. Danni's partner was with her when she breastfed their daughter for the first time, and at the beginning of her story she recalled asking him, "why does everyone not do this? it's so much easier [sic]". He is not mentioned much more during the entire story, except again when she describes her experiences on the ward:

'There was a midwife helping me in the hospital erm, when I've gone onto the ward and she, I remember she was the person that said to me, "it should not hurt" and you do, "if it's hurting you're doing it wrong" and she was about, she was younger than me and I remember thinking, "you can't give advice when you've not done it" and even my partner said, 'cause that's what upset me that, I took that on board and I know that's, that's just standard to them.' (Danni)

What is interesting about how Danni has included the father in the story is of his presence as another actor within each of these two scenes. His presence gives strength to the argument she is making. She paints a picture of successful breastfeeding with the initial feed. His presence in the scene allows her to use direct speech to emphasise (Buttny, 1998; Hall *et al.*, 2014), the fact that at this point in the story, breastfeeding was easy. On the ward he is again an actor who strengthens the thoughts she had about her midwife's advice. Yes, her thoughts are valid, but she includes the father to demonstrate that two people, and two important people, the mother and the father of the child, were thinking the same thing.

5.3.3 Father's Role: Childcare and Bonding

Faye who breastfed both of her children did not mention her husband specifically in her story either. He is mentioned vaguely, as a background character. She talked about the influence of his parents much more. In the second interview, Faye was asked why she thought it was the case that her husband had not previously been mentioned. She responded to this by saying "he's not really part of it" and that she "never thought to bring him into it". This is curious, because research

suggests that women breastfeeding for longer in part due to the support of their partners (Hewat and Ellis, 1986; Brown and Lee, 2011). Of course, Faye's partner may be very supportive indeed, although she did say that "I think breastfeeding suits him at times though as it means there's less for him to do". In *The Second Shift*, Hochschild (1989) identified that female partners do more work at home than their male partners and referred to this as the "double day". This has been noted more recently too, in 2016 women were found to be doing 60% more unpaid work in the home than men (Office for National Statistics, 2016). Izzy's partner Neil, who was self-employed and went back to work soon after their second child's birth, was also very briefly mentioned in her story. He was included when she talked about having to change her older child's bath time routine when she had to breastfeed their new baby:

'In the evenings I used to put him in the bath and, get him ready for bed but that something my partner's had to do now because I just couldn't, couldn't do the two of them.' (Izzy)

He is mentioned again, when Izzy discusses how she feels she could have prepared their son Matthew more for the arrival of his baby sister. If fathers were such an important part of the infant feeding journey, then it could be argued that they would have a greater part in the infant feeding story.

Becky mentioned her baby's father Derek more than any of the other mothers. Her decision to formula feed was attributed to a number of

things, one of them being to allow Derek to feed Jai, which Becky felt allowed Derek to “feel that bond” with his son. Becky reported that Derek “does all the night feeds” and provided evidence of the bond that has been created by saying “Jai looks for him on the nighttime he knows its Daddy that gives him his bottle”. It was clear that Derek did do these night feeds, when discussing how feeds are made during the night, as Becky’s language switched from the personal pronoun, I, to using, we, instead. “we take up a flask... we put his water into a bottle...we put in in a pouch”. Becky painted a picture of an idyllic family life. She demonstrated the good relationship she had with her partner by including reference to the way they share childcare. While Becky cannot demonstrate that she is a good mother by breastfeeding, she can demonstrate how she is a good mother, by allowing Derek to be a good father. Becky almost implies that breastfeeding is a selfish act for the mother by suggesting that it isolates other people. At the very end of the interview, Becky again refers to the fact that formula feeding allows fathers as well as Grandparents the chance “to get to bond with the baby” saying this is one of the things she liked about it”. Becky then goes on to say that formula feeding is beneficial as it stops the mother from becoming exhausted:

‘it’s not just all on the mother isn’t it that they’re not the ones who are exhausted from it, it can be shared.’ (Becky)

Helen too, described the way that switching to infant formula also allowed her partner time to bond with the baby:

'but it meant that my partner could, could feed her, and that erm and he could get that little bit of bonding.' (Helen)

Previous research shows that allowing the baby's father to feed the baby is quite a common reason women give for stopping, or not initiating breastfeeding. The findings here are very similar to the work of Earle (2000) who suggests that formula feeding allows mothers to share their baby's care with the father in two ways, firstly by relieving the "daily grind" of "continuous demands" from the child on the mother and also formula feeding is thought to provide an opportunity for the father to bond with their babies. Murphy's research found that some women were able to justify their decisions to formula feed by suggesting it was a way that the baby's father could take part in the child's care (Murphy, 1999). These "appeals to higher loyalties" (Sykes and Matza, 1957 p. 669 cited in Murphy, 1999, p. 198) also include being able to include the grandmother in the baby's care as well as not wanting to breastfeed to avoid causing offence to others when feeding in public:

'I think mams have got a stronger bond with their babies I didn't want to take that away from, I know Derek didn't understand at first he does now because he does get to give Jai his bottle and stuff so he does feel that bond with him.' (Becky)

If mothers are unable to demonstrate they are good mothers through breastfeeding, then they can demonstrate they are good mothers by enabling the father to be a good father. However, Helen also told of the agreement which was made between her and Sean that once she had switched to infant formula, Sean would begin to feed their

daughter through the night. This sharing of the childcare clearly did not take place which is representative of the way household duties are shared in households across the country (Office for National Statistics, 2016):

'the idea was as well that he was going to do some nightshifts and I think he's done one and that was because I went out so he had no choice.' (Helen)

Helen and Becky included their partners in their stories as a way to support their formula feeding decisions. They both argued that formula feeding allowed their partners to bond with their children. Mothers appear to almost self-sacrifice their own needs to put the fathers and the father-child bond between them.

5.3.4 Section Summary

The use of a biographical narrative methodology in this case resulted in a lack of inclusion of the fathers. This would of course have been different if they had been asked specifically to talk about their partner's role in infant feeding, although the mothers could have brought them in as actors in their stories at any point. It is not clear why the fathers were not mentioned. It could be because the mothers, like Faye they felt "he's not really part of it", or that mentioning the fathers might take away from some of the power behind the tales of the Complicating Actions (Labov and Waletzky, 1967; See Table 3.1 in section 3.7) as it could weaken, or dilute, the role the mother played at that time.

It could be argued that the lack of inclusion of the fathers at all in the stories emphasised the heroic qualities of the mothers, that actually the fathers in these families, did not play much of a part in the infant feeding. Inclusion of the fathers may have diluted the work done by the mothers when statistics show women still do the majority of household duties and childcare (Office for National Statistics, 2016). Becky's circumstances illustrate that ultimately the decision to breastfeed is taken by the mother and she made the decision to formula feed from birth. Faye's story also demonstrated that she made the decision, in this case to breastfeed solely and that the father of the baby was not part of this decision.

5.4 Chapter Summary

This chapter has demonstrated the impact close family members can have on breastfeeding practice. Grandparents have a significant role to play in supporting women through what is for most a challenging time in their lives regardless of the way the baby is fed. The mixed advice given to the women in this study demonstrates how complex a picture it is, although all the support given comes from a place of love and care. Fathers in this research have been presented as background characters.

Health professionals and colleagues in public health need to be aware of the impact family members can have on women's decision making in terms of both breastfeeding campaigns and face to face work with

families. The father of the baby is often encouraged to be part of the women's journey from the first few appointments during pregnancy, but perhaps more attention needs to be paid to the grandmother in terms of breastfeeding education and supporting them to support the mothers. Grandmothers can play an important role as mothering identity is passed on from one generation to the next. Although, as demonstrated by this research, care is needed with this to avoid grandmothers feeling judged for their infant feeding practice which was appropriate for that time. This adds to the argument that grandparents as well as society as a whole should be included in breastfeeding education.

The next chapter considers wider influences on the breastfeeding family. Health professionals, including midwives and health visitors were frequently included in the women's stories. Additional influences are also examined here, namely infant formula and the family's financial position. It was found that all can have a significant role in infant feeding practice.

Chapter 6: The Cast: Wider Narratives and Influences

6.1 Introduction

In the previous chapter, the mothers' families were discussed as actors who were included in their stories and who had influence on feeding practice. Health professionals too had a part to play in the women's stories and are discussed here, along with the additional influences of infant formula and the family's finances.

Health professionals were regularly included in the women's stories, although most of the time this was in a negative way. Some of the mothers reported feeling pressure from health professionals to breastfeed, seemingly following their NHS protocols and the women also reported receiving inconsistent advice or advice that was unhelpful. This chapter highlights how the health professional's own narrative is often conflicted by their targets, training and personal experience. What was found was that the relationship between the mothers and their health professionals was not always a positive one which could be problematic as health professionals have a significant role to play in supporting new families.

Another influence represented many times in the women's stories was infant formula. It played a powerful role in many of the women's stories. This chapter highlights the way brands and marketing of infant formula contributed to the choices the mothers made. Finally, reference is made to the family's economic situations, which was

ultimately one of the most significant influences within the stories and had the power to impact many of the decisions made.

6.2 Health Professionals

A certain amount of pressure from health visitors to breastfeed was expressed by the mothers, which corresponds to previous research by McFadden and Toole (2006, p. 161) who found that this led women to feel guilty. Izzy mentioned health visitors quite early in her story, and although she reported letting health visitors know that she was going to try to breastfeed she did feel some pressure from them:

‘it was kind of when the health visitors came round and everything they said, “what you gonna do?” and I said “well I’m going to try and breastfeed him” and they try and give you spiel of like, you know, “you should breastfeed” and then I’m like, “well I know”.’ (Izzy)

Izzy mentions the health visitors “spiel” in this section of text and it is quite clear that she has heard this public health message before and was perhaps expecting it. Spiel is defined (Cambridge University Press, 2022) as:

“a speech, especially one that is long and spoken quickly and is intended to persuade the person listening about something:

- a sales spiel
- They gave us a long spiel about why we needed to install double glazing in our house”

Izzy felt that her health visitor was trying to sell breastfeeding to her, which is peculiar as Izzy had 9 months of previous breastfeeding experience with her first child. This reported interaction almost closes

off the relationship between the two. Instead of asking about what worried her or how the health visitor could help they are reported to have closed the dialogue with a directive which Izzy is then left alone with to try and apply in her daily life. The message of “you should breastfeed” is far too simplistic. Izzy mentions this again a little later in her story:

‘the health visitor[s], they just had to say it don’t they, they have to tell you that [you should breastfeed] for 6 months exclusive.’
(Izzy)

Izzy is clearly aware that the health visitors are working towards targets of increasing rates of breastfeeding in the area and there is a need to create a good health visitor narrative and absolve themselves from any responsibility if Izzy then turns out not to breastfeed. Izzy appeared disappointed when she describes how she was not praised by her health visitor for achieving the recommended six months of exclusive breastfeeding:

‘I erm fed Matthew for 5 months exclusively it was kind of like, “oh well it should have been the 6 months” there was no kind of like, “Oh, well done” (laughs) it was just like, “You didn’t do it for the 6”, so yeah (laughs) you can’t win with them.’ (Izzy)

As a result of this and despite the previous conversations where Izzy had felt an element of pressure to hit the health visitors’ targets, she still had a desire to please them.

6.2.1 Inconsistent Advice

A shared narrative that health professionals gave inconsistent advice appeared in the women’s stories. Helen reported that she “was getting

conflicting advice... one thing off one person and then one thing off another person". She told how one midwife had suggested that Helen "squirt some breast milk" into her daughter's "gunky eye". However, when she mentioned it to her health visitor, she was told "well we actually don't recommend that because it's got protein and things like that in". Emily too, commented on seeing several different midwives:

'when you see the midwives as well the community midwives at the start you see I think I saw one person twice and other that that it was a different person every time and you get and obviously they've all had their training at different times 'cause they're different ages and I'm sure they get updated at different times you know every now and again, erm but it depends when they've had the updates 'cause it you know the advice changes so often, and it's, some people said "oh, just put her on one side one time and the next feed put her on the other side the next" other people were saying, "no she need to feed on both sides both times so put her on and when she comes off one put her on the other" well what do you do if she doesn't come off? or what do you do if she comes off early 'cause she's fussy.' (Emily)

'you know you might get one midwife saying, "oh yes you do need to feed them on both sides but you know feed them until they come off one and then off the other" then you get then you get the people saying, "oh yes, you do need both sides, do fifteen and fifteen" so yes there saying, they're both saying you need to do both sides but they're still not saying the same thing about it, so even when there is slight overlaps in the advice that's being given there's still something that's different.' (Emily)

Izzy also reported conflicting advice while in hospital following the birth of her first child, although she used it to her advantage:

'everybody came in with their little bit of advice and everybody came in with their little different bit of advice and it just felt that eventually it kind of, worked.' (Emily)

Being able to listen to the advice given by "everybody" and working out what worked for her, appears to have been a good strategy for

Izzy. It is clear that health professionals will give different advice based on their training and experience (McFadden and Toole, 2006) but what may need to be addressed is the anxiety this can cause to mothers at a vulnerable time in their lives. McFadden and Toole (2006, p. 164) suggest that to avoid inconsistent advice, health professionals need “good quality training and education”.

6.2.2 The Need for Nuanced Support

Helen included her health visitor in her story as someone who was not there for her when she was needed. As mentioned in Chapter 5, Helen returned to work when her baby was 10 weeks old and ended breastfeeding to fit with childcare arrangements. Despite the obvious difficulties of continuing to breastfeed a baby who was staying away from home for two nights a week, Helen reported that her health visitor did not validate her switch and did not offer any support about the best way to move from breastfeeding to infant formula:

‘when I did come, like when I did stop kind of gradually feeding her and not feeding her kind of thing, erm but I know, I know it’s part of her job but I just felt I suppose that like (1sec) I don’t know she could have been a little bit more kind of like, “right, right if that happens” or she could have give us a little bit of pointers and st., in terms of “right if you need to do that I understand so what you can do is” in term of you know me kind of starting to give her a bottle or because of the fact that I will have to eventually feed her maybes advice on, or which, which milk she thought was going to be the best or kind, I just felt like, she could have given me a little bit of help and advice in terms of because I had no choice in the matter, erm, you know in terms of that and, and help kind of thing ‘cause as I say, she was saying that, “we’ll come back in 3 to 4 months and talk about weaning and things” well I’m already back to work it’s too late.’ (Helen)

Helen needed nuanced support at this point in her early mothering, although it appears that the mandate to breastfeed was so fixed in the health professionals mind that the context of the family was not thoroughly considered. Burns *et al.*, (2013) suggest that health professionals can be seen to prioritise breastfeeding over other issues. Helen needed support to continue to be a good mother while seemingly going against the Breast is Best dominant narrative. Helen really did not have a choice about continuing to breastfeed or not. The health visitor could have supported this by listening and validating Helen's decision which would have then, in turn, developed their relationship. Marshall, Godfrey and Renfrew (2007, p. 2158) found that most of the health professionals in their study were able to "gather contextual circumstances in order to provide specific information relating to the problem or issues concerning each woman". This was not the case for Helen. The Health Visitor gave advice without taking all the complexities in Helen's life into account and instead appeared to have been completely focussed on the public health advice. By not taking Helen's complete situation into account, the health visitor alienated Helen, telling her what to do rather than working with her and supporting her to be the best mother that she could be, given all her life's constraints and the different family and social actors and factors that she had to contend with.

Some of the health professionals however were more nuanced with their advice, and supported the mothers, listening to their

circumstances and responding sensitively to their needs. Some of the mothers reported that their health professional validated their decision to switch to infant formula. Helen had a more positive experience with her doctor and re-enacted the scene of her six-week check with her doctor, including direct speech to strengthen the argument (Buttny, 1998; Hall *et al.*, 2014):

'I went to the doctors at one point it was just like my 6 week check or whatever or, and hers and you know they were asking, "how are you feeding her?" and I was like "argh, breastfeeding and stuff" and erm and I was talking about through different things and I was wondering if I was doing it right in some ways because she was like on us for so long, it's like, "is this normal?" type thing, she was like and they argh she was like you know "that's fine" and, and you know "formula isn't poison you know you know, they've done a lot of like research into it" and I, I was like, "I know, I know it is" but as I say I just kind of (1sec) wanted to go for as long as I possibly could.' (Helen)

Helen's doctor was sensitive to the situation, they listened to the context of her life and supported her to navigate the decision to end breastfeeding, supporting her status as a good mother while doing so. Burns *et al.*, (2013, p. 67) suggest that "relationship orientated" practice is important to understand the context of a situation. Similarly, Gina reported how her health visitor had told her "it's not the devil, like, your baby will be fine on it". She also spoke about how the health visitor related the switch to infant formula in terms of Gina's happiness as a mother:

'the health visitor came out (1sec) erm for her first appointment and she had actually said, "if you're suffering so much, just what's the problem like why are you so against it?" and I'd been telling her she went "yeah, it's, it probably is healthier" she says, "But happy" what did she say? "Happy Mam equals

happy baby or something” she said so, she was a lot more supportive about moving to formula.’ (Gina)

Gina’s switch to infant formula was validated in these few words. The difference between these examples and the experience Helen reports to have had with her health visitor are blunt. The approach taken by these health professionals was very different. These experiences link closely to the work of Cowley *et al.*, (2018, p. 406) who suggest that:

“highly developed skills, flexibility and autonomy in practice are necessary to enable health visitors to tailor provision to need and maintain client sensitive care, particularly where there are complex needs or tensions between public health expectations, official requirements and parental beliefs and context”

It is suggested that these highly developed skills, flexibility and autonomy comes with experience, so mothers are likely to find a mix of support from their health professionals. Those who follow protocols more rigidly than others may be newly qualified.

6.2.3 Unhelpful Health Professionals

Emily questioned the practical knowledge her health visitor had about breastfeeding support in the area, when she asked her health visitor for help with her breastfeeding problems:

‘so I said, “you know well that, that you know I’ve heard that there is more support either with, you know, with the NHS” and things like that and, so she said, “oh well I’ll look into it for you” well I mean surely they should have a bit more than a vague idea about what support there is, for a start I mean fair enough maybe having to look into what Sure Start help there is because that’s a different, that’s a separate thing but surely, they should know what NHS help there is, they work for the NHS.’ (Emily)

Emily's point is a fair one. In terms of developing a relationship with the family, the health visitor has missed an opportunity here, although Emily did defend the health visitor with her next comments:

'she's lovely, she's lovely and friendly and great with her and great with weighing her and looking at how she is developing and things like that which I know is basically what they are for and what their job is so she is good at her job but if she is supposed to be my breastfeeding support I think that's pretty dire.' (Emily)

Despite supporting the health visitor here, in this section of text the emphasis is on how lovely the health visitor is, with the baby, the relationship with Emily as her mother is missing. Emily also criticised the knowledge of midwives when she was concerned about her daughter's bowel movements:

'at the beginning there was one time when she went, when, very early on when she went 8 days but the midwives weren't, didn't even seem bothered they felt her tummy and went "well she's exclusively breastfed erm so it's quite normal to go a long time between" and yet I've had other people say like peer supporters and things like that say, "oh no even with breastfeeding we'd still prefer three dirty nappies a day".' (Emily)

Emily started to question the advice she was getting from her midwives, she felt she was "just literally feeding her about 24 hours a day". She reported that the midwives were telling her "oh even if she is just snacking you've just got to keep feeding her on demand". Again, the relationship between the family and the health professional can be questioned here, a "relationship orientated" (Burns *et al.*, 2013, p. 67) approach was not apparent. Emily was potentially at a vulnerable point in her life, 8 days after the birth of her child and

needed their support. The midwives had the power in this situation and instead of using this to work together to support the health of both mother and baby they dismissed her feelings with an instructive approach. Emily then broadened out her conversation to critique many of the health professionals she sought advice from:

'basically every midwife and health visitor and even doctor that I saw when I showed them the nipple damage basically said erm it's normal you'll get over it.' (Emily)

No one appears to have worked with Emily, offered solutions or understanding. She has tried to engage with health professionals, but they have not engaged with her, at her level, even though she appears to have been very explicit and forward about the help she needed.

6.2.4 Questioned Health Professionals Training

Emily questioned the training that health visitors get around breastfeeding:

'I just think erm (4sec) although people do really try hard with the support I just think the knowledge isn't there I mean I, from a couple of erm the health visitors have said, "oh you know that the, the breastfeeding training that we've had had was half a day's conference" and I just think how on earth, especially those who haven't got kids, or had your kids (1sec) you know a long time ago or formula fed your kids, you know, things like that.' (Emily)

Here, Emily appears to give more value to the personal experience the health visitor has rather than any education given as part of their training, this is in keeping with the work of Hoddinott *et al.* (2012) who found mothers preferred to take advice from other parents rather than health professionals. The advice provided via training only appearing

to be trusted if it also comes from a place of personal experience. However, Dykes (1995) suggests that health professionals are also influenced by their own background and their personal values and experiences, and this is something that needs to be addressed in their education. Emily's attempts to get some support for the issue of tongue tie lead her on an expensive journey to see a private lactation consultant. It is disappointing as she states here that this was not picked up during those first few conversations with the health visitor:

'and also I mean even if you have somebody whose breastfeeding training is really, really good do they know about tongue tie, if they know about anterior, do they know about posterior, do they know what to look for erm you know especially with this like you know if my nipple damage was so tell-tale, of, er tongue tie of because of where it was.' (Emily)

Simmons (2003) argues that health professionals need to have an up-to-date knowledge of breastfeeding issues to best support mothers and avoid issues with inconsistent advice. However, she also stresses the need for good communication skills to be able to do this.

6.2.5 Section Summary

The health professionals included in the stories who appeared to support the women best, provided a more nuanced approach to the advice and support given. This then supported a good "relationship orientated" (Burns *et al.*, 2013, p. 67) approach between themselves and the families. Rather than take a didactic approach it was the health professionals who allowed the women to claim ownership over their own bodies, their baby and their motherhood, who had the most

success in developing trust and respect. These health professionals respected the interpretative views of the mothers. The mothers were supported to shape their practice in a way that worked best for them, the baby and the broader social support network. They were able to use their own subjectivities to make sense of the world around them to make infant feeding decisions or guide their practices. Some health professionals appeared to find it difficult to see anything other than the imperative to breastfeed, sticky closely to their objectively established truths, when clearly this was often not the best thing for the mother. The mothers were negotiating their early days of parenting, trying to live by their own values and constructing an image for themselves as a good mother in relation to many, often complex factors involved in parenting.

6.3 Infant Formula

When women did not breastfeed or ended breastfeeding, infant formula appeared to provide the stability and reliability that they were looking for. Many of the women put their trust in brands they were familiar with and were reassured to be able to follow a set of rules about how much to give their baby. The way infant formula is marketed has created a wonderful narrative about how easy it is to use, rather than the reality, that this along with all aspects of parenting can be challenging. Infant formula manufacturers have gained the trust of mothers through their marketing campaigns.

6.3.1 Infant Formula Brands

The brands of infant formula used appeared to be important to the mothers, and, as will be discussed in Chapter 8, they helped the mothers to demonstrate they were the best mothers they could be. They chose what they felt were the best brands. Formula feeding allows mothers to choose between brands, while breastfeeding does not give a similar type of choice. Consumption choices based on brand name were important to Claire, who switched formula brands a number of times. Claire switched from Cow and Gate, to a reflux milk, back onto Cow and Gate and then onto SMA. The brands appeared to be important to her. Brands can be displayed to others and tell others something about the person using them (Miller, 2009). The brand name and stages were the only things that were mentioned when Claire told the story of how she was able to sort out her daughter's reflux. There was no mention of any other strategies used such as changing the teats, winding the baby in a different way or trying different bottles. Claire has been clearly influenced by branding and infant formula marketing strategies. The way that Claire referred to the unbranded whole milk she gave Sophia when she reached one year of age was also very interesting. Claire said that, "she has it during the day as a like as a, just as a drink". Milk appeared to have lost all of its significance, it was now referred to as 'JUST ... a drink'. The reflux milk was the only one which did not have a brand and she stopped feeding that to baby Sophia. Although not discussed in the story, Claire may be familiar with certain brands, as her sister formula fed

her children and Claire told me that she had fed them. Research by Which (2017), the consumer rights organisation found that there are significant differences in prices between brands which could suggest to parents that some infant formulas are better than others. However, the manufacture of infant formula is highly regulated and content between brands and the products themselves remains very similar, so manufacturers need to do all they can to promote their brand to parents. In the absence of conformity to the dominant Breast is Best narrative, using recognised brands may be a further strategy through which mothers can overtly demonstrate their care for their child and reclaim an identity as a good mother.

6.3.2 Marketing of Follow-on milk

Marketing regulations for infant formula mean that only products designed for consumption for babies from six months of age are allowed to be advertised (UNICEF, no date a). To get around this, manufacturers have developed a completely unnecessary product, follow-on milk. Parents see the advertisements for follow-on milk and because the packaging and logos are so similar, they believe the product is the first stage milk (Baby Milk Action, 2021). The marketing of infant formula plays an important part of the decision making process for families. We know this from the significant amount spent on advertising (Sears Allers, 2017, p. 47). Izzy, who breastfed her children, discussed infant formula in a historical context when she

attempted to justify her own mother's infant formula feeding practice in the 1980s.

'maybe there, there would have been new, new kind of formulas out or something which was kind of advertised I mean obviously they were able to advertise then weren't they kind of like new formulas out which were advertising I don't know (1sec) as good as breastfeeding.' (Izzy)

She was aware that there was a time in British Society when women were actively encouraged to formula feed their babies rather than breastfeed. This section also demonstrates that Izzy was aware of the advertising legislation surrounding infant formula, and like any other commercial product, is marketed in a way to sell as many units as possible. Despite regulation of the advertising of infant formula intended to encourage breastfeeding (UNICEF, no date a), brand marketing was present in many of the women's stories.

Infant formula manufacturers spent millions on marketing each year (Sears Allers, 2017, p. 47) and as demonstrated below we know this marketing works. Brand marketing was very evident in Claire's story who formula fed her daughter from birth. In the final part of her interview, Claire was asked about the advantages and disadvantages of formula feeding. She responded in the following way:

'er, the advantages, I'd say, that if they do take to it, it could make, it could help them like in the futures as they are growing up.' (Claire)

'right, what way, what way could it help them?' (Justine)

'just give them all, all the vitamins and what they need till they, till they start growing up, until they er can get, can get the proper stuff that the need.' (Claire)

Claire appears here, to be concerned about how her daughter will grow and her future. Vitamins are mentioned, but not specifically, she uses the term “and what they need” alongside the word vitamins. As Claire was speaking during the interview, I had the feeling I had heard what she had said before but could not quite place it. Later, during transcription I realised where I had heard this before. When comparing Claire’s words to a transcript for the advertisement for Aptamil Follow-on Milk being shown at the time of the interview, similarities can be seen, words have been italicised in both transcripts which link the advertisement to Claire’s speech.

“Since their very first days, your baby starts to write *their future*, and breastfeeding provides them with the best start in life, inspired by 30 years of research on breast milk our researchers created Aptamil follow-on milk with its *unique pro nutra plus complex*, if you chose to move on, it will *help prepare your baby today for their tomorrow*, Aptamil follow-on milk, *their future starts today*.” (Aptamil, 2015)

Claire’s thoughts about the “future” could be seen to be reflected back from the words and images of the advert. The advert itself showed young babies, seemingly practicing to become their older selves. A baby girl stands and kicks like her older self the ballerina, a baby boy is playing with an abacus and is then seen as a mature man, quite obviously in a scientific role working out a difficult mathematical equation. The gender stereotypes themselves within this advert have recently been challenged and this advert was one of a number banned from further broadcast (Scott, 2017). I found it interesting to compare the way Claire refers to vitamins as “vitamins and what they

need". It could be argued that this is rather similar to the quite ambiguous "unique pro-nutra plus complex" (Aptamil, 2015) which is mentioned in the advert. It could be argued that media campaigns may have played a part in the decision making process for Claire and that any health advice from healthcare professionals has badly failed her. She appears to have been consumed by the non-specific claims of the marketing and is perhaps unable or unwilling to critically interrogate what is presented to her by the media. The marketing strategies used by infant formula companies are very, very effective.

However not all consumers of branding and marketing take it at face value. Amy, who formula fed her second son from birth, appears to be aware that these non-specific claims are something to be wary of:

'it says the green milk was, the, so close to breastfeeding the best ever, I mean so close to breast milk, how?' (Amy)

Amy also mentions TV advertising in her story, although in a different way. When asked what she knew about the benefits and disadvantages of formula feeding, Amy said:

'ah well nothing, nothing there's nothing really out there about formula feeding, there's so many things about breastfeeding, it's even advertised on the telly.' (Amy)

It is suggested that the breastfeeding advertisement Amy has seen on television is actually one of the those for infant formula, possibly even the Aptamil advertisement transcribed above. Due to the regulations around the marketing of infant formula, the advertisement begins by saying "breastfeeding provides them with the best start in life"

(Aptamil, 2015). Breastfeeding itself has not been the subject of a public health TV advertisement in England for many years despite the “Sorry not Sorry” campaign in Northern Ireland (Public Health Agency Northern Ireland, 2018). The dominance of infant formula marketing over campaigns about breastfeeding is a public health cause for concern, as this allows brands and formula feeding to become normalised in society. Amy questioned why information was not readily available about infant formula and demonstrated her desire to know more about a product she was using everyday:

‘why don’t you get anything about formula feeding? so I know nothing, I don’t know how it’s made I don’t know what’s in it, it says the green milk was, the, so close to breastfeeding the best ever I mean so close to breast milk, how? what’s in it to make it like that I really haven’t got a clue there could be sugar in, there could be flour there could be talc in it for all I know you know no one really tells you anything about it.’ (Amy)

The brands were important to the mothers, but it was also noted that the three women who formula fed from birth all changed brands on several occasions. Claire’s brand changes have already been mentioned; she changed brands to try to deal with the symptoms of reflux Sophia was showing. Becky’s formula feeding story was also not trouble free. In fact, she described many challenges. She told me that her son had issues with wind, reflux, sickness, screaming after every bottle, not settling, constipation and having “really loose poo which was green”. The infant formula brand was changed a number of times to try to relieve his symptoms. He was initially given ready-made Aptamil which was changed to SMA, then he was changed to lactose free SMA milk (both parents are lactose intolerant), then moved back

to SMA and finally back to lactose free SMA. Becky described one particularly frightening experience when she had to call an ambulance when her son “had milk coming out of his nose when he was being sick and he was like choking and he couldn’t get his breath”. Amy’s story followed a similar pattern to Becky’s. Amy’s son also had issues with gastroenteritis and was still having issues at the time of the interview, she told me “he’s had problems with his bowels he’s waking up during the night loads of times loads for his age”. Amy told me that she “chopped and changed” the infant formula brands many times to try to resolve the issue. Changing brands did not appear to have the desired outcome for either of the three formula feeding mothers.

6.3.3 Formula Feeding Rules

The women who formula fed from birth, and in particular those who switched to formula feeding earlier than they had planned, appeared to take comfort in the fact that formula feeding had rules they could follow. Rules appear to be lacking in the world of breastfeeding. Claire liked the fact that she was able to measure the quantity of milk she gave her baby, by following the guidelines on the infant formula tins, something which would not have been possible if she had breastfed. She told me:

‘well the, the tubs on the baby milk like tell you what they’re getting, it’s just, it’s hard to tell what they are getting when you are breastfeeding.’ (Claire)

The quantity of milk that is given to babies is known to be very reassuring to new mothers as it appears to be with Claire, and it could

be argued that if the volume of the milk the baby drank, corresponded to the amount on the back of the tin Claire would be reassured. Claire provided her daughter with what was recommended, she was in control by following the rules, and did it the right way. Despite this, however it is interesting to see how Claire phrased the following section of text, she claimed that bottle feeding was better for her as a mother. She chose to refer to herself here, rather than baby Sophia which may suggest who bottle feeding suited most:

'I mean I've got nothing against breastfeeding erm (3sec) it's just I thought it was like, a little bit better bottle feeding (7sec).'
(Claire)

'so you thought bottle feeding was, was better?' (Justine)

'yeah better for me.' (Claire)

Gina was also reassured by following the manufacturer's instructions when moving from breastfeeding to combining the use of expressed breastmilk and infant formula:

'I stopped expressing completely erm and then (1sec) I'm trying to think how long (3sec) aye it would have been 4 weeks so I had just put her on bottles and I just went by obviously the guide on there to see how she got on and she seemed to be going longer between feeds and she seemed a lot more content erm and a lot of people say 'cause it's harder to digest or something it's like they feel full for longer or something erm, so basically she was happy, I was happy and I, I've just continued on formula since.' (Gina)

In these two examples, Claire and Gina followed the formula feeding rules, provided the babies with the stated amount of infant formula and this resulted in happier mothers and happier babies.

The rules of formula feeding also allow parents to progress through a range of arbitrary stages of infant formulas from formula specially designed for new-borns to those for toddlers and beyond. Claire's story included reference to not only different brands of infant formula, but also these different branded stages:

“cause I was on the infant milk which was the number 1 and I was gonna go to, the stage 2 one but when she turned one I skipped the stage 2 and I went to the toddler milk.”
(Claire)

These stages of infant formula are not necessary (Brown, Jones and Evans, 2020). It is known that they exist purely as a marketing strategy for the formula companies and there is no medical reason why babies need to move up through the stages. Clearly this marketing strategy works as thousands of parents follow the guidelines the formula companies themselves write. Research shows that parents do not know this (Palmer 2009). However, Danni was aware of the issues surrounding the unnecessary introduction of follow-on milk for babies from 6 months, she told me “then there's the whole thing with like the following on milks and stuff which they don't need which you get told about and it made me worry a bit”. This marketing works well. It is supported by our culture of weighing, measuring and checking babies at particular milestones to check they have reached the desired weight and height. This feeds into the desire for staged infant formula.

6.3.4 Section Summary

Infant formula is a lifesaving product used by million of families across the world. It was a key actor in many of the women's stories and this demonstrates the power and role it plays in society. Follow-on milks are not necessary and have been created by manufacturers to sell their products. These products are expensive. The influence of marketing on the way Claire told her story is powerful.

6.4 Family Finances

The women's financial situation has been included in this chapter as it played a significant part in their lives. Amy referred to the lack of family finances frequently in her interview. She drew attention to the cost of infant formula, comparing the situation at the time of the interview to that of being a mother for the first time:

'The prices then I, I look back now and erm the weren't too bad plus you got milk tokens which were great you know one milk token would get you one milk, like one, you would go down the doctors or the clinic and they would give you them then I just remember 9 year ago now it's completely different it's shocking now, your er milk tokens you only get a set amount off your milk, which is shan, even though the milk prices have went up dramatically and they've just only recently went up by 50p from £8 to £8.50 and, when I, looked it up it was just to encourage more people to breastfeed with the price but that's not fair cause isn't it freedom of the persons choice, so we're suffering financially even though we've got no money to start with where's all these extra 50 pences going? Everyone's buying from the government, they're just taking, taking advantage of people and it's not fair cause they can do it no wonder people are struggling (3sec) They wouldn't put other things up just because people chose them instead of something else, so why? why target people who feed their baby with formula?'
(Amy)

This large section of the interview was analysed in three parts by the panel. This panel consisted of two men who had no children and no experience of feeding babies. Their perspective was useful as they questioned what Amy was referring to when she mentioned milk tokens and asked how long a tin of infant formula would last for. Previously one of these panel members had hypothesised that Amy might give her baby hungry baby milk for financial reasons. This demonstrates how the subjective views of the panel members introduced new perspectives to the analysis.

As discussed in Chapter 4, it was not until I interviewed four out of the five women for a second time that they revealed to me the financial issues they were faced with. These issues ranged from having a low income and working part time, to more complex situations involving debt, ex-partners and maintenance payments paid by their partners. This really is an important consideration for the women who live in this area and perhaps one which would not be felt by mothers who live in a more affluent area. The mothers who had to work, felt that they had no other option. Helen found returning to work very difficult when her baby was 10 weeks old. The other mothers were dealing with complex financial issues which took time and energy. It is easy to see why this may have contributed to making a choice to formula feed with a trusted brand. Poverty and low income contribute to poor health outcomes (Institute of Health Equality, 2022), and a preference or

necessity for formula feeding may contribute to this (Ip *et al.*, 2007; Quigley, Kelly and Sacker, 2007).

6.5 Chapter Summary

This chapter has analysed the roles of health professionals, infant formula and finances within the women's stories. Each of them play a significant role in what can be a difficult time of women's lives, at a crossroads of competing discourses. In terms of health visitor support, findings reveal the need for nuanced support for new families, responding to their particular circumstances, rather than focusing on public health targets. In terms of infant formula, the chapter revealed the way that marketing of the product has found a place in people's lives and that the brands and stages have become very familiar. Most significant of all perhaps is finance and the impact this can have on people's lives, as well as on the way this may limit the choices women have in terms of infant feeding.

Chapter 7: The Setting

7.1 Introduction

The mothers perceived differences in the attitudes around feeding babies in different areas of the city. These perceptions ultimately had an impact on their own feeding practice. Some areas of the city were perceived to be more breastfeeding friendly than others and these assumptions were intertwined with class identity. In the more affluent areas of the city, where, as described by Amy, “people are nice and rich and posh”, it was perceived that breastfeeding was appropriate. However, in the areas where they lived, the least affluent areas of the city, the mothers were aware of a dominant infant feeding narrative; that breastfeeding was “not the done thing”. I argue that this is an added complication for the women who are trying to display and maintain their Good Mother “Front” (Goffman, 1959) as they manage their identities and try to avoid any discreditable information about themselves coming to light which could result in a spoiled identity and stigma (Goffman, 1963). Society expects good mothers to breastfeed (Murphy, 1999; Bailey, Pain and Aarvold, 2004), but in the case of these mothers, their local community expected them to formula feed. This created a potential identity conflict. This chapter examines the tensions that arise from the need to uphold a good mother identity on the one hand, while simultaneously conforming to other socially acceptable narratives. The women described a range of feeding strategies they used to fit into the social norms of the geographical area they were in at the time to manage the tension. The feeding

strategies they used while in their local community included not going out at all, hiding away to breastfeed, and feeding with solid food, infant formula or expressed breastmilk. Goffman (1959, p. 114) suggested that social life was like a theatre, with “Front Stage” and “Backstage” areas. Thus, they were maintaining breastfeeding as a private Backstage activity. However, breastfeeding being seen is an important step to normalising the behaviour (Hoddinott and Pill, 1999) and changing the narrative around infant feeding. It is argued that these differences in attitudes in local communities across the city then have an ongoing impact on breastfeeding rates, and thereby perpetuate health inequalities.

This chapter begins with a discussion of the women’s perceptions of breastfeeding in public and then moves onto a discussion about breastfeeding in the two geographical areas.

7.2 Breastfeeding in Public

Breastfeeding in public is a much-researched area. Despite laws in place across the UK (Breastfeeding etc. (Scotland) Act, 2005; *Equality Act 2010*), research over a number of years shows that many mothers have and still feel nervous about breastfeeding in public (Sheeshka *et al.*, 2001; Forster and McLachlan 2008; Amir, 2014; Grant, 2016; Brown, 2021a). Similar concerns were echoed by the participants who took part in this research, suggesting little change in the issue.

7.2.1 Concerns about the Feelings of the Audience

Participants who breastfed were particularly concerned about how other people felt when they were breastfeeding, often putting the other person before the baby. Izzy said, “I always felt like I had to apologise for it” that “your baby should come first but, I always kind of judge on how the other person might feel”. Izzy was aware that she had an audience when breastfeeding and that she was being observed by others. In this example Izzy was an actor, a performer on the Front Stage who reacted to the presence of an audience. She was aware of the impression she was giving to others and conscious of the identity she was creating about herself through breastfeeding. In the Backstage area, at home, Izzy could relax and be herself. She avoided leaving her house when she knew her baby was due to breastfeed.

7.2.2 Anticipating Challenge and Judgement

The majority of the participants who breastfed anticipated challenge and judgement before they attempted to breastfeed in public, in the Front Stage. Danni felt restricted in where she could go:

‘It panicked me a little when I thought about all the places I would normally go to in town and if there was anywhere that you could breastfeed and knowing that some people don’t appreciate it when you do it in public.’ (Danni)

Danni clearly felt that she would be judged negatively for breastfeeding in public which is similar to findings in other studies, such as McFadden and Toole (2006, p. 159) who found that most of

the women in their study, “felt uncomfortable because of the perceived reaction of others”. Gina and Helen also appeared to feel embarrassed about the thought of breastfeeding in public. Gina suggested that she found breastfeeding in front of other people difficult, implying she was tied to the home before moving to infant formula:

‘when I started putting her on formula, I could then leave the house, people could come over because I didn’t have her constantly on the breast.’ (Gina)

Gina and Helen were concerned about breastfeeding Front Stage where they knew an audience would be present. However, Backstage breastfeeding at home, which should have been more comfortable for Helen also became an anticipated challenge for Helen when her father-in-law temporarily moved in with the family towards the end of her pregnancy:

‘I thought, “ah god, he’s gonna be here, I’m gonna have my boob out, I’m gonna be like, “argh””, I was just, I was, honestly in a bit of a tiz about it.’ (Helen)

Helen’s vulnerability resonates with the findings of a Canadian study where women identified themselves as feeling “vulnerable”, “self-conscious” and “nervous” (Sheeshka *et al.*, 2001, p.36) before breastfeeding in public. Many of the women in the Canadian study said they would “role play in their minds how they might handle negative attention” (Sheeshka *et al.*, 2001 p. 37). Similarly, in Australia, Forster and McLachlan (2008, p. 121) reported that women had a range of feelings before breastfeeding in public from,

“uncomfortable, shy and self-conscious” to the more severe “exposing, paranoid, fearful and ashamed”. The worry and anxiety this perceived challenge can cause is very real for women, at a significant, perhaps vulnerable period in their lives, as they make the adjustment to motherhood.

Breastfeeding mothers are protected by law (*Equality Act 2010*) but as Amir suggests, “the general public may not be aware of this” (Amir, 2014, p. 1). Perhaps this anticipation comes from the various media reports of women being challenged when breastfeeding in public (Amir, 2014; Brown, 2021a; Grant, 2016), and the resulting, well publicised nurse-ins (Dettwyler, 1995, p.199; Grant, 2016, p. 53; Brown, 2021a, p. 240). Perhaps, if this Act of Law was publicised as much as media coverage of women being challenged for breastfeeding in public, then women might feel more confident about breastfeeding Front Stage.

7.2.3 Positive Experiences of Breastfeeding in Public

The reports that the mothers gave about breastfeeding in public suggest that despite their reservations, those who did breastfeed in public reported very little challenge or specific difficulties. Helen breastfed in front of her family, and although she said she was comfortable with this, she reported that she used humour to warn her family of her impending actions:

‘I just kept whipping., I was just saying, “oh I’m just going to get my boob out” kind of thing ‘cause as I say they don’t really see

anything and if they do like they they'll be looking (laughs) but like as I say erm if other people were in the room, you know, friends, f., family, whoever I wasn't actually bothered I really wasn't bothered at all and I thought I was gonna be really conscious about it.' (Helen)

Helen also breastfed in a café when her daughter was 4 weeks old.

Despite her worries about feeding in public, Helen reported that she

“wasn't actually that bothered and nobody actually even came up to

us and said you know, “*you shouldn't be doing that here*” or anything”.

Forster and McLachlan (2008, p. 122) found that some of the women

in their study who expressed concerns before breastfeeding in public,

ultimately experienced no negative situations. The women continued

to breastfeed, supported by the fact that they were comfortable

feeding anywhere. This is important as it demonstrates the women's

perception that they would be challenged was not correct. This

important message needs to be disseminated in order for more

women to feel comfortable enough to breastfeed in public.

Just two of the participants in this study reported negative experiences

of breastfeeding in public and only one of these related to her own

personal experience. Faye reported how her friend's husband had

been “horrified” when Faye breastfed her child during a day out to a

Theme Park. He was reported to have said “*ah, it's just not right...you*

can't be doing that”. Amy, on the other hand, reported on her

experiences of working as a waitress in what might be classed as

quite a middle-class venue: the Marks and Spencer's café in town.

There, she described how breastfeeding women were judged and

treated unfairly by the “older generation” and how this would occur “pretty regularly...at least once a month someone would complain”.

Amy explained how she and her colleagues followed the policy of the café:

‘we would just say it’s natural and people are welcome to do it we’d say we are very, very sorry can we offer you an alternative seat away from it and sometimes they would move or sometimes they would just tut and storm out.’ (Amy)

Amy identified “older women” as being the group who would be most likely to complain about women breastfeeding in the café. Previous research has identified a number of different groups of society who are most likely to judge, complain or be offended by breastfeeding. Acker (2009, p. 478) refers to this by suggesting that “studies of adults have generally failed to find strong, consistent gender differences in breastfeeding attitudes”. Acker (2009, p. 488) identified that men who displayed “hostile sexism” were the most intolerant group in her study. One of the participants in Lavender, McFadden’s and Baker’s (2006, p. 152) research reflects Amy’s opinion, she said, “it’s the older women who don’t like breastfeeding... people are getting more acceptable of their bodies, but older people, they still cover up”. Brown (2021a, p. 239), however suggests it is the older generation, the over 60s who are most supportive of breastfeeding.

Positive experiences of breastfeeding in public are not widely reported in academic literature. Positive and uneventful breastfeeding experiences may simply be less often told and shared as consumers

desire more dramatic stories (Pinker, 2018). Sheeshka *et al.*, (2001, p. 35) did report on a very positive breastfeeding experience when they overheard a woman sitting at another table using the fact that the participant was breastfeeding “as a learning experience for her school aged daughter”. More experiences like this would enable breastfeeding to become the social norm.

7.2.4 Formula Feeding in Public

While the mothers in the research found breastfeeding in public difficult, formula feeding away from home was not necessarily an easier option. Helen took a long time to explain how feeding with infant formula had proved to be problematic for her during a meal with friends at a local pub. Helen was outraged that the pub’s policy was not to provide hot water for babies’ bottles:

‘and I goes, “what., what’s the difference between getting a bottle of hot water for a bottle and a pot of tea?” and he looked at us and he and he basically smiled and he actually shrugged his shoulders and said, “exactly” but he wasn’t allowed to give us so I had to buy a bottle of tea for £2 to get hot water for my baby’s bottle, so in that respect I was like I wish I had just obviously continued to breastfeed her (laughs).’ (Helen)

Becky, who formula fed from birth also acknowledged the fact that feeding babies with infant formula requires more planning and equipment:

‘you’ve got to take more things with you breastfeeding mothers just go with a bag of nappies whereas I carry 2 bags of stuff for Jai.’ (Becky)

The idea that breastfeeding in public is difficult and formula feeding in public is easy is demonstrated here to be wrong. The issues are much

more complex. Availability of hot water, as well as finding somewhere clean to prepare the feed is a worry that infant formula feeding mothers may have as they venture away from the home. The paraphernalia needed to feed with infant formula, described by Claire above can be cumbersome, yet the carefully chosen brands with well-marketed products and their logos help to create the view that formula feeding is straightforward, and the social norm.

In the second part of this chapter, the way the women spoke about infant feeding in the two different geographical areas is explored. Geography appears to add an additional layer of challenge for the mothers.

7.3 Geographical Differences

Earlier in this chapter it was argued that women were aware that they had an audience when they performed breastfeeding on the Front Stage. Here it is argued that the women perceived their audience to be different, depending on the geographical area they were in.

7.3.1 A Local Counter Narrative

Some areas of the city were perceived by the mothers to be much more breastfeeding friendly than others. This difference was described in the stories of women who breastfed as well as those who formula fed and was linked to social class. There was a clear division between two specific localities within the city. The areas where breastfeeding was perceived to be more acceptable were more

affluent where breast feeding rates are higher. The areas where breastfeeding was perceived to be least accepted were less affluent areas of the city, the areas in which the participants lived, and where rates of breastfeeding are much lower. Although the women were aware of the overall dominant societal narrative of Breast is Best, a counter narrative (Bamberg, 2004) existed in their local area, which for many, influenced their practice. These two separate narratives around infant feeding highlight the known health inequalities between neighbouring areas in the same city which also include a range of issues including smoking, drinking and rates of illness. While the mothers may not have been able to quote the breastfeeding rates in the different locations of the city directly, they were aware of the differences.

Amy described herself as “living in a bottle-fed world”, but at the same time, she was well aware of the existence of the “breastfed world” nearby. The explicit use of the word “worlds” is striking and reinforces the clear difference drawn.

Amy, who had limited breastfeeding experience with her first child and then formula fed her second from birth, spoke about these different worlds (further illustrated in Figure 6.1) while she was discussing the public health messages surrounding breastfeeding:

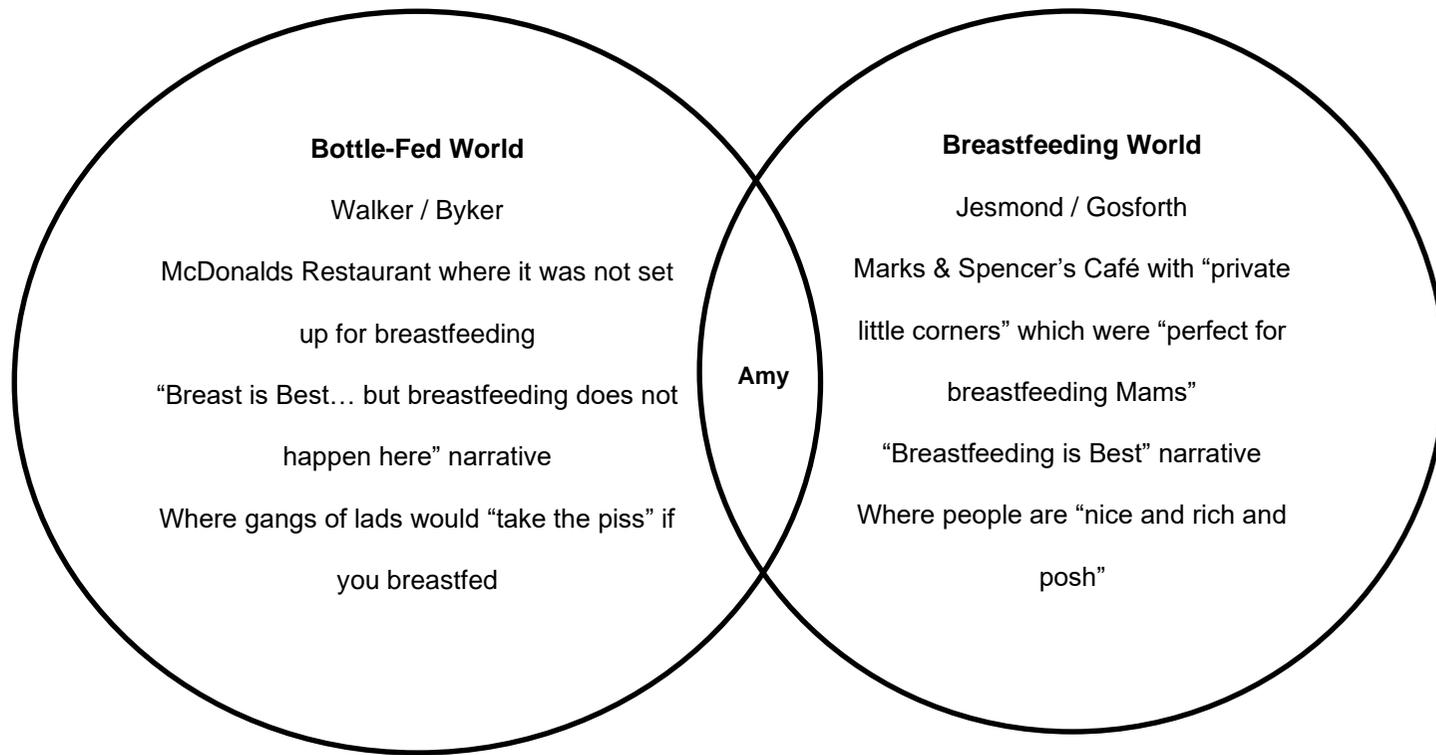


Figure 7.1 Amy's Worlds

'you know some of these people who are advising all of this mebies they need to do a bit more studies themselves and mebies they need to experience what it's like, what it's like living in a bottle fed world then living in a breastfed world you know.' (Amy)

The 'they' she refers to are public health practitioners who she clearly has placed in the 'breastfeeding world' as she recommends, they try living in her "bottle-fed world". Amy referred to the "breastfeeding world" as the more affluent parts of the city "where people are nice and rich and posh" and in which it was more acceptable to breastfeed. She also compared restaurants where people may or may not feel comfortable breastfeeding. When discussing her own experience of working in a Marks and Spencer's café, she suggested that people from the area of the city where she lived are more likely to go to McDonalds than Marks and Spencer's. In the UK and beyond, dining at a McDonalds restaurant is associated with working class populations while dining at a Marks and Spencer's is more associated with middle class communities (Jeffries, 2004; Carpenter, 2011; Arnade, 2016). Despite working at Marks and Spencer's, Amy felt that that people from her area did not belong there as customers and faced social restrictions in where they could go:

'I don't want to like be prejudice or judgemental but, more (2sec) un (1sec) I don't know what can I say to this, people like from [this area] are more likely to go into McDonalds than they would Marks and Spencer's, or something like, that's what I'm trying to say.' (Amy)

However, Amy also revealed her perceptions about other restrictions they faced from within their area. She spoke about the reaction women would get if they breastfed in her local area:

'you wouldn't want to breastfeed walking around here, you'd feel like you've got more chance of a pile, a gang of lads coming over to you and taking the piss you know if you were in your garden if it was a nice sunny day rather than if you were in a nice posh area where everyone was nice.' (Amy)

Amy identified herself in terms of her class status and she knew that social norms played a role in this. Scott *et al.*, (2015) found differences in social attitudes to breastfeeding in public in four different European areas, namely Glasgow in Scotland, Stockholm in Sweden, Granada in Spain and Reggio-Emilia in Italy. They found that the perceived social norms of each place exerted a “stronger influence on breastfeeding outcomes than a woman’s breastfeeding attitudes and knowledge” (Scott *et al.*, 2015, p. 78). Amy had considered the differences in the infant feeding narratives and attitudes across parts of the same city and her views about this absolutely highlight the way that social norms can play a part in breast feeding inequalities.

Amy’s comments take this issue beyond just the geographical areas and into social class, which influences how people behave. Amy identified that people from her area (working-class) would not go into more middle-class venues in town.

A local “Counter Narrative” (Bamberg, 2004) weakened the impact that the dominant societal Breast is Best narrative had over the mothers’ practice. It is argued that community norms and values are extremely important factors in the decisions women make about breastfeeding and that in some communities, breastfeeding is not

regarded as a valuable attribute (Peregrino, Watt, Heilmann and Jivraj, 2018). The women's conversations about breastfeeding in public in the areas where they lived and also the more affluent area nearby helps us to unpick the complexities of the issue. The norms and values within the local area became, at times, a very strong counter narrative (Bamberg, 2004) to the dominant societal Breast is Best narrative.

Amy, who had breastfed her first child for a couple of days and had formula fed her second child from birth, was acutely aware of the differences between her local area and the more affluent communities nearby:

'If someone breastfed around here you would get judged you'd get, you'd have kids, you know with it being a rough area, whereas if it was in Gosforth or Jesmond where people are nice and rich and posh, breastfed, breastfeeding is more accepted and so the areas where you are from does have a huge impact into your thinking and your decisions.' (Amy)

This is important as the idea that a good mother is a mother who breastfeeds has been discussed previously. The participants were aware of the dominant societal Breast is Best narrative that influenced their infant feeding practice in various ways. However, what is being suggested here is that a different narrative is in circulation in the participants' community. Amy's comments demonstrate how this counter narrative (Bamberg, 2004) could weaken the Breast is Best dominant societal narrative. This counter narrative (Bamberg, 2004) supports women's decisions to end breastfeeding sooner than they originally intended and also supports them in their decision to formula

feed from birth. In a Lancet Series on Breastfeeding (2016) it was suggested that:

“The success or failure of breastfeeding should not be seen solely as the responsibility of the women. Her ability to breastfeed is very much shaped by the support and the environment in which she lives. There is a broader responsibility of governments and society to support women through policies and programmes in the community”

7.3.2 Fitting into Local Social Norms

This perceived difference in breastfeeding attitudes between geographical areas was acknowledged by mothers who had breastfed for longer periods of time. Faye, who breastfed both of her children for several months before moving onto formula acknowledged the geographical differences which ultimately led her to avoiding activities in the more affluent areas:

‘like a lot of the groups round here there (1sec) like, not many people would breastfed in them, erm, apart from that one that [Sure Start] does the only one round really here, erm, but if you go ones in Gosforth, and Jesmond and everybody breastfeeds there so, think it’s just, nearly feel the other way when you go to them groups you feel bad to have a bottle ‘cause everybody’s breastfeeding (12sec).’ (Faye)

Faye responded to the different social norms and values in the way she fed her baby in different parts of the city. There was a risk, for her, of judgment in both places but directed at different behaviours. When breastfeeding, Faye described how she would try to plan her breastfeed to avoid breastfeeding when she was at the local baby group where the mothers formula fed:

'the groups round here you tend to find that er, you'd be the only one breastfeeding so normally I go to a group here I try to plan it so I don't have to feed when I'm out (1sec) so (1sec) erm (3sec) just I don't know if it might, sort if I just maybe make other people feel uncomfortable.' (Faye)

Previous research suggests that breastfeeding in a formula feeding culture is a risk for women, "jeopardising their perceived competence as a mother" (Groleau and Rodriguez, 2009, p. 96). However, Faye then described how, when she ended breastfeeding and began to formula feed her child, she avoided going to the baby group in the more affluent area where women predominantly breastfed, to avoid formula feeding in a breastfeeding culture. She described how she felt unable to feed her baby infant formula in a bottle at a breastfeeding group:

'I think by the time I was ready to go with Catherine I was I was combination feeding⁶ so I couldn't really feel comfortable to go then, because I thought it would have been all sort of breastfeeding people.' (Faye)

The strategies Faye took to avoid being seen doing the wrong thing in the wrong place helped her to fit in with the local social norms and values. Support groups for parents with young children such as Sure Start Children's Centres are known to have many benefits including an increase in maternal wellbeing (National Evaluation of Sure Start Team, 2012). Not being able to be authentic at these groups would have placed additional strain on Faye in terms of the way she

⁶ Combination feeding involves combining breast and bottle feeds (Public Health England, no date b)

presented herself. Her performance needed to be carefully planned and executed. Ultimately Faye stopped attending the group where the mothers breastfed. The lack of participation in the group and loss of support from the group members was an unfortunate consequence for Faye and her family.

Risking their hard-earned Good Mother identities appears to be a particular challenge for mothers who live in the local area. These identities were at risk in different ways, depending on the geographical location of the mother. Goffman (1963) suggested that we all have something about ourselves that we would like to hide from others, an attribute that could be seen as discreditable and could ultimately discredit us. For Faye at the Jesmond baby group the discreditable attribute she possessed was the fact that she was formula feeding. Faye felt that it was important for her to hide the fact that she was no longer breastfeeding while she was at this group. If this had come to light then Faye may have felt she risked being discredited, stigmatised and perhaps would feel a personal moral failing. Brown (2019a, p. 42) found that some women who had stopped breastfeeding sooner than they had planned avoided friends who were breastfeeding as the “strength of their emotion and grief” was overpowering. So, it was important for Faye to hide the fact that she was no longer breastfeeding. The effort that Faye had gone to manage her identity to avoid this discreditable information coming to the fore is significant. Faye’s identity and personal narrative as a Good Mother was

challenged. She felt judged in the two separate geographical areas for her infant feeding practice. Table 7.1 sums up the identity dilemma she faced:

Table 7.1 Faye's Identity Dilemma

Area	Walker Group	Jesmond Group
Social Norm	Formula Feed	Breastfeed
Feelings about group	Cannot go when breastfeeding	Cannot go when I stopped breastfeeding
Sense of Belonging	Live here, but do not belong?	Do not live here, belonged for a while, but not now
Strategies to 'fit in'	Aim: To avoid being seen breastfeeding. Breastfeed before going to the group or express breastmilk into a bottle	Aim: To avoid being seen formula feeding Breastfeed When formula feeding, feed before going to group, stop going to group

Goffman (1963) suggests that stigma occurs in the relationship between the attribute (in this case not breastfeeding and formula feeding) and the audience (in this case the two social groups in different geographical locations). This helps to explain why Faye felt the need to modify her breastfeeding practice to fit in with the audience in each of the areas. The “discreditable attribute” has changed here, depending on the geographical context. Ultimately, Faye avoided being stigmatised by bringing her attendance at the group to an end.

7.3.3 Strategies Used to Avoid Breastfeeding in Public

Breastfeeding is not visible in the area, partly due to the lower rates. However, the women explained how they would rather stay indoors or

develop strategies to avoid being seen while breastfeeding which also reduced the visibility of breastfeeding. It was found that breastfeeding in public can be an emergency response when other strategies have failed. If breastfeeding is not seen, then it may be assumed that the norm in the community is to formula feed.

However, we must also consider wider influences at play. Dedicated breastfeeding areas are present in many high street stores, providing places where breastfeeding is acceptable. This still implies however, that breastfeeding is something women should hide away to do.

Public breastfeeding Front Stage was avoided by most of the participants, as much as they possibly could. Their perceived lack of acceptance and therefore discomfort about breastfeeding in their local community caused them to adapt strategies to remain invisible.

However, each strategy allows the mother to demonstrate their own agency and identity.

They described five different strategies used to facilitate this:

- 1) Not going out
- 2) Planning trips out around feeds
- 3) Hiding away to breastfeed
- 4) Offering solid food instead of the breast
- 5) Feeding expressed breast milk or infant formula

7.3.4 Strategy 1: Not Going Out

As previously discussed, Gina did not leave the house while she was breastfeeding. When she began formula feeding, she commented that she could start to go out and people could start to come over. Izzy described how breastfeeding her first child had taken place in the main at home as she was “a little bit more funny” about breastfeeding in public with him and “was always in a hurry to get him home”. We know from other research that breastfeeding women do spend significant amounts of time at home. To avoid breastfeeding in public, McFadden and Toole (2006) found that the Bangladeshi mothers in their study did not leave their homes, as breastfeeding in public was not perceived as acceptable by the Bangladeshi community. Staying at home to breastfeed certainly does not promote the idea of breastfeeding being the normal way to feed a baby. However, this Backstage area provides a comfortable environment for new mothers to learn the art of breastfeeding.

7.3.5 Strategy 2: Planning Trips Out Around Feeds

The mothers went to great lengths to time trips away from home around breastfeeding, and to avoid having to breastfeed in public. Izzy, for example, described how she “worked out the timing” to be able to feed her second child Grace, while taking her son Matthew to playgroup avoiding the need for her to breastfeed Front Stage in public:

'it's not really something I feel comfortable with [breastfeeding in public] but erm, but it is, kind of, because she cluster feeds⁷ in the morning and she cluster feeds on a nighttime so I can kind of work my day around, around it so it feels a bit more erm (2sec) erm it feels like, I can, I can manage without doing that, I mean to be fair if I had to then, I would, erm but it's kind of in some circles I don't feel comfortable, yeah so as I say I can work, I can work my day around it (19sec).' (Izzy)

Later in the interview she gave more information about the window of opportunity during the middle of the day, when she was able to leave her home:

'yeah so as I say I, she, in the middle of the day she's, she, she doesn't need feeding so that's when I'll go out with Matthew and things like that.' (Izzy)

The necessity of having an older child who needed to go to regular activities appeared to force Izzy out of her home. Izzy emphasised how she worked her day around her daughter's usual breastfeeding pattern to avoid having to breastfeed Front Stage. Izzy described how the middle of the day was seen as a safe non-breastfeeding period where she was able to take her son out without risking the need for a breastfeed. She could go Front Stage without having to risk taking part in the Backstage activity of breastfeeding.

The extraordinary lengths women went to, to avoid breastfeeding in public were highlighted when Faye explained how a trip to the dentist took her three hours to prepare for. As she told her story, I wondered why she did not just take her baby to the dentist with her, but for Faye

⁷ This term refers to a period of time when babies breastfeed frequently (Public Health England, no date c).

this Front Stage environment, even though it was a medical one was still not a place in which she could be seen breastfeeding:

'I had erm, an electric pump this time, but it literally used to take me like an hour just to get a couple of ounces so it just wasn't worth the hassle [with first child] yes, and I tried again with expressing with her, never, really happened so, erm, 'cause like I had to go to the dentist so, it took me like three hours the night before just to get a couple of ounces (laughs) not really worth the hassle.' (Faye)

Timing the feed to allow mothers to breastfeed at home was also a strategy identified in an Australian study (Sheehan, Gribble and Schmied, 2019) where mothers spoke about breastfeeding just before going out or expressing to avoid breastfeeding in public. In a systematic review of literature from 2002-2012, it was found that one of the reasons women expressed milk was to be able to allow "the baby to be fed by someone other than his/her mother" (Johns *et al.*, 2013, p. 12). It could be suggested that at least some of this group of mothers who wanted to leave the baby with someone else did so to avoid feeding in public, in the way Faye avoided breastfeeding on her trip to the dentist. Li *et al.* (2008, p. 574) suggest that:

"if society perceives breastfeeding in public as normal behaviour, the need for mothers to leave infant at home might be eased"

These findings are very important as they describe the effort and determination mothers go through to make breastfeeding work for their families while also avoiding breastfeeding in public. For mothers like Izzy and Faye, their desire to breastfeed goes against the social norm of feeding with infant formula in the local area, yet they are so aware of this social norm that it impacts on their behaviour.

7.3.6 Strategy 3: Hiding Away to Breastfeed

Hiding away to breastfeed is another strategy used by participants to make breastfeeding work for them. Izzy described how she hid away to breastfeed, using the car or indeed other rooms of her home as the Backstage:

'at times when we have been out for like a meal or something like that I've just gone out into the car to feed er fed her in the car I just feel that [baby crying talks to baby] but erm, so er yeah I've done that and then at times where erm there's been like people from my family and stuff erm I've been round to Neil's mum's house so I will, I'll feed in a different room.' (Izzy)

When Faye breastfed in public, she used blankets and shawls to cover up, while Izzy referred to the way her mother threw a cover over her every time she started to breastfeed:

'[My mother]...was kind of all right about it then [in Izzy's home], but when I went to her's at Christmas it was kind of like, I was always being covered up by blankets and things (laughs).' (Izzy)

Research shows that women often chose to or are encouraged to use toilets or baby changing areas, or designated breastfeeding rooms to feed their babies (Amir, 2014). It has been suggested that these spaces to support breastfeeding mother may actually do little to support breastfeeding as they support the idea that breastfeeding is something to be done Backstage in a private area, and certainly not in public. Izzy did not feed in a toilet, instead she chose to breastfeed in the privacy of her car, or in another room at her in-laws' home. The use of blankets and covers to hide the breastfeeding act away from public view is also discussed. Amir (2014, p. 1) revealed that one

women she supported who used a nursing cover ended up with mastitis from feeding “awkwardly”.

Despite being the Backstage area, the mother’s own homes were also a place where they did not always feel comfortable in feeding their babies. Izzy found it difficult to feed at home with others present when the Backstage became the Front Stage:

‘with some people I feel comfortable about feeding in front of and there’s other people I won’t, so I’ll just go upstairs and feed.’ (Izzy)

This became a more significant issue when male relatives were present. Izzy mentioned one occasion when her partner’s male cousin came to stay with the family overnight. Izzy did manage to breastfeed Grace in front of her visitor but found it difficult trying to feed without revealing her breast:

‘so I was really kind of like, trying to do it really kind of, like without showing anything at all but then she was getting frustrated because she couldn’t latch on, (laughs) so it ended up being more of a you know a thing than it probably would have been normally so, erm, so yeah, you just, yeah ridiculous really.’ (Izzy)

She went onto say that she had even tried to latch Grace on to her breast, in a different room, to avoid exposing her breast to her visitor:

‘I started with trying to go into a different room and get her latched on and came, and come and sit down and then that didn’t work and erm, erm, it was never anything like, “well, no you’ll not do it in front of me” or anything like that you know he’s quite a like a liberal person, he wouldn’t ever you know be offended by anything like that so I think it’s just er it was just me having to get over the thing you know (3sec) it does sound silly now (18sec).’ (Izzy)

Ultimately, Izzy said she realised that she “just had to” breastfeed, because she was not prepared “to spend all evening upstairs”. Izzy said she had to “get over that” and actually after all of that he “wasn’t bothered”. McFadden and Toole (2006, p. 159) found that women in their study had difficulties breastfeeding in their own homes, particularly around male relatives. As previously mentioned, this was also true of Helen who was particularly worried and was “in a bit of a tizz” about feeding in front of her father-in-law. This private Backstage space, the family home, has somehow become more like the Front stage public space that women are greatly apprehensive about feeding in. If some women are not comfortable breastfeeding in their own homes, then this highlights the great challenge faced by Public Health campaigners in trying to make breastfeeding the social norm.

7.3.7 Strategy 4: Offering an Alternative to the Breast

Once babies are weaned onto solids, food rather than breastmilk can be used as a strategy to avoid breastfeeding in public. Faye said that once her daughter started eating solid food, going out was easier she did not have to breastfeed and she could “give her something to eat instead”. This would buy Faye some time until she was able to get back home. It is currently recommended that babies are weaned onto solid food at six months of age (NHS Choices, 2017). Six months may be considered by some to be an incredibly long time for women to wait to be able to use this strategy in order to facilitate leaving the home with their child.

Expressing milk to feed to babies in a bottle may be seen as a useful strategy for women who feel uncomfortable breastfeeding in public.

Amir (2014, p. 2) would agree that “expressing milk for healthy term infants might help women extend their duration of breast milk feeding, but it doesn’t help normalise breastfeeding at the breast”. Helen suggested that expressing might be a good option for many mothers who are put off breastfeeding in front of other people:

‘argh no definitely I would have done [fed expressed milk in a bottle] because you know you because as I say that was the main reason why I wanted her to have erm, why I wanted to breastfeed her I mean I think, to be honest I think more people would probably breastfeed (1sec) if they didn’t have to get their boob out (laughs) if that makes sense, I do it think a lot of people are icky about getting their boob out kind of thing in public or in the home ‘cause some people are like that. If they could get their milk into a bottle they would probably feed them hersel., there selves kind of thing like that, if that makes sense.’
(Helen)

Helen however, had acknowledged that for her, expressing had been unproductive and she had “only managing to get like a bottle a day”.

Andrew and Harvey (2011, p. 55) found that in their research in Berkshire, England that although “expressing milk was helpful for some participants, others reported difficulty expressing enough milk”.

Manufacturers of electric and manual pumps are aware of the desire for women to express their milk to feed to their baby in a bottle. A baby being fed breast milk in a bottle, may of course be seen by many as a better alternative to a baby being fed infant formula.

Even breastfeeding women who are confident and feel comfortable to breastfeed in public may choose to express milk into a bottle to make

trips away from home a little easier. Emily who was breastfeeding at 16 months, at the time of our second interview, took expressed breastmilk or infant formula with her when out in town. She explained this was not because she was embarrassed to breastfeed in front of others but because breastfeeding was just so time consuming for her:

'I need to have something with me whereby I can just keep sticking it in her mouth for a few minutes, because otherwise I'd literally be tied to a cafe so I don't think I'm tied to being in the house, but I am tied to needing somewhere to sit and feed her for long period of time.' (Emily)

Forster and McLachlan (2008, p. 121) also found that some women in their study also used infant formula to feed their babies when they were in public. This research took place in Melbourne, Australia, where breastfeeding rates are much higher than in the North-East of England. Although Emily's reasons for not breastfeeding while away from the home are different, she still represents another invisible breastfeeding mother who lives in the area.

7.3.8 Invisible Breastfeeding

As previously mentioned, feeding babies with infant formula is seen as the social norm in the local community, however 69.4% of babies were breastfed at birth in Newcastle upon Tyne in 2016/17 just short of the then England average of 74.5% (Public Health England, 2019) showing a willingness at least to "give it a go" (Bailey, Pain and Aarvold, 2004) and that breastfeeding is actually the social norm across the city. The findings from this research reveal that a lot of the breastfeeding that is taking place in the area is hidden away and ultimately becomes

invisible to the general public. This may maintain the social norm in the community that breastfeeding is not the normal way to feed a baby and the narrative that, breastfeeding does not happen here, despite the fact that many women are breastfeeding. Invisible breastfeeding was also found in research carried out by Steans (1999).

It is argued that if breastfeeding is not actually observed in a community then this can prevent future mothers from breastfeeding. Observing other women breastfeeding is known to be a breastfeeding enabler (Hoddinott and Pill, 1999). Andrew and Harvey (2011, p. 57) suggest “the difficulty that many mothers experience breastfeeding in public is particularly relevant because it may perpetuate the belief that breastfeeding is not the norm”. The fact that breastfeeding is not seen in the community means that breastfeeding skills are not passed on through the generations.

7.4 Chapter Summary

Breastfeeding in public was an issue raised several times during the women’s stories. It is known to be an important issue which has been part of many other research projects around infant feeding (Sheeshka *et al.*, 2001; Forster and McLachlan 2008; Amir, 2014; Brown, 2021a; Grant, 2016). Similar to previous research, the mothers were concerned about breastfeeding in public and anticipated issues, however in reality they had little difficulty if circumstances meant they had to do it. However, women demonstrated how they went to

extraordinary lengths to avoid breastfeeding in public as much as possible. This included breastfeeding in front of other people at home and a range of strategies were presented to show how this was facilitated. This included hiding away to breastfeed and planning trips out to avoid the times when babies were likely to need a feed. The inconvenience of breastfeeding for a mother who was happy to breastfeed in public was also highlighted, she explained how taking a bottle or formula or expressed breast milk out on shopping trips allowed her to have a better shopping experience. This all leads to an environment where breastfeeding is invisible even though it is happening.

The mothers perceived differences in the attitudes around feeding babies in different areas of the city which had an impact on their feeding practice. The more affluent areas were deemed to be more accepting of breastfeeding than the less affluent areas where the mothers lived. It is argued that these social norms were being perpetuated by the women themselves, through their stories and judgement of one another.

It is argued here that overall, the Breast is Best dominant societal narrative was present, and all mothers were aware of it and responded to it. However, a counter narrative (Bamberg, 2004) that, breastfeeding is not the done thing, was present in the local area

which acted against the Breast is Best narrative and weakened its strength.

The next chapter shows how breastfeeding was integral in the degree to which a good mother identity could be claimed. It demonstrates how the mothers were about to support and construct their identities as Good Mothers in the way that their stories were told.

Chapter 8: The Plot: Stories About Extraordinary Maternal Identity

8.1 Introduction

This chapter explores the way each of the mother's stories helped them achieve and demonstrate their social aim of being a good mother and suggests that the way infant feeding stories are told may have an impact on the initiation of breastfeeding in communities. Women in the UK report that they feel under pressure to be recognised as "good mothers" (Murphy, 1999; Furedi, 2008; Brouwer, Drummond and Willis, 2012), and infant feeding decisions are just one of the ways mothers feel that they are judged by society (Murphy, 1999; Bailey, Pain and Aarvold, 2004). All of the mothers were aware of the dominant "Breast is Best" (Palmer, 2009; Brown, 2021a) narrative present in UK society and their stories reflected this, whether they breast fed, formula fed or used a combination of the two.

The nine mothers who took part constructed their stories in a way which demonstrated their good mother "Front" (Goffman, 1959, p. 32)⁸. Goffman describes a Front as the role people play, when out in public view. This chapter draws further from Goffman's (1959, p.16) theories of social interaction; specifically, the concepts of the "Given" (the message a person intends to give about themselves), and the

⁸ Key terms in this chapter, such as Goffman's (1959) Front, Given, Given Off, and Labov and Waletzky's (1967) Complicating Action and Coda are referenced many times in this chapter. For ease of reading (in this chapter only) they have been formally referenced once and then capitalised.

“Given Off” (the actual message a person gives off about themselves) to understand the ways that the potential for moral judgement is negotiated by the mothers. It is argued that participants’ good mother Fronts were in jeopardy at moments in their stories when their Given Off challenged their intended Given message as that of a good mother. This occurred for women as they moved from breastfeeding to formula feeding and for others who formula fed from birth. These points in the stories were framed as significant “Complicating Actions” (Labov and Waletzky, 1957) and the mothers cited extraordinary circumstances to support their stories and infant feeding decisions. They demonstrated that their mothering stories were not ordinary and that they had been through extraordinary and exceptional circumstances which led them to infant formula. The end of breastfeeding became a way of demonstrating strength, and this in turn raised their status to that of an extraordinary mother.

This chapter demonstrates how the mothers’ stories followed the culturally preferred restitution narrative (Frank, 2013). The restitution narrative comprises a story with a beginning, a middle and an end, very much like the order of Labov and Waletzky’s (1967) Narrative Sequence. Frank’s restitution narrative (2013) consists of an individual who can bring a significant Complicating Action of ill health or disease to a positive, restorative conclusion. This restores the person’s identity to that of a well person or even improves their identity to that of a survivor or hero. Many of the infant feeding stories told by the mothers

followed a restitution narrative, only for them it was their good mother Front that became restored or improved by the end of the tale. The stories of both breastfeeding and formula feeding contained elements of challenge. For the women who formula fed from birth, the ill health of the babies formed an additional element. To incorporate this, although participants who formula fed from birth continued to follow a restitution narrative, they told their stories in a slightly different way which ultimately protected their good mother Front.

This chapter argues that the culturally preferred way of telling stories in the UK, with a restitution narrative structure may encourage the distribution of breastfeeding horror stories around the community. It goes on to suggest that this may, in turn, contribute to lower rates of breastfeeding in certain areas. In doing so, this research makes a key contribution to the existing literature in that it demonstrates how stories are used to maintain morality and the potential impact this may have on breastfeeding practice.

8.2 Demonstrating the Good Mother Front in the Stories

UK society expects good mothers to self-sacrifice and put their children before themselves (Murphy, 1999; Furedi, 2008). Murphy (1999, p. 187) suggests that a woman who formula feeds “exposes herself to the charge that she is a ‘poor mother’ who places her own needs, preferences or convenience above her baby’s welfare”.

Women are aware that in the UK they should be a good mother and

know they need to be seen in this way. All the women were involved in some form of moral work when telling their stories. In research carried out with breastfeeding mothers from across the UK, Ryan, Bissell and Alexander (2010, p. 954) found that:

“moral work as biographical repair was undertaken by several women who wished to modify their sense of self from an undesirable or uncomfortable position to one that they felt or thought would be more comfortable or socially acceptable.”

Moral work is important in creating the ideal good mother Front. My research demonstrates the way mothers do this in an area where breastfeeding is not the norm.

A concern to demonstrate their good mother Front was apparent in each of the nine stories told at the heart of my research, albeit accomplished in different ways, and was identified at each panel analysis session as a key hypothesis (see Chapter 3). Goffman (1959, p. 32) used the term Front to refer to the image a person gives of themselves to others in their “Performance”. This can include a person’s conduct, appearance (which involves a degree of stereotyping) and what the person says about themselves. Goffman (1959, p. 44) suggests that performance is “‘socialised’, moulded and modified to fit into the understanding and expectations of the society in which it is present”. This Given Front, the social aim for all nine women was that to be seen as a good mother. However, for six of the mothers their Given Off, the act of feeding with infant formula

challenged their Given as their actions did not support the assumption in society that good mothers breastfeed their children.

Becky, who fed her daughter with infant formula from birth demonstrated her good mother Front by showing that she had to work hard to “beat the system”, and had demanded that health professionals test her daughter for lactose intolerance:

‘but just you know [health professionals] don’t give first time mothers the credit isn’t it? They just brush you off straight away...I, I had a feeling you know when something is not right and I’m a [childcare professional] as well so I’ve fed kids before I know when things aren’t normal do you know what I mean or not the norm should I say and erm (2sec) but yeah the just, the looks that you get (4sec) you’ve just got to beat the system don’t you when you’re a first-time mother.’ (Becky)

Becky demonstrated that she was a good mother by explaining that she knew what was best for her child. She felt that health professionals ignored her when her baby was poorly with a whole range of health issues including thrush, wind, reflux, sickness, loose green stools, constipation and choking. However, because she was a good mother, and more specifically a good formula feeding mother, Becky fought to make them listen.

For Izzy, breastfeeding took up most of her day due to issues her daughter had with frequent vomiting. This made it very difficult for her to see friends or leave her home. Izzy, however, was clear that she did not regret making these sacrifices to breastfeed:

'It does sometimes feel a bit restrictive and a bit draining but I think it's, I don't, I don't feel resentful or anything like that you've just, you've just, you've just got to get on with it really.'
(Lizzy)

Expectations about being a good mother often begin during pregnancy (Thompson *et al.*, 2001). At that time women plan their future biography, they write birth plans and purchase the “stuff” (Miller, 2010) they imagine what they will need for their new lives with the new baby. This planned biographical trajectory builds up an expectation of how things will be once the idealised future child has arrived (Thompson *et al.*, 2001), including where and when the baby will sleep (Luzia, 2011) and what it will be fed (Murphy, 2004).

It can be assumed from the initiation of breastfeeding statistics that around 73% of women in the UK plan to breastfeed (NHS Digital, 2020) therefore seeking to align their practices with what they felt was the omnipresent Breast is Best narrative (Carter, 1995; Brown, 2021a). The act of breastfeeding is almost a message to society to say that a woman is a good mother, and this is part of the women's Given. Society places these expectations on women and expects them to do the right thing. Danni, Gina and Emily spoke about the plans they made during their pregnancies to breastfeed. Danni had observed her sister bottle feed, however Danni wanted to “give it [breastfeeding] a go” as she was aware of the health benefits. Gina was “set on” breastfeeding despite hearing about the “cons” at a breastfeeding workshop. Helen said that she wanted to give her

daughter the “best possible start” by breastfeeding despite living in a community of bottle feeders:

‘I was re., wanting to give her the best possible start, and then, and obviously I was hearing about other mothers and stuff and saying, “oh” they would just you know, they didn’t bother with breastfeeding and things erm, I know my partner, his, his erm work colleagues couldn’t believe I was breastfeeding they were like “argh nargh we just put ours straight on the bottle” and things like that.’ (Helen)

This suggests that Helen, along with Danni and Gina were planning their Front in terms of their future mothering identity during their pregnancies. However, as will be demonstrated further, the reality of motherhood does not always follow the anticipated future and in the end Helen, Danni and Gina all ended breastfeeding sooner than they had planned. This disruption to the three women’s planned biographical trajectories caused a predicament. Their good mother Front was at this point in jeopardy as their Given Off contradicted the good mother Given, presenting a different, less desired message to society. To repair this, the three mothers constructed their stories in such a way to defend their good mother Front by referring to evidence of the extraordinary circumstances they had to endure.

8.3 Extraordinary Circumstances and Mothers

Disruptions to our biographical trajectory, such as for Danni, Helen and Gina who did not breastfeed for as long as they had first intended, cause individuals to re-story and repair. Ryan, Bissell and Alexander (2010, p. 952) suggest women reconstruct events when breastfeeding has not gone the way a woman had planned, helping to “restore

equilibrium". Riessman (1993, p. 2) suggests that reconstructing events help people to "claim their identity". Indeed, re-storying is a technique used in narrative therapy to help people recover from traumatic events (White and Epston, 1990). All the breastfeeding stories I was told had happy, successful outcomes including those where the women did not breastfeed for as long as they had first intended. They followed the culturally preferred restitution narrative (Labov and Waletzky, 1967; Frank, 2013), ending with a positive Coda despite some significant Complicating Actions.

Helen, Danni and Gina's identities are ultimately challenged by the messages Given Off when they move to formula feeding, but are repaired by attributing the decision to switch to an extraordinary Complicating Action, thereby retaining their good mother Front. Table 8.1 provides an overview of the restitution narratives in the three mothers' stories, before they are then analysed in greater detail.

Table 8.1 Restitution Narratives - Mothers Who Stopped Breastfeeding

	Abstract	Orientation	Complicating Action	Evaluation	Resolution	Coda
Danni	Not provided.	Decided to breastfeed during first pregnancy, wanted to “give it a go” people around her bottle fed, friends further away breastfed. Easy start to breastfeeding.	Increasing levels of pain, followed by mastitis, a breast abscess and then breast surgery when baby was 4 weeks old.	Upset, felt judged by others for bottle feeding. Felt was not given enough guidance about breastfeeding but was starting to feel uncomfortable breastfeeding anyway and was considering combination feeding.	Felt baby was “doing fine being bottle fed” . Bit concerned about infant formula not being “natural” but baby was interested in other food so milk is not as important .	Would breastfeed future children despite others thinking she is “crazy”.
Gina	Not provided.	Decided to breastfeed during pregnancy with first child. Attended a breastfeeding workshop at 32 weeks.	Uncertainty about doing it right, breastfeeding “constantly” but poor weight gain. Breast pain increased throughout feeding period from “a little” to “excruciating” pain with bleeding nipples . Also “excruciating” toothache - ongoing since pregnancy.	Was not shown what to do or what to look out for while in hospital. When baby’s weight dropped a midwife helped with technique and suggested expressing after every feed and waking baby every three hours to feed. Feeding and expressing every three hours was becoming unsustainable.	Dentist advised not to breastfeed while taking antibiotics for toothache . Gina gave infant formula during this period, but breastmilk supply went “right down” so stopped breastfeeding at 4 weeks and continued with formula.	Baby more content on formula. “she was happy, I was happy” . Baby’s weight moved from 25th to 75th percentile when she switched to formula. People could now come over and she was “getting more of a life back”. Glad she “gave it a go” .

Table 8.1: Restitution Narratives – Mothers Who Stopped Breastfeeding (Continued)

	Abstract	Orientation	Complicating Action	Evaluation	Resolution	Coda
Helen	Breastfed for ten weeks until return to work.	Was always going to breastfeed “to give her the best possible start” . Very easy start to breastfeeding first child.	Self-employed. Returned to work early . Baby stayed overnight for childcare with Grandmother who lived a distance away	There was no alternative other than infant formula as “work and money dictate”.	Feels guilty “in the background” for ending breastfeeding but no alternative.	Would definitely breastfeed future children , “if possible, I will try and do it longer”.

8.3.1 Danni's Surgery

Danni's story was complicated by surgery for a breast abscess, a significant Complicating Action and extraordinary circumstance. Her story (see Table 8.1) follows the classic restitution narrative (Labov and Waletzky, 1967; Frank, 2013) which helped her to give emphasis to the Complicating Action of Surgery which in turn supported her good mother Front.

Danni sets the context at the beginning of the story by saying that she wanted to breastfeed. Danni's story of pain and challenge begins with a very positive start, she breastfed in hospital and initially it worked well. She went to great lengths in the beginning of her story to set this up, including her partner and the use of direct speech to lend authenticity to her story (Buttny, 1998; Hall *et al.*, 2014):

'erm, so when she was born erm I initially though it was really easy and I remember saying to my partner, "why does everyone not do this? it's so much easier".' (Danni)

Danni painted a picture of an easy transition in identity, from that of a pregnant woman to a breastfeeding mother. This contrasts starkly against the severity of the Complicating Action and extraordinary experience that was to come, which consisted of four weeks of hurt, pain and perseverance. Her story detailed her experience of mastitis, a breast abscess, surgery and unplanned formula feeding. She upheld her good mother Front by breastfeeding for as long as she possibly could, despite the extraordinary experience going on. Danni spoke about those early weeks:

'I continued to like persevere with it and even though it hurt and erm it, it started to settle after about maybe three or four weeks and then I found that I was just having pain in one breast and I spoke to the midwife about it and she again just told me to persevere and then one night it hurt so much I couldn't sleep and I didn't know what it was 'cause I'd, no one had give me kind of advice on what it was, so I had to go to the erm, like to the out of hours GP at the hospital on the Sunday, got a prescription for mastitis which then the day after I thought I'd never heard of it before so I just thought it was the mastitis coming to a head but I'd actually developed a breast abscess, so erm I stopped feed, breastfeeding there and then so that was like four, how old was she? four weeks, and, erm, and you know having to erm [crying] sorry, and the, and ended up having to have surgery.' (Danni)

Danni described how she was uncomfortable with her identity transition to that of a formula feeding mother. Her Given Off was now in conflict with her good mother Front. She explained how she had previously been quick to judge women who were not breastfeeding:

'when I was breastfeeding if I saw someone bottle feeding I'd be a bit like, "why didn't you give it a go" because a lot of people just don't do they?' (Danni)

Now as a formula feeding mother, she felt she was the one being judged:

'I do sometimes feel that people look down on you as well if you bottle feed and yes people don't always know your story do they?' (Danni)

Even in this brief comment that "people don't always know your story" Danni defended her good mother identity. She intended to breastfeed, but there is a reason and a valid extraordinary reason that she did not. She was aware that her Given Off was letting down her good mother Front. She maintained her good mother identity by attributing the ending of breastfeeding to the surgery. She made it clear in the way

her story was told that she stopped breastfeeding through no fault of her own and that she really did try to breastfeed for as long as she possibly could. Another way she was able to repair her identity was by saying in the Coda that she would try to breastfeed any further children:

'I had another I would probably try and breastfeed again, but everyone is like, "you're crazy, don't" [laugh].' (Danni)

This appears, in the context of her story to be quite a heroic, selfless thing to do. Danni was able to repair her good mother status by telling the tale of the extraordinary circumstances, but also by suggesting she would breastfeed any future children. Danni follows the classic restitution narrative to tell her story; by suggesting that breastfeeding was so easy at the beginning in her Orientation and by suggesting she would breastfeed future children at the end in the Coda, Danni's identity is restored to that of a responsible, good mother who would breastfeed future children, putting her children's needs before her own.

8.3.2 Helen's Early Return to Work

Helen's story relays the conflict she felt about returning to work, a commonly recognised Complicating Action for new mothers (Marshall, Godfrey and Renfrew, 2007; Thomson *et al.*, 2011). Helen described how she was caught in a dilemma between wanting to be a mother, and the need to earn money and have a successful career, with this

itself putting her good mother Front in jeopardy, alongside the issues she faced with infant feeding.

Helen was self-employed, so received limited maternity benefits and told me that although her partner worked full time, money for the family was tight. Helen returned to work when her daughter was just a few weeks old. She described how people had told her this was “quite early”, drawing upon the opinion of others to support her claims that the situation was more extraordinary than ordinary:

‘to be honest I didn’t want, I didn’t want to give her away like the first morning I had tears rolling down my face and up unt., up until going back I was like, I didn’t really want to do it and it, and a lot of people said like it’s been, “it’s quite early” kind of thing and we understand and again but everybody been saying, “well, I suppose it’s only 2 days”.’ (Helen)

Helen’s mother provided childcare. However, as she lived quite a distance away from the family, childcare involved a series of long-distance journeys, drop off points and overnight stays. Helen felt guilty about ending breastfeeding as well as returning to work and appeared aware of the messages this could have Given Off but, like Danni, was able to repair her identity by emphasising the extraordinary circumstances and the associated guilt she felt:

‘that’s why I feel guilty because I feel like that she should be getting the best possible that there is, erm but because of, unfortunately money makes the world go round. Mam has to go to work and get some, get some pennies together and I know, like, well me fiancé he’s he has a good job, it’s not brilliant, it’s not like thousands and thousands and thousands of pounds but it keeps us going.’ (Helen)

Like Danni, Helen began her initial story very positively and described a trouble-free breastfeeding experience. She appeared to balance out the guilt she feels for stopping breastfeeding at ten weeks by celebrating the sense of achievement she felt in breastfeeding at all:

'when you heard she was putting on a bit of weight and things 'cause of what you'd done as well it was really quite like positive and really you know erm I felt really proud of myself in some ways, you know I was like giving her like a good, good chance.' (Helen)

To further add to the moral work she was doing, Helen, like Danni also indicated that she would breastfeed any future children she had in her

Coda:

'if, if I ever children, like have any more children which I really do want I'm definitely gonna be breastfeeding definitely again I don't know for how long or whatever, it depends on what my work I suppose you know work and money dictate in terms of that (10sec) erm just trying to think if there's anything else (18sec) I don't I can't think of anything else.' (Helen)

8.3.3 Gina's Toothache and Breast Pain

Breastfeeding for Gina did not go well. She experienced pain during her four-week breastfeeding experience and the way she constructed her story and her use of language helped her to evidence this Complicating Action in depth (Labov and Waletzky, 1967). Her description of the way the pain built up helped to turn quite an ordinary and commonly reported breastfeeding experience into an extraordinary one. At first, Gina reported that "it started getting a little bit painful" then "it was getting extremely painful" and then "it was like unreal the pain... I was crying every time I was feeding her". Finally, she refers to the "excruciating pain" she felt due to both the

breastfeeding and toothache she had been battling with since pregnancy. In the end Gina said she had to end breastfeeding to take antibiotics as advised by her dentist⁹:

'I had like excruciating toothache and it turned out I had an infection in me wisdom tooth which they [the dentist] told us I need antibiotics for and they told us I couldn't use my breast milk while I was on the antibiotics, so after I had been through all of that I thought, "argh my god", but the[y] only, the[y] only gave us three days of antibiotics so I thought I'll just keep expressing to keep me supply going and then obviously I'll go back to giving her the milk again, so I put her on the bottles for those three days and I was just like getting rid of the milk, but because I was kind of getting comfortable with just giving her bottles I was expressing less and less like by the last day and I went back to the dentist and I needed more, so I thought "argh" so I had like another few days worth and I just kept expressing less and less so by the time I got back to feed her the milk, my supply had gone right down.' (Gina)

With the ending of breastfeeding, Gina's good mother Front was in jeopardy. As for Danni and Helen, her Given Off was contradicting her Given. However, Gina was able to maintain her Front as a good mother by including the extraordinary experience of "excruciating pain" in her story. For Gina, who had battled against pain, there appeared to be no choice but to end breastfeeding. Towards the end of her story, Gina summarised the experience she and her baby had gone through and positions both of them in the Coda as happier:

'I was thinking like the first few weeks I thought I did not expect, to, like it to be this difficult I couldn't leave the house, I was in pain obviously from birth anyway so I was in constant pain, erm obviously not sleeping which you expect anyway, but I just I was getting like really upset constantly, even when I wasn't feeding her I was to the point I was so down erm and I thought

⁹ It is important to point out here that current NHS guidelines suggest that most antibiotics are considered safe and suitable for breastfeeding mothers (NHS, 2021a).

it's not right to feel that way, but then obviously when I started putting her on the formula I could then leave the house, erm, people could come over because I didn't have her constantly on the breast, and I felt like I was getting more of a life back and she like I say was more content so she settled for longer so we were both kind of happier for it really, (11sec) and now she's a little chunky [to baby] (laughs).' (Gina)

This happy ending elevates Gina's status to an even better mother than before, she was now an extraordinarily good mother. She had gone through this extraordinary experience with her baby and had not only restored her identity but had improved it to that of a survivor or hero, in the same way Frank (2013) found his participants did following their own battles with ill health.

8.3.4 Breastfeeding Stories were Easily Narratable

Danni, Helen and Gina followed a commonly used restitution narrative framework to tell their stories. For each of the three women, their stories of ending breastfeeding could have damaged their status as a good mother. The extraordinary circumstances they included in their stories could have resulted in tragedy, in an unhappy ending of personal defeat, but they did not. Danni, Helen and Gina were able to use the narrative format that we are all accustomed to as children to tell their tale and repair and indeed enhance their status at the same time. Their good mother Fronts were intact and in fact lifted to that of a survivor or hero.

8.4 Extraordinary Formula Feeding Mothers

Just like the women who ended breastfeeding early, the women who formula fed, included in their stories a range of circumstances which supported their decision to feed infant formula to their children. These extraordinary circumstances were different to those of the breastfeeding women but were still extraordinary enough to protect their good mother Front despite formula feeding Giving Off another opposing message. All the mothers faced challenges whether they breastfed, or formula fed, and all the stories came to a resolution (a happy ending) which fits with the way we, as a society, like to tell (and expect to hear) stories. The three stories of women who formula fed at birth will be considered next (see Table 8.2 below).

The stories the women who formula fed told were structured in a different way to those of the breastfeeding women, these formula feeding stories appeared to have a disconnect between the extraordinary circumstances they faced, the Complicating Actions and their Codas. All of the mothers who formula fed appeared to follow the culturally preferred restitution narrative albeit in a limited way. They all included an Orientation and a Coda, but their evaluations and resolutions were chaotic, so much so that it has been impossible to categorise them into a neat table as has been done with the women who ended breastfeeding.

Table 8.2 Narratives - Mothers Who Formula Fed from Birth

	Orientation	Extraordinary Circumstance / Complicating Action / Evaluation / Resolution	Coda
Amy	Was very young when had first child	living in a bottle-fed world where breastfeeding would not be appropriate ill health of the baby – constipation, irregular bowel movements, reflux, vomiting “Chopped and changed between four different milks” even though Amy “knew it was wrong” Baby still having issues with digestion and waking up during the night “loads”	Son was “thriving”
Claire	Age 21 when had baby, living with parents, close knit family	Choosing the best brands and bottles for her baby ill health of the baby -reflux Changed brands of infant formula a number of times	“it was a good choice to choose”

Table 8.2: Narratives – Mothers Who Formula Fed from Birth (Continued)

	Orientation	Extraordinary Circumstance / Complicating Action / Evaluation / Resolution	Coda
Becky	Thought of herself as a “lost cause” in terms of breastfeeding	Had to fight against the system as a first time mother to defend her choice ill health of the baby –wind, sickness, screaming, thrush, “loose green poo”, constipation, lactose intolerance and emergency hospital visit Changed brands a number of times to sort out digestive issues	Milk was never really that important anyway “he’s not fussed really on his milk

For the three stories of formula feeding, it was difficult to identify one Complicating Action as the stories were quite “chaotic”. Frank (2013, p. 97) defined the “chaos narrative” as “hard to hear” because “the teller... is not understood as telling a “proper story”. Furthermore, Frank refers to the syntax structure of chaos narratives where tellers move from point to point with an “absence of order”. This is certainly the way the formula feeding stories were told. However, unlike Frank’s chaos narrative where there is no clear end to the story, all three women brought their stories to a close with a Coda. The women did not leave their stories in chaos, all three included a happy ending, a happy ever after Coda which protected their good mother Front.

The stories of formula feeding did contain extraordinary circumstances, with all three mothers speaking about the ill health of their child, but this was not directly or specifically linked to the ending of the story. Amy, Claire and Becky spoke about issues with their baby’s health and how they had to change the infant formula several times but none of the three appeared to suggest a link between the ill health of the child and formula feeding. This contrasts with the ending of the breastfeeding stories which closely followed Labov’s structure and include a Complicating Action, an extraordinary circumstance attributed to something external to maintain the good mother Front.

8.4.1 Amy's Youth and Living in a Formula Feeding Community

Amy began her story by emphasising that she was a young mother, having her first child at 18, and that she lived in a community not set up for breastfeeding:

'right, well I've got two children and erm while I was pregnant (2sec) me thoughts about feeding them were completely different, erm I was pregnant at eighteen with me first, and pretty much from the beginning I was only young, it was an unexpected pregnancy, but I was determined to breastfeed, erm I'd read up all the benefits of it and, obviously being a hell of a lot cheaper, so I thought I'm determined to breastfeed and when he was born, I did ask the midwife to help us, show us what to do but to be honest she didn't really seem to help us a lot she guided us putting him on me boob, and that stuff like that but she left us to me own devices and I was struggling and erm Simon, that's me eldest his first feed was off the breast, and apparently I've heard that's the best for your baby the first ever feed as long as you can get the first couple of feeds in and I did, but when I got home I tried it and I just couldn't get the hang of it, so, I basically gave up.' (Amy)

It could be argued that the opening of this narrative helps to orient the listener to the key message of Amy's story; that she did try to breastfeed her first son but there were barriers in her way. She was aware that her Given Off could suggest to others that she may not be a good mother so she defended her position. Amy's story contains a lot of justification, to suggest why the world is not set up to help women from her area with anything, including breastfeeding. The reasons she did not breastfeed are often attributed to other factors, beyond those within her individual control. She blames others, referring to unhelpful midwives and health visitors, and feels that it is not seen to be acceptable to breastfeed in the area where she lives, as mentioned in Chapter 7, citing a fear of young people in particular.

Amy did not breastfeed her son but was able to repair any damage done to her maternal identity by reinforcing the characteristics of the community in which she lived and drawing upon the exceptional circumstances of her age and her community. Her situation was not ordinary, it was extraordinary, and this accounted for her behaviour.

Amy told me how she broke the rules of preparing and storing infant formula to try to make parenting her son fit with her circumstances. Her son had health issues including constipation, irregular bowel movements, reflux, and vomiting but Amy appeared to overlook this when bringing her story to an end. Like the other formula feeding mothers, Amy changed brands many times, but she made an active decision to feed her newborn son a follow-on milk, the "blue milk" (stage 2) which is manufactured for babies 6 months and above. She gave him this milk from birth to try to prevent him from getting hungry:

'and it was just pretty much a bad idea I thought I would be doing right in starting him off so he wouldn't get hungry, but he got constipated really bad the first couple of months of erm, his, his life I was chopping and changing milks, I s., tried so many different milks 'cause his erm his bowel movements were so irregular, the w., he was always crying constipated and I knew it would be because of the milk I tried the comfort milk, erm I tried the colic milk, the, I chopped and changed between four different milks and I knew it was wrong and I knew you were not really meant to but I was just at a loose end, so in the end I just persevered with the blue milk number 2 and after a while he started getting used to it, tolerant to it, and his poos started to come regular, but it was a hard long process.' (Amy)

It is impossible to say why her baby had digestive issues but along with starting him off on a formula designed for older babies, Amy revealed some other details of her feeding practice which may have

had an influence on her son's ill health. She told me how she warmed her son's bottles up in the microwave despite knowing it was "dangerous because you can get hot spots in the milk". She also revealed her evening routine, making up a number of bottles at once, storing them unrefrigerated and feeding them cold to the baby. This is against current NHS advice (NHS Choices, 2021a), which Amy was aware of:

'I don't care what, is said I'll make before I go to bed I'll make up 3 bottles, just with a small amount of milk in each of them because he can't settle it, without erm his bottle and I'll make like 3 or 4 ounces and I'll have them ready in the bedroom and I'll give him them cold, he'll drink them at nighttime when he is still tired and I'll just give him them and he is fine, so I don't worry about the bottles lying about too long 'cause you. I've done it now for a few month for him, plus it's, it's convenience for me as well I couldn't possibly be getting up 4 times in the middle of the night and making fresh bottles each time.' (Amy)

Amy ended her initial story in a positive way, her Coda made no connection between the possible link with her son's poor health and the way she had prepared and stored the feeds:

'he's thriving now, so the milk has helped him I'm still giving him milk now, he's ten and a half month.' (Amy)

At the time of the interview Amy's son was still having issues and "waking up during the night loads of times loads for his age" but she told me he was "thriving". Not following health advice may have caused issues for Amy and her son, but she did not appear to connect the two.

8.4.2 Claire's Extraordinary Bottles and Brands

Claire was 21 years old and living with her parents when she had baby Sophia. She described a close-knit family, with relatives very present in her story. Claire's mother and sister had both formula fed their children. Her story began in a way that surprised me when she told me the colour of the bottles she had planned to use to feed her daughter:

'so please can you tell me the story of your experiences of feeding milk to your baby.' (Justine)

'well I started when I was pregnant, erm, I've always wanted to bottle feed her er, 'cause there was pink bottles that I wanted to get her erm and also knew the milk that I wanted to put on her erm, and just bottle feeding become very easy to us.' (Claire)

Claire wanted to use pink bottles for her daughter. This suggested immediately that Claire sought to demonstrate her care for her child, and her good mother identity through these visible markers, her Given Off which was signalled to others. The pink bottle could be seen as a "stage prop" (Goffman, 1959, p. 32) part of the setting which moves with the performer. It must be stressed that participants were given free choice in the way they told their stories, and here I believe the strength of the interview style is revealed. I certainly would never have asked about the colour of bottles in a more traditional semi structured interview. Claire's pink bottles caused a great deal of discussion during panel analysis. It was hypothesised at the very beginning of the panel meeting that perhaps Claire felt threatened by being interviewed, her story was very short and it was thought that she may have felt judged because she was not breastfeeding and she needed

to prove to me that she was performing well as a mother. However, in the end Claire defended her story just like the other mothers in that she was, demonstrating that she had made good consumer choices and was therefore a good mother.

Throughout her story, Claire mentions a number of brands of infant formula and baby bottles. As discussed in Chapter 6, the brands display to the world the image she wants to portray of being a good mother. The brands also demonstrate the importance women can place on preparing for becoming a mother through their consumption choices. Thompson *et al.*, (2011, p. 211) describe how women “buy... products which fit with the type of mother they seek to become”. Claire had been careful with the choices she made. To buy the pink bottles and the right infant formula clearly meant a great deal to her and she had obviously given that a lot of thought. There are other items she would have needed to formula feed such as sterilisers and different types of teats, but she focused this story on the things that were important to her, the pink bottles and the correct brand of milk. The pink bottles helped her to perform her new identity of being a mother. Bottle feeding is a very visual way to perform motherhood. She had gone beyond the arbitrary normal colour bottle to demonstrate her love for her baby and that she was a good mother because she made the right consumption choices. Thompson *et al.*, (2001, p. 219) describe the commercialisation of motherhood and that “younger

mothers tended to choose expensive top-end brands as a form of display”.

However, Claire’s pink bottles failed to work, and the infant formula was not able to get through the teat, so Claire’s mother suggested she use Avent bottles. Phillips Avent are a very well-known manufacturer who produce a whole range of baby paraphernalia from bottles and sterilisers to soothers and breast pumps. Their products are often pricier than other brands. Claire found these much better, but in describing this part of her story, she does not talk about the practical function of the bottles, but focuses on the brand name. She could have chosen to describe these new bottles in terms of the shape of the teat or the size of the hole within the teat or the speed of the flow from the teat. But she does not and remains focused on the branding of the Avent bottles. Claire gave an initial account of the challenges she had faced during her very brief story:

‘She [baby Sophia] went from I think it was Cow and Gate onto a reflux milk ‘cause she ended up with reflux erm and she also went from that back to Cow and Gate and then that didn’t agree with her so I went to SMA and I’ve been on that ever since and she’s took to that, better than she took to the other ones.’
(Claire)

Claire’s story comes to a very quick Coda, her story took less than five minutes to tell:

‘so it was a (2sec) it was a good choice, to choose (3sec) and she hasn’t been sick off it neither, I think that’s all I can think of for that (11sec).’ (Claire)

Claire's story was very short compared to the other interviews. It appears that she, perhaps more so than some of the other mothers is telling her story not just to me as the researcher but also to herself. Frank (2013) suggests that stories are often created as they are told. Claire was probably pulling this story together for the first time, as mothers of young children are not often asked to tell their infant feeding stories in their entirety. It could be argued that formula feeding stories, and certainly those which include some difficulty, are not the normal stories heard. For Claire, this was probably the first time she had been asked to tell her formula feeding story. For the breastfeeding women, their stories of pain and challenge were perhaps better practised. Claire wanted to portray her formula feeding story as easy. In reality, Claire has dealt with difficulties such as reflux and changing brands and it could be reframed as a very negative story. Claire ended by saying it was a "good choice to choose" which had not made her daughter sick despite the challenges she had described, disconnecting the Coda from the Complicating Action without any Evaluation, much like Amy had done.

8.4.3 Becky's "Lost Cause"

Becky formula fed from birth and was very insistent throughout the interview that this was her choice, despite advice and conversations with health professionals and her partner. Becky recalled a conversation she had with her midwife about breastfeeding during her pregnancy and she re-enacted the scene:

‘when I was pregnant me midwife like said to us, “have a thought about breastfeeding?” and I said, “well I haven’t really give it much thought, it’s just a no, no for me” and she was quite harsh with us (laughs) and said you know like, “research it” and I said well “but I know personally that I can’t do it”.’ (Becky)

This scene was recreated once more during sequential interviewing:

‘she kind of like tutted at us when I said that I was going to going to like bottle fed she was like, “just read, just research, just read it” but I was like “it’s my personal choice you know it’s my choice how I’m going to feed my baby I’m gonna be bottle feeding”.’ (Becky)

This resonates with the work of Lee and Furedi (2005, p. 4) who found that that women who formula feed, may take a “posture of defiance, articulated through the claim that ‘mother knows best’”. Becky reported that after this event the midwife “never ever brought it back up” at this point Becky was asked why she thought this was the case:

‘because she knew I wasn’t going to breastfed him, I’m a lost cause.’ (Becky)

Being a “lost cause” while initially sounding quite dramatic could be quite a realistic view of the situation. She was clearly aware that her Given Off put her good mother Front in jeopardy. In terms of encouraging and supporting her to breastfeed, perhaps the midwives had realised that Becky could not be persuaded, so they felt it appropriate to stop asking. When asked how she would have responded if the midwife had “brought it back up” she said:

‘I would have said I haven’t researched it no; I would have said “it’s my choice I don’t want to”.’ (Becky)

Becky had obviously spoken to her health visitor about problems her son Jai, was having with his feeding. She reported that he “started to suffer quite bad with his wind” had reflux and “was being sick quite a bit...[and] screaming after every bottle”. Becky’s health visitor advised that she switch infant formula, so Becky moved from the Aptamil to SMA but found that it did not make a difference. Becky explained that on one occasion her son was quite ill, and he ended up in hospital:

‘he had milk coming out of his nose when he was being sick, and he was like choking and he couldn’t get his breath, so, we called an ambulance erm and when we were up at the hospital she says to keep him on it [lactose free formula] until he was six months old the milk erm.’ (Becky)

She reported it was this event that had convinced her own GP to allow her son to continue to be prescribed lactose free formula. Becky was quite dismissive of the value of the input she had had from health professionals and explained how she felt judged by them:

‘you know don’t give first time mothers the credit, isn’t it? The [sic] just brush you off straight away.’ (Becky)

Becky had very strong feelings about her choice to formula feed and used her experience of working with children to defend her position. She believed that she had evidence to challenge the health professionals’ practice. By mentioning that she had worked with children, Becky was conveying her knowledge about childcare; she had experience of feeding babies. Becky’s comments about beating the system as a first-time mother are also noteworthy. Here she puts the health professional into a more powerful position than herself as a

first-time mother. She is acknowledging that health professionals have power and are gatekeepers to medical care, however she challenges their knowledge and approach and shows her own agency. Becky gave lots of evidence to support her choice not to breastfeed by including stories from other people who had had difficulties.

Becky was also able to defend her good mother status from that of a "lost cause" by downplaying the value of milk during the Coda. She described Jai's reaction to infant formula as it stood at the time:

'he still has his bottles and stuff but he's still, he's never been a big drinker of his milk, he's still only has 6oz and he's 8 months old and that's very rare that he might drink all of that, he's not, he's not fussed really on his milk, he loves his food, absolutely loves his food too much (3sec) you know, he tends to drink his formula like just before bed, he still wakes for a bottle during the night and his early morning one they are the ones that he really wants the rest of them he's just, he just has a play with them.' (Becky)

Becky's son was eight months old at the time of her first interview. He was still waking "for a bottle during the night" as well as having his "early morning one" and one "just before bed". What Becky described sounded like a typical feeding pattern for children of that age, and reported that that he does not really want "the rest of them" and he just "has a play with them" helped to support her good mother Front even though most babies of the same age would follow the same pattern. Becky made this sound more extraordinary than it is.

Frank (2013, p. 97) describes a chaos narrative as one "without sequence or discernible causality". During panel analysis one of the panel members became very frustrated with the lack of a timeline in

Becky's story and this was recorded in the field notes from the session:

JG states there was an incident where they had to call an ambulance and baby was rushed to hospital – this is when they were advised to stay on the lactose free milk. PM1 refers back to the lack of timeline, PM2 agreed. PM1 sighs and throws down their pen. JG suggests that PM1 is really frustrated by the method, they say they are. PM1 says that Becky almost doesn't understand herself what the important bits are, that it just all comes out. PM2 adds "it's all jumbled". PM1 says you have to interpret it – which they say is "what we are doing I suppose". PM1 says that Becky's "not strong in her own mind what the problem was".

These field notes illustrate the chaotic nature of Becky's story. Frank (2013. p. 99) refers to the syntactic structure of one narrative saying that it followed a pattern of, "and then and then and then". This is exactly how Becky told her story. Becky's narrative was chaotic, but it ended in resolution which repaired her good mother Front.

8.4.4 Formula Feeding Stories were Not as Narratable

The formula feeding stories were not as narratable as the stories of women who had ended breastfeeding sooner than they had wanted. The formula feeding stories were more chaotic and there was a definite missing link between the extraordinary circumstances, Complicating Actions, and the Coda. The potential for judgement is greater with these stories as the women did not give breastfeeding "a go" (Bailey, Pain and Aarvold, 2004) and the women were aware of this. The ailments described by the mothers were not linked to the ending of the stories. The mothers also appeared more reluctant to move into greater detail when telling their stories; this could be

because it would have expanded their Given Off more than they would have wanted. Closing down the conversation and not linking the end of the story together allowed the mothers to maintain their status. The structure of these stories was different to those of the women who had ended breastfeeding, as they had to work harder to maintain their good mother Fronts.

Good mothers who do not breastfeed may feel the need to repair the messages Given Off, as if they do not breastfeed they may feel that they are judged as inadequate (Lee, 2007). As the status of their good mother Front is at risk from the beginning, their telling of the infant feeding story does not fit into the neatly packaged section of the restitution narrative. If it did then it had the potential to expose them as poor mothers as they might feel they could not live up to the Breast is Best dominant narrative'.

Frank's (2013) chaos narratives are told when lives are in chaos. These three formula feeding stories are different to Frank's (2013) chaos narratives because these stories come to a resolution. They are like them in terms of syntactic structure and jumping from issue to issue however they had a definite ending. While it is argued that the women may have added the Coda to the narrative to end the stories to help repair their good mother Front, there could be another reason for the happy ever after Coda. It could be argued that the women added an ending to their stories due to the biographical narrative style

of interview. As the interviews did not stop until a Coda was heard, perhaps the women were forced to add one. However, it is clear that, whatever the reason, formula feeding stories may not be as easily told as they do not always fit with the narratives we like to hear.

8.5 Stories within the Stories

A significant finding from this research is the way that messages about breastfeeding are passed on in other people's stories. The mothers included the stories of others in their own infant feeding stories. These stories were generally about breastfeeding problems. There were a very limited number of positive breastfeeding stories and none of the participants told stories about how others had used infant formula. These stories, and the messages they could support are summarised in Table 8.3.

Table 8.3 Stories Within Stories

Mother	Stories Passed On	Message Passed On
AMY (1 st child breastfed for 2 days; 2 nd child formula fed from birth)	FAMILY- had all formula fed – no ‘stories’ included in her story.	None.
BECKY (formula fed from birth)	FRIENDS - “had quite bad experiences breastfeeding and stuff” Two had mastitis and one was hospitalised.	Breastfeeding causes mastitis.
	FRIENDS – told her “it can be hard to wean them” “they just associate the mam with breastfeeding”.	It’s hard to wean breastfed babies from the breast. Breastfeeding is tying for the mother.
	FRIEND – Becky helped her by buying infant formula as “the baby was crying ‘cause she wasn’t getting enough milk”.	Breastfed babies might not get enough milk.
CLAIRE (formula fed from birth)	OTHER MOTHERS AT GROUPS – told her that breastfeeding was “hard” particularly when trying to get the babies attached.	Breastfeeding is hard.

Table 8.3 Stories Within Stories (Continued)

Mother	Stories Passed On	Message Passed On
<p>DANNI (breastfed for 4 weeks)</p>	<p>PARTNER'S AUNTIES - told her they "couldn't, like, ever go out anywhere" while breastfeeding.</p>	<p>Breastfeeding is tiring for the mother. You shouldn't breastfeed in public.</p>
	<p>PARTNER'S AUNTY- had three young children and had breastfed two but not the third as "she couldn't deal with the three of them".</p>	<p>Breastfeeding is hard. Infant formula is an easier option than breastfeeding.</p>
	<p>PARTNER'S MUM - told her that he was "breastfed only for a few weeks, because he wanted too much, and she couldn't deal with it so she bottle fed him".</p>	<p>Breastfeeding is hard if you have a "hungry baby".</p>
	<p>TWO BEST FRIENDS- Told her how difficult it was. One fed for a month and the other for about 6 weeks.</p>	<p>Breastfeeding is hard.</p>
<p>EMILY (breastfed for over 9 months, was breastfeeding at time of 2nd interview)</p>	<p>PEOPLE – "had heard so many horror stories of people having to fight" for treatment of tongue tie. MOTHER-IN-LAW – Breastfed her 4 children but one was a big baby and it was difficult to satisfy him so was advised by a health visitor to wean early. MOTHER – breastfed to a schedule, not on demand. 2 OR 3 PEOPLE IN A GROUP – had been told by their health visitor that breastfeeding hurt more if you had blonde or ginger hair or fair skin.</p>	<p>Breastfeeding can have challenges that are not easily sorted out. Breastfeeding is hard if you have a "big baby". Breastfeeding is tiring for the mother. Breastfeeding is hard and some people have difficulties they cannot avoid.</p>
<p>FAYE (breastfed for 7 months)</p>	<p>FRIEND'S PARTNER – thinks breastfeeding in public is "just not right". SISTER – couldn't breastfeed her son as he looked like her father. FEW PEOPLE – had colicky babies when formula feeding.</p>	<p>You shouldn't breastfeed in public. Breastfeeding is a sexual act. Breastfeeding is good for reducing colic.</p>

Table 8.3 Stories Within Stories (Continued)

Mother	Stories Passed On	Message Passed On
GINA (breastfed for 4 weeks)	MOTHER AT A GROUP - told her she had “struggled to breastfeed” and ended up having to express to feed.	Breastfeeding is hard.
HELEN (breastfed for 10 weeks)	LOADS OF PEOPLE – told her that breastfeeding “really hurts and you get cracked nipples and stuff like that”.	Breastfeeding hurts.
	UNSPECIFIED PEOPLE – told her about women who had mastitis due to breastfeeding.	Breastfeeding causes mastitis.
	FRIEND – mother felt like a dairy farm “producing loads” when expressing as baby was in special care baby unit.	Breastfeeding makes you feel like a cow.
	COUSIN – got mastitis and switched to infant formula.	Breastfeeding causes mastitis.
IZZY (1 st child breastfed for 5 months; 2 nd child breastfed for 9 months)	PARTNER’S AUNTY – had fed her own children and offered tips and positive support regarding building up supply.	Breastfeeding is a good thing to do and you can get over any challenges.
	FRIEND - breastfed her first child but “got loads of problems...like mastitis”.	Breastfeeding causes problems including mastitis.
	UNSPECIFIED PEOPLE – told her that giving a baby a bottle of infant formula at night will help the baby sleep. Implying breastfed babies have difficulty sleeping.	Breastfed babies don’t sleep well.
	SISTER’S FRIEND- had planned to breastfeed but baby “had problems” and the midwives told her “you have to bottle feed”.	Breastfeeding is hard.
	UNSPECIFIED PEOPLE- heard stories about mothers who had tried to breastfeed, and the baby lost weight.	Breastfed babies can lose weight.

8.5.1 Breastfeeding Horror Stories

We like to tell stories. It is how we, as human beings, communicate with each other. However, we don't want to hear ordinary stories; we like to tell and listen to extraordinary stories. Pinker (2018) suggests that negative stories in the press are increasing as consumers demand more dramatic stories. None of the participants told ordinary stories about other people's experiences, they all told stories which included significant, exceptional events. Moore and Coty (2006, p. 40) found that their participants were "frightened by the horrible breastfeeding stories they heard from co-workers, family and friends" and suggested that the "impact of breastfeeding horror stories ... has not been well documented" (Moore and Coty, 2006, p. 42). Marshall, Godfrey and Renfrew (2007, p. 2155) found the women in their study included reference to the "stories of friends and relatives" about "not having enough milk" or "milk drying up", but discount them as "apocryphal" meaning that they doubted their authenticity. My research shows that the stories women have heard are repeated and distributed across families and friendship groups, with breastfeeding horror stories more likely to be told and shared than ordinary uneventful experiences of breastfeeding. Stories of other people's difficulties with infant formula such as colic, digestive issues and changing brands were not shared.

Becky, who formula fed from birth included a lot of others' stories within her own, to demonstrate that breastfeeding was problematic.

She spoke about having first-hand knowledge and experience of breastfeeding mothers and their children and suggested that she had heard from them how challenging breastfeeding could be in comments such as “it can be hard to wean them” and “they just associate the mam with breastfeeding”. Becky also spoke about how she helped other mothers, her friends, and acquaintances at work with their breastfeeding challenges, likely drawing from the breastfeeding horror stories she had heard. Becky referred to one incident when she had helped a friend who was struggling with breastfeeding. She told me “the baby was crying ‘cause she wasn’t getting enough milk”. Becky helped by encouraging her friend to start using infant formula:

‘I would go up and like settle and I ended up buying her bottles and I was like, “just try it” and after that her baby settled right down and now she’s just had her second and she breastfed while she was in hospital and now the baby is straight on bottles, she says she wouldn’t go, put herself through that again.’ (Becky)

Stories about mothers with mastitis were included in the women’s accounts. Becky told me of two friends who had had mastitis and that “one of them has ended up in hospital with it” emphasising the extraordinariness of the situation which supported her own decision to formula feed from birth. Izzy’s friend also had mastitis. Her friend breastfed but “got loads of problems...like mastitis” so formula feeding seemed like “the right thing to do”. Izzy’s friend didn’t put any pressure on Izzy to formula feed, but Izzy, a breastfeeding mother was very willing to share this breastfeeding horror story to me. We all continue to tell these stories no matter how we feed our babies.

Breastfeeding horror stories have been included in research before (Sheeshka *et al.*, 2001; Moore and Coty, 2006). However, the analysis presented here expands upon this work, arguing that it is cultural expectation to adhere to a restitution narrative which help to create and reproduce these horror stories. For example, Gina's story of pain, mastitis, breast abscess and surgery would provoke fear and horror in any pregnant women's mind. The Complicating Action of the culturally expected story and the extraordinary experience which supported her decision and helped to repair her good mother Front inevitably creates a horror story. In telling their stories to me it could be argued that the mothers were performing their stories in an artificial way. However, they referred to these additional stories without any prompting. Given the dominant Breast is Best narrative, this requirement to perform is likely to be reproduced in other places with friends, family, and colleagues and even if the stories are not completely accurate, they have the potential to produce very real effects.

8.5.2 Continuing to Spread the Stories

Danni's own story of mastitis, a breast abscess and surgery is quite an unusual and extreme example of a breastfeeding story. Mastitis occurs in 10-33% of women who breastfeed (Epsom and St Helier University Hospitals NHS Trust, 2019) and abscesses occur in just 3-11% of those with mastitis. Therefore, the chances of women developing this condition are very low. However as seen with Becky and Izzy we know that stories about women developing mastitis are

told and retold. Danni's story included reference to her boyfriend's cousin:

'my boyfriend's cousin had a baby a month after me and she was planning on breastfeeding as well and she just didn't, just, I don't know what it, I don't know if it was, 'cause it was as similar just as I'd gone through everything, I don't know if that put her off she's never said, but she just didn't, she just bottle fed straight away.' (Danni)

Danni's boyfriend's cousin had intended to breastfeed but for some unknown reason, after Danni had her surgery for her breast abscess, the mother had changed her mind and decided to formula feed. Danni speculated about how her relation had changed her mind after hearing stories about what she had gone through:

'there's a, there's a month between her [Danni's baby] and the other baby, so that's when everything happened yes, so I think that's what happened, she's never actually said it but, she always said she was going to and then just didn't, so, I didn't want to ask.' (Danni)

This highlights the fact that stories can be an important influence on practice. It looks as though Danni's experiences have directly influenced the breastfeeding practice of another.

These stories within the participants' stories were not asked for but offered to me as part of the mothers' natural story telling processes. It is argued that this is the way breastfeeding horror stories may be spread in the community. None of the women included any reference to formula feeding stories of others, other than Amy who told me all of her family had formula fed. But no one included any stories about how other people had difficulties with infant formula and we know that even

within this small sample that women do have challenges with infant formula. It is suggested that telling tales of failed infant formula attempts risk damaging a mother's good mother front and there is a lack of an audience for stories about formula feeding as it is such an everyday occurrence.

8.6 Chapter Summary

This research demonstrates the potential storytelling has for influencing infant feeding practice. The combination of telling a culturally accepted story alongside keeping up the appearance of being a good mother is significant.

Culturally in the UK, there is a strong need to follow a restitution narrative, with a beginning, a middle and an end; a happy end which returns the actor to the same status or greater status than before. The transition stories, where mothers ended breastfeeding and began to formula feed, all include significant Complicating Actions; challenges with breastfeeding, but their happy ends were demonstrated by their happy, healthy babies. Despite these happy endings, these stories are more likely to be retold and spread through the community than those from the formula feeding women and may be classed as horror stories. Evidence has been provided here to demonstrate how other similar breastfeeding horror stories have already been told to the participants. The women in the research use other people's stories to

illustrate points in their own and to help them defend and justify their decisions.

The formula feeding stories told however, do not appear to be retold. The extraordinary circumstances and Complicating Actions in these stories were not evaluated fully, which means they do not fit with the way that we tell stories, and the story is not as easy to tell. It could be argued the participants did not include stories of other people formula feeding in their own stories because they had not heard any. The formula feeding challenges are therefore not spread as widely as the breastfeeding ones. This is important because the formula feeding stories that are told (if they are) end up with a positive ending or outcome, the challenges do not appear to be connected to the act of formula feeding and the breastfeeding stories always have a complication.

These findings are important because they can have an impact the feeding practice of others. Maintaining the good mother Front means that the stories told by the mothers who transitioned from breastfeeding to infant formula had a Complicating Action, a problem to be solved, which the story centres on. The resolution to these stories involved feeding their babies with infant formula and the women had to be clear in justifying their positions to maintain and often improve their good mother Front. Formula feeding stories on the

other hand felt a bit disconnected and were generally harder for the women to tell using the culturally preferred narrative.

It is argued that this means when all these stories are told in the community the breastfeeding experiences are then thought of as difficult while the problems with formula feeding may not really be discussed. Early motherhood can be difficult for everyone, but it is the transition from breastfeeding stories in this research that are the ones told with emphasis on the problems. The challenges with formula feeding are downplayed.

To summarise, it is suggested that these mothers told two types of stories. The first were very easy to tell, possibly previously told, transition from breastfeeding to formula feeding stories with an interesting, dramatic Complicating Action that is attributed to an external factor but ends positively with a thriving baby and a good mother. The second were stories of formula feeding, which may not have been told before, but include some significant challenges, no particular evaluation of the challenges but a happy outcome, a thriving baby and a good mother. This moves on knowledge in the area adding an understanding of precisely how and why these stories were constructed in the way they were and their potential impact.

Chapter 9: Conclusion

This chapter addresses the three research questions in considering what infant feeding stories are told, how they are passed on and how this may influence breastfeeding practice. This chapter also considers limitations to this research including a reflection on how the social world has changed since the collection of the data with the increased use of social media, the Covid-19 pandemic and the 'fed is best' movement. A summary of the contribution to knowledge made by the research, and key messages for policy makers are provided at the end of the chapter.

Woven through this discussion, the findings are considered in terms of ecological systems theory (Bronfenbrenner, 1979) which draws together the layers of influence mentioned within the women's stories and their impact on infant feeding practice. As discussed in Chapter 2, this theory can help us to make sense of the complex nature of infant feeding in this area of North-East England. There are many factors which have influenced the choices made by each of the nine women, and this work demonstrates that infant feeding choices are not only down to individual woman, but other factors have a significant part to play in the success of her feeding journey.

The themes of this research and the layers of influence present for the participants have been mapped according to ecological systems theory (Bronfenbrenner, 1979) in Figure 9.1 below:

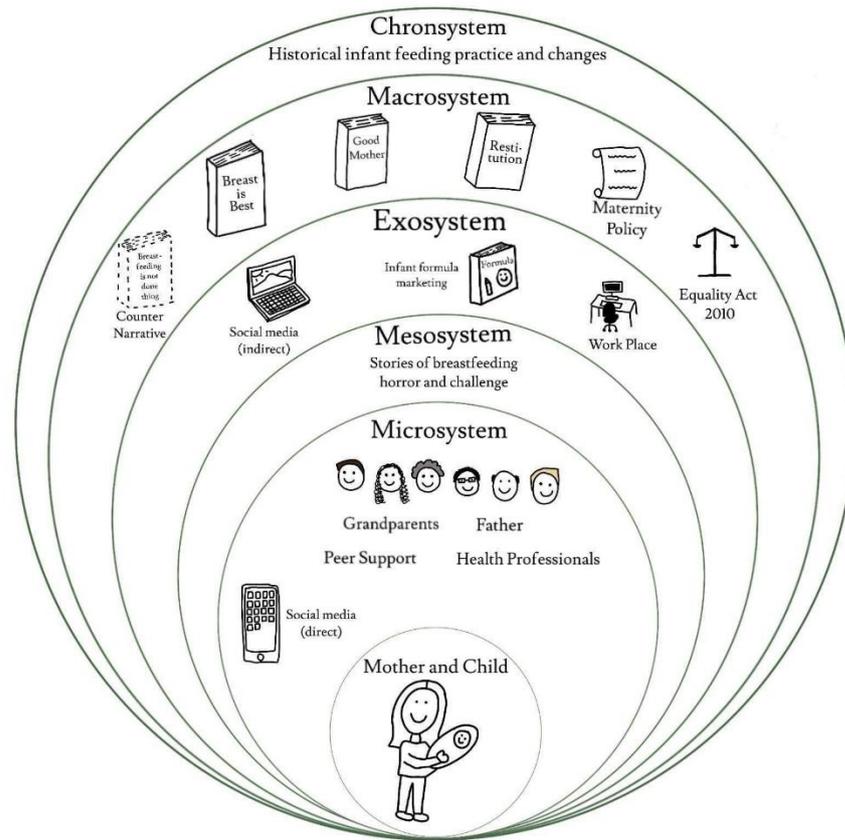


Figure 9.1 Infant Feeding Ecological Systems Model
Adapted from Bronfenbrenner (1979)

This model was inspired by two similar interpretations of the theory, representing early child development (Young, 2021) and black youth development (Stern, 2021; Stern, Barbarin and Cassidy, 2022). As discussed in Chapter 2, each of the systems include influencing factors that can shape and impact behaviour (Snyder *et al.*, 2021). The ecological model is useful as it not only demonstrates how various factors have influenced mothers but it also acknowledges their agency. This research clearly shows the influences present for new mothers. It is argued that some of the women who took part in this study have very little individual choice about their feeding method due

to the layers of influence on them. Although it has been demonstrated that women have been influenced by factors across each system, it is difficult to quantify this to further consider how much a woman's own agency has an impact on initiation rates and practice. Hiding away to breastfeed, for example, may not have been Izzy and Faye's preferred choice but it was a decision they made because of the environment they were in at the time. It is also argued that Izzy's mothers' behaviour of throwing blankets over her breastfeeding daughter may have been partly influenced by dominant narratives around the sexualisation of the breast in the macrosystem (Figure 9.1). This contextual view is important; Bengough *et al.*, (2021, p. 1) recommend that health professionals provide "different forms of support based on socio-cultural norms and personal backgrounds of women".

9.1 Research Question 1: What stories are women telling about their infant feeding practice?

This research confirms that women tell each other stories about infant feeding. The nine mothers included at least thirty other peoples' infant feeding stories, which demonstrates the powerful and potentially significant influence they can have. These stories exist in the mesosystem (Figure 9.1) and have clearly been told and retold. The mesosystem is different to the other systems around the mother and baby as this system represents the interactions that take place within the microsystem. It is significant to note that almost all stories in this

system were about breastfeeding rather than feeding with infant formula and that the majority were about breastfeeding challenges.

Telling stories about breastfeeding challenges can normalise issues about breastfeeding being difficult (Earle 2002). Positive and uneventful breastfeeding experiences may simply be less often told and shared, as consumers desire more dramatic stories (Pinker, 2018). These stories were told with an awareness of dominant narratives in society which are found in the macrosystem (Figure 9.1), namely Breast is Best and the Good Mother narrative. The mothers' moral tales have a beginning, a middle and an end; a happy end which returns the mother to a good mother identity.

Formula feeding stories on the other hand were generally harder for the mothers to tell, although they did attempt to use the culturally preferred restitution narrative (Figure 9.1). In telling their stories, they were mindful of the dominant narratives in the macrosystem to protect their identity, namely Breast is Best and the Good Mother (Figure 9.1).

9.2 Research Question 2: How are infant feeding stories passed through generations and across friendship groups?

The breastfeeding stories were structured with the use of a restitution template (Frank, 2013). This fits with learned social conventions surrounding storytelling. Following the culturally accepted restitution

narrative found in the macrosystem (Figure 9.1), the women in this study told stories that contained a twist or Complicating Action (Labov and Waletzky, 1967); an extraordinary circumstance such as pain, surgery, or an early return to work, that make the story interesting to the consumer of the story. Despite having a restitution template, the formula feeding stories on the other hand were structured in a different way, disconnecting the ending of the stories, the Codas with any Complicating Action (Labov and Waletzky, 1967). This made the formula feeding stories more difficult for the mothers to tell. Stories of other women's attempts to formula feed were missing from the women's stories while stories of breastfeeding problems were found in abundance.

The mothers also used other people's stories to illustrate points in their own and to help them defend and justify their decisions. For example, stories about mothers with mastitis were included in the women's accounts. Becky told me stories of two friends who had mastitis; one who was admitted to hospital due to the condition, which supported Becky's own decision to formula feed from birth. This story sharing takes place in the mesosystem (Figure 9.1). Pinker (2018) notes that consumers desire more dramatic stories which can explain why stories of breastfeeding challenges have been found in abundance as they may be more interesting to hear, and therefore are more readily spread than breastfeeding success. It is argued that social norms were being perpetuated by the women themselves,

through their stories. This passing on of only the breastfeeding ‘horror stories’ suggests that stories play a role in breastfeeding practice which is further explored in the answer to the third research question.

9.3 Research Question 3: How do infant feeding stories influence the initiation and experience of breastfeeding?

This research suggests that the way infant feeding stories are told with a focus on breastfeeding difficulties, may have an impact on the initiation of breastfeeding in communities. As discussed, the mothers often used other people’s infant feeding stories, found in the mesosystem (Figure 9.1) as evidence to support their own practice. Many of the mothers reported that they had heard breastfeeding was hard or it tied the mother to the baby or the home. Others mentioned more significant issues such as mastitis. It is suggested that breastfeeding horror stories influence the decisions of other mothers. For example, when Danni experienced mastitis and surgery, this is believed to have influenced her relative’s feeding decision. These breastfeeding horror stories appear to be easier to tell than the formula feeding stories as they more readily fit the culturally preferred restitution narrative (Frank, 2013). This thesis argues that the culturally preferred way of telling stories in the UK, with a restitution narrative structure, may encourage the distribution of breastfeeding horror stories around the community and contribute to the absence of alternative, more positive accounts of breastfeeding. In order to increase rates of breastfeeding, we need to unearth and share

different narratives to balance out those currently being heard by focussing research on all communities.

As discussed throughout this thesis, these infant feeding stories do not exist in a vacuum, they are ultimately linked to, and influenced by other dominant narratives in society, including Breast is Best and the Good Mother narrative found in the macrosystem (Figure 9.1). In the interviews the mothers were asked to tell their infant feeding stories and they all did this while maintaining their Good Mother “Front” (Goffman, 1959, p. 32). This could be seen as a challenge for mothers who formula fed, who were conscious that they were going against the Breast is Best dominant narrative. Each of the mother’s stories helped them to achieve and demonstrate their social aim of being a good mother. Both of these dominant narratives need to be changed in order to provide support to all mothers and families.

This chapter will now consider other important findings from the research.

9.4 Influence from the Microsystem and Mesosystem

The microsystem includes the mother’s family, friends and health professionals. Grandmothers have been a key part of this research, perhaps more so than the fathers. This research demonstrates the way that grandmothers want to help their daughters and that their support comes from a place of love and care. Their desire to support

their daughters at emotional and vulnerable times in their lives is admirable, however this did not always follow the public health advice. From this research, it is suggested that grandmothers and other family members should be routinely included in ante-natal and breastfeeding education alongside the baby's father. This would be useful for all grandmothers, including those who have breastfed. This research also demonstrated the role wider family members played in supporting the mother and baby. Grandfathers and step-grandfathers also played an important part in these woman's stories. Grandparents need to be included more in infant feeding education, in a sensitive way, whatever the method of feeding. Of course, grandparents have played an important part in the lives of the mothers in this area, but it is acknowledged that this is not the case in every area where grandmothers would not be available. In more affluent areas, for example, grandmothers may provide less childcare (Cisco, 2017) and may have less influence over their daughters feeding practice. The extent of grandmother influence will vary from location to location.

It is suggested that health professionals and colleagues in public health should be aware of the range of influences that impact on mothers and that nuanced support is made available, responding to their particular circumstances, rather than focusing on public health targets. Health professionals are now encouraged to follow new Baby Friendly guidelines which include more of a focus on supporting families to build close and loving relationships. This has involved a

distinct change in focus which incorporates relational aspects of breastfeeding (Aryeetey and Dykes, 2018).

9.5 Wider Influence (Exosystem, Macrosystem and Chronosystem)

The thesis demonstrates the powerful force that infant formula narratives play in everyday lives. Marketing of the product has found a place in everyday lives and the brands and arbitrary stages have become very familiar (Brown, Jones and Evans, 2020). This was shown in the way that Claire's own words echoed the language of the Aptamil TV advert for follow-on milk, when she suggested that formula milk "could help them like in the futures as they are growing up".

This research found that breastfeeding in public continues to be a contentious area. The dual role breasts have in society for both sex and for feeding babies continues to make public breastfeeding difficult. Wider policy to support mothers to feel comfortable is required. This would encourage the mothers who are breastfeeding in an invisible way to feed on demand, as is recommended practice.

Family finances played a significant role in many of the women's stories. For women who want to breastfeed, lack of money can be a barrier. The government need to make sure all women have access to good maternity pay, including women who are self-employed like Helen who found it hard to return to work when her baby was ten

weeks old. The other mothers had to deal with complex financial issues which took time and energy. It is easy to see why this may have contributed to making a choice to formula feed with a trusted brand. In an area classed as disadvantaged, the health behaviour of an individual mother is very much determined by her economic situation. This research shows that a mother's economic situation limits her agency and the choices she has in terms of infant feeding.

This research has demonstrated that historical infant feeding practice, which is found in the chronosystem (Figure 9.1) is important. If a woman chooses to breastfeed but lives in a “bottle fed world” as Amy describes, then it can be difficult for her to get the practical and emotional support this often requires. A woman's mother is known to be a significant role model and influence in her parenting style (Dykes and Griffiths (1998) and as has been demonstrated in this research, grandmothers and other family members who only know how to feed babies with infant formula will not have the breastfeeding knowledge that is needed to help. This research found that historical breastfeeding practice too can hinder the support provided as in the past four hourly breastfeeds were common practice for example.

9.6 Contextual Influences: Geography and Changing

Demographics

This research demonstrates that the layers of influence surrounding the mother and child are even more complex for the mothers who

lived in a less affluent area of the city with low rates of breastfeeding. In their day-to-day activities, the mothers described the way they regularly moved between areas of the city where influences change and in effect, the women are part of more than one neighbourhood. There was a clear division between two specific localities within the city. The areas where breastfeeding was perceived to be more acceptable were more affluent where breast feeding rates are higher. The areas where breastfeeding was perceived to be least accepted were less affluent areas of the city, the areas in which the participants lived, and where rates of breastfeeding are much lower. The women were aware that the layers of influence change within a couple of miles from their front door. A counter narrative (Bamberg, 2004) that, breastfeeding is not the done thing, was present in the local area which acted against the Breast is Best narrative and weakened its strength (Figure 9.1). This influenced the practice and decisions made by the mothers, such as Faye who felt compelled to stop going to a baby group in the more affluent area when her breastfeeding journey ended, and Amy who made comparisons between the breastfeeding and bottle-feeding worlds on her doorstep.

As well as geographical differences, the changing demographics of the area are an important factor to consider. This research was carried out with women who described their ethnicity as White British or White Irish. Although most of the population of the area studied would describe their ethnicity as White British, a growing diversity of

population can be seen. In 2019-2020, 11% of Newcastle's population described their ethnicity as from a minority group (Newcastle City Council, 2021). However, from the same period, 24% of school age children in Newcastle upon Tyne described their ethnicity as from a minority group (Newcastle City Council, 2021). This means that population demographics are inevitably going to change. In addition to future consideration about population, a significant point to note from this research is that the three women who were still breastfeeding at the time of the interview had all moved to the area as adults. In contrast to this, the women who formula fed from birth had family roots, going back 4 or 5 generations, in the local area. Acknowledging the limitations of the small sample size, this may be important to consider as a potential topic of future research.

The changes in population demographics are important to note because previous peer support organisations will target an area where there is deprivation (Hunt, Thomson, Whittaker and Dykes, 2021) and they need to be cognisant of the population in the area they target. Similarities and comparisons can also be made to research around the infant feeding practices of migrant women who come to the UK. Hawkins *et al.*, (2008, cited in Condon 2018) suggests that the rates of breastfeeding in migrant mothers who move to the UK go down once they have settled in a community. Condon (2018) suggests that this could be down to structural factors such as employment but also due to 'acculturation' as the mothers adopt the behaviours of the host

society. The ecological systems model can help us to understand how the breastfeeding horror stories, spreading within the mesosystem (Figure 9.1) and other influences from the exosystem and macrosystem may gradually have an impact on the mothers' behaviour.

9.7 Research Limitations

As with the nature of PhD research, this work was conducted by a single researcher which could be seen as a limitation to the study in terms of project scope, researcher knowledge and positionality. However, the research was made more rigorous with the inclusion of the panel analysis as discussed in section 4.10. Another strength of the PhD process is that it allowed me to follow my research interest without influence from any research funding criteria.

A lack of specific information around the participants socio-economic or educational status could be seen as a limitation, however much of this was included in the women's stories. It was not felt appropriate to ask these questions in case of offending the mothers and hindering their story telling process. Additionally, this research was limited to one geographical area. This research may have benefitted from being carried out across several deprived areas in the north east.

As mentioned in section 9.6, the results of this research with limited diversity, may not be transferable to everyone in the community and it may be limited in time as the population changes.

Nine women took part in this research which may be considered a limitation. However, although the sample size with qualitative research of this nature is always low, it allows the researcher to spend more time interviewing each participant and ultimately collecting richer data which leads to a greater depth of understanding. Despite the small number of participants, a strength of the research is that the women interviewed had a range of infant feeding experience. Three had fed infant formula from birth, three had ended breastfeeding sooner than they had originally planned and the remaining three had breastfed for a longer period.

It is important to acknowledge that the world has changed since the women were interviewed in 2014 and 2015. These changes have included the increase in use of social media, the Covid-19 pandemic, and the 'fed is best' narrative. It is acknowledged that these three issues could be present in the mothers' stories if the interviews were to be carried out in 2022. What may not have changed, of course, are the close family and friends present in the microsystem which have been identified in this research as having a significant role in influencing the mothers' practice.

9.7.1 Social Media

The use of social media platforms such as Facebook, Twitter, and Instagram have increased in popularity over recent years with billions of people using these across the world daily (Facebook, 2022; Statista, 2022). TikTok is a relatively new platform, being released to the world in 2018 (Schwedel, 2018).

Social media has been found to be a source of knowledge for mothers and can fill the gap, providing a level of peer to peer support, when they have difficulty accessing face-to-face services (Morse and Brown, 2021; Morse and Brown, 2022). Access to face-to-face services varies across the country and this form of support has been reduced in recent years due to government funding cuts (Jackson and Hallam, 2021). Based on their research on a closed Australian Breastfeeding Association Facebook group, Bridges, Howell and Schmied (2018, p. 3) suggest that a lack of services cause women to turn to social media, primarily for support with “breastfeeding management” which is described as:

“the physical management of breastfeeding, including timing and frequency of feeds, feeding to sleep, breast refusal (inc. distracted breastfeeders, biting and pinching while breastfeeding), breastfeeding with large breasts, positioning and attachment, mastitis, blocked ducts, cysts, white spot, thrush, sore and damaged nipples”

Regan and Brown (2019) suggest that research has often focused on the benefits of the use of social media, and in UK based online research they found evidence of negative experiences in online

research in the UK, including suggestions that a lack of regulation of these sites means that unhelpful material and inaccurate information is published. Murphy (2004, cited in Moukarzel *et al.*, 2020, p. 8) suggests that “health misinformation on social media” spreads “farther, faster, and deeper” than accurate information which resembles the findings of my research in the spreading of breastfeeding horror stories.

As discussed in the literature review, the use of social media to support breastfeeding has been found to be positive, increasing mother’s confidence (Black, McLaughlin and Giles, 2020) supporting emotional wellbeing (Morse and Brown, 2022) and providing reassurance. However negative emotions have been reported with the use of social media for breastfeeding support, including judgement when beginning to use infant formula (Regan and Brown, 2019, p. 2) and exclusion from groups due to “polarised debate” (Regan and Brown, 2019, p. 7; Morse and Brown, 2022).

Away from the support groups of Facebook, social media is of course also used in a more informal way. TikTok challenges are commonplace and breastfeeding is now no exception to this. The #DropEmOutChallenge is one example of this where videos of babies’ reaction to seeing their mother’s breasts is uploaded. This “adorable” (Today’s Parent, 2020) reaction would appear to be a good way to normalise and make breastfeeding visible which in turn may support

other mothers to breastfeed (Earle 2002) if it were not for the overly sexual lyrics accompanying the video clips which include:

“Drop 'em out
1, 2, 3, 4
Drop 'em out
Let me see them titties¹⁰
Gonna take a long look at those tig 'ol bitties
Areolas lookin' nice, nipples lookin' real pretty
Come on let me gander at your boobs
Drop 'em out”
(Lyrics, 2022)

Marcon, Bieber and Azad (2018) suggest that social media could be used to help support the normalisation of breastfeeding. They suggest that although sites like Instagram are being used to share breastfeeding content, create networks, and sell products, in their review of over 4,000 images and 8,000 comments, “very little education content was found” (Marcon, Bieber and Azad, 2018, p. 10). Snyder *et al.*, (2021, p. 1) also call for “evidence-based social media strategies” to support breastfeeding education but also to “increase cultural acceptance of breastfeeding” Snyder *et al.*, (2021, p. 6). Morse and Brown’s (2022) research suggests that any negative influence towards breastfeeding found in the context in which a mother lives may be offset by her involvement in a social media group. To develop the findings from my research, the ways in which infant feeding stories and identity presentations are evident in social media would be worthy of further study.

¹⁰ Microsoft Office suggested “this language may cause offence to your reader”

9.7.2 The Covid-19 Pandemic

The mothers and their families who took part in this research had not experienced a global pandemic which had an impact on face-to-face services (Brown and Shenker, 2020; Renfrew *et al.*, 2020; Brown, 2021b) as well as other aspects of family life. The Covid-19 pandemic resulted in various lockdowns across the world and placed restrictions on health services (Brown and Shenker, 2020; Renfrew *et al.*, 2020; Brown, 2021b; Hoying *et al.*, 2021). The opportunity for mothers to interact with their family, peers and health professionals was significantly reduced. The start of the pandemic was particularly difficult for new parents with mixed messages coming from health providers (Renfrew *et al.*, 2020) as well as a lack of support (Brown and Shenker, 2020; Ceulemans *et al.*, 2020). Ceulemans *et al.*, (2021) “found high levels of depressive symptoms and generalized anxiety among pregnant and breastfeeding women during the Covid-19 outbreak”. Latorre *et al.* (2021) suggest that lockdowns had a negative, direct impact on breastfeeding rates. Based on results of an Italian group during the initial stages of the pandemic it was suggested that a lack of access to feeding support and being isolated from family and friends had a negative impact on breastfeeding rates. Brown and Shenker (2020) however found that breastfeeding mothers experienced lockdown in different ways. Some felt protected by the lockdown while others found they lacked the support they needed which resulted in ending breastfeeding before they had planned. The First 1001 Critical Days Best Start for Life programme (HM

Government, 2021, p. 67) suggests that services have learnt from the experiences of the Covid-19 pandemic and online and digital services will continue to be delivered alongside face-to-face services to provide easy access and convenience to parents.

9.7.3 Fed is Best

As discussed, the dominant Breast is Best narrative is widely known and this research shows how this can play a part in influencing practice. Since the data collection took place however, a new 'Fed is Best' narrative has increased in usage to challenge the dominant 'Breast is Best' message. The recent and exponentially increased use of this phrase since the year 2010 is demonstrated in the Google Ngram ¹¹in Figure 9.2 below:

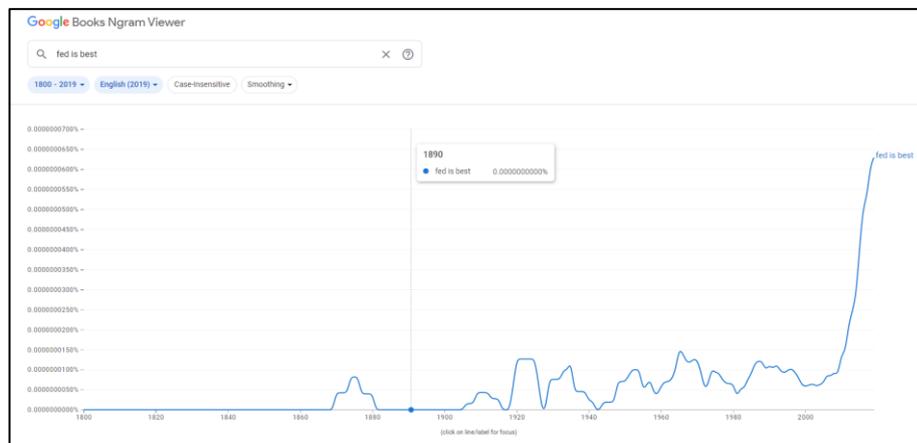


Figure 9.2 Google Books Ngram of Fed is Best (Sourced from Google, 2022b)

The Fed is Best Foundation is an American organisation based on the personal experiences of the founders who claim to have had

¹¹ A Google Ngram is a tool used to find patterns of word usage (Byrne, 2021)

difficulties breastfeeding at birth resulting in ongoing health complications for their children (Fed is Best Foundation, 2020). They campaign to change hospital practices to include more weighing and checking of the newborn as well as mothers' milk supply. The organisation states their mission to be, "Safe Breastfeeding and Bottle-feeding Support" (Fed is Best Foundation, 2020) and in clear opposition to Breast is Best, use the 'Fed is Best' slogan profusely. Their practice has been critiqued with Brown (2017) suggesting that Fed is Best "sounds suspiciously like a slogan to promote formula milk".

Breast is Best divides mothers into groups who are seen to be doing their 'best' by breastfeeding and others who may be incorrectly perceived as falling short in their responsibilities. However, the Fed is Best slogan can also add to this division and is often used to feed the breast verses bottle binary debate. In addition to this, Brown (2021) found that some mothers found the phrase unhelpful, as it did not consider their emotions at a vulnerable time in their lives. Brown (2021, p. 343) found that when breastfeeding had not gone the way some mothers had planned and they were told not to worry because Fed is Best, "all they could hear was that no one cared about how they felt and that the main thing was that their baby was fed".

9.8 Contribution to Knowledge

This research adds originality to existing knowledge in terms of its' location. This research was carried out in an area of North-East England often described as deprived, with low rates of breastfeeding. Areas considered to be deprived tend to have lower rates of breastfeeding and therefore higher rates of formula feeding than other, more affluent areas (Brown *et al.*, 2010). Research around infant feeding in the geographical area studied is not common. The location of the study enabled me to interview women who had not breastfed. Through this research, I have enabled previously unheard voices to be heard. Some of the challenges reported were similar, for example issues around breastfeeding in public, but additional struggles were evident, in terms of the perceived attitude regarding feeding in different areas of the city. The biographical approach taken helped draw out contrast in how stories were told depending on the mother's approach to feeding. While statistics describe a picture of uneven distribution of breastfeeding, this is not currently nuanced by publications of the experiences of women who choose to formula feed.

The research reveals the perceived attitudes around feeding babies in different areas of the city. Some areas of the city were perceived to be more breastfeeding friendly than others and these assumptions were intertwined with class identity. The way the mothers managed to work between these areas is new knowledge.

There is originality in the approach to the work; the use of a biographical narrative approach has not been found in research around infant feeding. One of the benefits of using a biographical narrative methodology was to avoid the use of words such as choice and decision in the language that surrounds infant feeding research. This was part of the strategy to avoid making the women feel judged, which many women report feeling if they do not breastfeed or breastfeeding does not go to plan (Dykes, Moran, Burt, and Edwards, 2003, Grant, Mannay and Marzella, 2018).

Finally, the use of a biographical narrative approach enabled the generation of new knowledge around the way mothers told stories about infant feeding and becoming a mother. The mothers were able to tell their breastfeeding stories and the stories of other breastfeeding women quite easily, but they found their formula feeding stories were more difficult to tell. This thesis demonstrates how and why breastfeeding horror stories are produced as well as the function of stories in maintaining or reclaiming positive mothering identities. This then contributes to the complex influences faced by mothers in the local area.

9.9 Key Messages for Policy Makers

The findings from this research demonstrate a very complex picture of infant feeding in the UK with mothers at the heart of this debate. If public health teams want to continue to increase rates of

breastfeeding in the UK, then it is recommended that changes are made across a number of areas, including additional funding for health professionals to provide nuanced support, additional online services and focused peer support. As has been demonstrated, infant feeding practice is not limited to a choice by individual mothers. Wider societal and policy changes are also needed to change attitudes and dominant narratives to provide the right conditions for mothers to feed their babies in whichever way they desire.

9.9.1 Recommendation 1: Nuanced Support

A nuanced approach to infant feeding support is recommended. In this research, health professionals were generally criticised by the participants for being unhelpful or providing inconsistent advice. This supports previous research (Simmons, 2003; McFadden and Toole, 2006) including Bengough *et al.*, (2021, p. 1) who recommend that health professionals provide “different forms of support based on socio-cultural norms and personal backgrounds of women”. Health visitors who were praised by the mothers were found to have been able to provide nuanced, subjective advice to the mothers, rather than the objective, protocol driven advice given by some. The relationship between a family and a health visitor is important. This research demonstrates the important role health visitors can play in infant feeding support. Health professionals need the time, space and funding to develop relationships with the mothers and their families as

recommended in the new Baby Friendly guidance (World Health Organisation (2022b)).

9.9.2 Recommendation 2: Educational Material and Support to be Available Online

This research supports the recommendation that, delivered alongside face-to-face support, additional online support and information should be provided for new mothers and their families. More recently, lessons learnt from the Covid-19 pandemic (HM Government, 2021) and research into support provided on social media (Brown, 2021b, p. 139) have opened up possibilities for a greater use of online services. This includes the use of social media to provide educational material (Marcon, Bieber and Azad, 2018; Snyder *et al.*, (2021). To increase rates of breastfeeding, different narratives need to be shared in order to balance out the horror stories heard from other mothers and the narratives coming from infant formula manufacturers. This universal support has the potential of reaching women in communities where breastfeeding rates may be low and their infant feeding practice may not match those of the dominant narratives present and mitigate any negative impact and influence from the community.

9.9.1 Recommendation 3: Targeted Peer Support

Breastfeeding peer support is known to be beneficial for some mothers (Arlotti *et al.*, 1998; Wade, Haining and Day, 2009; Thompson and Tricky, 2013; McFadden *et al.*, 2017), particularly

when supported by professional input (Thompson and Tricky, 2013).

This research demonstrates the need for additional funding to provided targeted peer support where the support offered is tailored to the specific needs of the community. It is suggested that along with providing support and information, peer supporters could be encouraged to share more stories of breastfeeding success to broaden the range of stories families hear.

9.9.2 Recommendation 4: Addressing Issues from the Macrosystem

Down

This research has clearly shown how infant feeding practice is influenced by factors in all systems of the ecological framework (Figure 9.1). The wider influencers found in the macrosystem could be changed with policy intervention, which could place greater importance on the early years and parenting. This includes making changes to the marketing regulations of infant formula to close loopholes that allow companies normalise their brands and unnecessary stages of milk. Supporting women to take appropriate periods of paid maternity leave (including those who are self-employed and on precarious contracts) would also be a positive step. Involving grandparents and wider family members in infant feeding education where identified as significant people in the families' lives is also recommended as a way to specifically support their learning around updated guidance.

Finally, the introduction of a new and more specific law around breastfeeding in public to replace or supplement the less well-known *Equality Act 2010*, would also help to increase the number of women who breastfeed and breastfeed for longer.

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Appendices

Appendix A: Glossary

Many of the participants, like me, spoke with a strong local dialect.

These idioms have been included in the thesis, rather than translating the language used into 'Queen's English'. Without this, I feel much would be lost in terms of context and meaning. The disadvantage of this, however, is that some words may need to be translated.

shan not fair or shocking

us me (this a particularly important word to point out, as it has a singular meaning and not plural as it may sound)

wa we are

wu we

Appendix B: Post Interview Consent Form



POST INTERVIEW AUDIO CLIP CONSENT FORM PHDE05.2

Project Title: 'An exploration of socio-cultural factors relating to infant feeding, in an area with low breastfeeding rates.'

Named Researcher: Justine Gallagher; justine.gallagher@northumbria.ac.uk

	YES	NO
<i>Please tick where applicable</i>		
1. I agree that all audio clips taken from my interview today can be used by the researcher in any future presentations		
2. I agree that audio clips take from the interview today may be used. However I would like the researcher to contact me again to gain permission before they are used.		
3. I agree that audio clips from part of the interview today can be used. The issues I do not want to be used have been shared with the researcher.		

Please sign, print your name and date

Signature of Participant _____ **Date** _____

NAME (IN CAPITALS) _____

The named researcher signs/dates in the space provided to confirm the participant understands the question being asked about the use of audio clips in future presentations.

Signature of Researcher _____

Appendix C: Participant Debrief Sheet



PARTICIPANT DEBRIEF SHEET PHDE07

Project Title: 'An exploration of socio-cultural factors relating to infant feeding, in an area with low breastfeeding rates.'

Named Researcher: Justine Gallagher; justine.gallagher@northumbria.ac.uk

1. What was the purpose of the project?

The aim of this study is to consider women's experiences of feeding milk to their babies. This includes mothers who give their babies infant formula, breast milk or a combination of the two. The researcher is particularly interested in speaking to mothers who have 'never breastfed', as she feels that these mothers have been under represented in previous studies. This particular geographical area has been chosen as it has lower than the national average rates of breastfeeding. The researcher is also interested in how 'infant feeding stories' may be passed through families and friendship groups.

2. How will I find out about the results?

If requested (via the informed consent form), once the study has been completed and the data analysed, the researcher will e mail a general summary of the results to participants. This is likely to be in 2017.

3. What will happen to the information I have provided?

Your data will be stored safely, and will remain confidential. It will be destroyed 3 years after the end of the research period.

4. How will the results be disseminated?

The data might be published in academic journals or may be presented at a conference. Please be reassured that the data will be generalized, and your personal information will not be identifiable.

5. Have I been deceived in any way during the project?

No.

6. If I change my mind and wish to withdraw the information I have provided, how do I do this?

If, for any reason, you wish to withdraw your data please contact the named researcher within a month of your participation. After this date, it may not be possible to withdraw your individual data as the results may already have been published. As all data are anonymised, your individual data will not be identifiable in any way.

Consent to use audio clips taken from the interview has been discussed with you, and, if you have agreed, a separate consent form has been completed. If for any reason you wish to withdraw or change your consent for this, please contact the named researcher as soon as possible.

7. Who can I contact if I feel I need to talk to someone about some of the issues I have discussed?

If you feel you need to talk to someone about issues you have discussed during the interview, please contact either your GP or Health Visitor.

8. If I require further information who should I contact and how?

If you would like to ask any further questions, register a complaint, or to withdraw your data, please contact;

Named Researcher

Justine Gallagher
Graduate Tutor
Faculty of Health and Life Sciences
Room G210
Coach Lane Campus East
Benton
Newcastle upon Tyne
NE7 7XA
Tel: 0191 215 6706
justine.gallagher@northumbria.ac.uk

Principal Supervisor

Deborah James
Reader in Child and Family Communication
Faculty of Health and Life Sciences
Room H021
Coach Lane Campus East
Benton
Newcastle upon Tyne
NE7 7XA
Tel 215 6287
deborah.james@northumbria.ac.uk

9. Who can I contact if I am unhappy with the conduct of the research?

If you are in any way unhappy with that conduct of the research, you may approach

Associate Dean for Research and Innovation

Professor Olivier Sparagano
Northumbria University
Coach Lane Campus
Benton
Newcastle upon Tyne
NE7 7XA
Tel: 0191 215 6044
olivier.sparagano@northumbria.ac.uk

Thank you for taking part in this research.

Appendix D: Anonymised Risk Assessment

Justine Gallagher, Northumbria University, PHDE02.

Northumbria University

Appendix 3 General Risk Assessment Form

DATE: 30/04/2014 ASSESSOR: Justine Gallagher LOCATION: Sure Start Children's Centres XXXXXX and participants' homes

AREA/ACTIVITY GENERIC LONE WORKING RISK ASSESSMENT

Item no.	Activity/equipment/materials, etc.	Hazard	Persons at risk	Severity	Likelihood	Priority H 48-100 M 20-40 L 0-16	protective measures required	Result*
1	Lone Working	Physical Injury or Illness or assault	Staff	5	1	5	a) Ensure that all employees who are required to work alone are provided with effective means of communication and defence by their Line Manager and that they are competent in the use of the device e.g. Personal alarms, mobile phones, etc	A
		Geographical location		1	1	1	b) Staff using cars to attend other locations must be authorised car users.	A
		Travelling location		2	1	2	c) Staff and students must not knowingly go to any location where there have been ongoing incidents of aggravation, aggression or danger due to environment, time of day, crime, politics or specific groups of people and must acquaint themselves with the background and local conditions by making general enquiries with colleagues.	A
		Stress		3	1	3	d) <u>Self Risk</u> Assessments: Staff to regularly assess the situation in which they are delivering a service and feedback issues immediately direct to line manager.	A
		Low Morale		3	1	3	e) Worker diaries, use of mobile phones and logging in/out procedures with base must be used so that all staff can be contacted at all times and details of <u>actions to take</u> where an employee fails to report back at the end of a visit or does not respond to a check call or visit.	A

*Key to Result: T = Trivial risk; A = Adequately controlled; N = Not adequately controlled; U = Unable to decide

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Appendix D: Anonymised Risk Assessment (Continued)

Justine Gallagher, Northumbria University, PHDE02.

Northumbria University – Risk Assessment Form

To be completed by the staff member undertaking the risk assessment	
Name: Justine Gallagher	Job Title: Graduate Tutor
Signature: JGallagher	Date: 30/04/2014
To be completed by the Senior Manager	
I consider this risk assessment to be suitable and sufficient to control the risks to the health & safety of both employees undertaking the tasks and any other person who may be affected by the activities.	
Name: Deborah Henckert	Job Title: Reader in Child and Family Communication, Business and Engagement Lead for Social Work and Communities
Signature: DHenckert	Date: 30/04/2014
NB – if senior managers do not agree that the risk assessment is suitable and sufficient then the assessment must be reviewed.	

Appendix E: Informed Consent Form



INFORMED CONSENT FORM PHDE05.1

Project Title: 'An exploration of socio-cultural factors relating to infant feeding, in an area with low breastfeeding rates.'

Named Researcher: Justine Gallagher; justine.gallagher@northumbria.ac.uk

<i>Please tick where applicable</i>	<u>Y</u> <u>S</u>	<u>N</u> <u>O</u>
1. I have carefully read and understood the Participant Information Sheet.		
2. I have had an opportunity to ask questions and discuss this study and I have received satisfactory answers.		
3. I understand I am free to withdraw from this study at any time, without having to give a reason for withdrawing, and without prejudice.		
4. I agree to take part in this study.		
5. I understand the data gathered in this project will form the basis of a doctoral thesis and may inform reports and/or publications and/or presentations.		
6. I understand that my name will not be used in the named researcher's thesis and in any other report, publication, and/or presentation resulting from the data collected, and that every effort will be made to protect my confidentiality.		
7. I agree that the area in which this research takes place (at ward level) will be identified in the named researcher's thesis and in any other report, publication, and/or presentation resulting from the data collected.		
8. I understand that the researcher has a duty to report any child protection or welfare concerns to a designated member of staff in their organisation and/or report any concerns to local Children's Services/Police.		
9. I consent to being audio recorded for purposes of data collection.		
10. I consent to audio clips being used in any of the named researcher's presentations resulting from the data collected, and that every effort will be made to protect my confidentiality.		
11. I know that if I am in any way unhappy with the conduct of the research, I may approach Professor Olivier Sparagano; Associate Dean for Research and Innovation; Northumbria University; Coach Lane Campus, Benton; Newcastle upon Tyne; NE7 7XA; Tel: 0191 215 6044; olivier.sparagano@northumbria.ac.uk		
12. I would like to receive feedback on the overall results of the study at the following email address;.....		

Please sign, print your name and date

Signature of Participant _____ **Date** _____

NAME (IN CAPITALS) _____

The named researcher signs/dates in the space provided to confirm the participant understands the purpose of the research, their role, and that they have the right to withdraw at any time.

Appendix F: Information Flyer



Dear Parent

My name is Justine Gallagher and I work at Northumbria University as a Graduate Tutor.

Before working at the University, I was employed at a Sure Start Children's Centre in XXXX as a Community Worker. At the moment I am doing some research about infant feeding and social support in the North East of England, as part of my PhD.

I would like to invite you to take part in this research. This will involve an interview with me at Sure Start Children's Centre XXXX. If this is not convenient I could interview you in your own home. I will ask questions about your experiences of feeding your baby and your relationships with friends and family members. Mothers, with children under one, who have either bottle fed, breastfed or combined the two are very welcome to take part.

I have attached an information sheet which gives more details about the study. Please contact me to arrange an interview or if you have any further queries.

Best Wishes

Justine

Justine Gallagher

Graduate Tutor

Tel: 0191 215 6706

justine.gallagher@northumbria.ac.uk



Appendix G: Participant Information Sheet



PARTICIPANT INFORMATION SHEET PHDE04

Project Title: 'An exploration of socio-cultural factors relating to infant feeding, in an area with low breastfeeding rates.'

Named Researcher: Justine Gallagher; justine.gallagher@northumbria.ac.uk

1. What is the purpose of the project?

The aim of this study is to consider how family and friends support women to feed their babies. This includes mothers who give their babies infant formula, breast milk or a combination of the two. I am particularly interested in speaking to mothers who have 'never breastfed', as I feel this group of mothers have not been included in previous studies. This particular geographical area has been chosen as it has lower than the national average rates of breastfeeding.

I am also interested in how 'infant feeding stories' may be passed through families and friendship groups.

2. Why have I been selected to take part?

It is important that as many people as possible are interviewed and you have told me that you are interested in taking part in this study, and that you are an adult aged over 18 with a child under the age of one.

3. What will I have to do?

You will be asked to attend an individual interview held at the XXXXXX. If this is not possible then you may be interviewed in your own home. Before the interview begins, I (Justine Gallagher) will answer any of your questions. After signing a consent form, I will first of all ask you questions about yourself (date of birth, postcode etc). If you do not want to answer any question (for whatever reason) then that is fine, please just let me know.

I will then ask you questions about your relationships with your friends and family members and your experiences of feeding your child. Again, if you do not want to answer any of these questions then this is fine, just let me know and I will move onto the next question. Once the interview is complete, I will give you a debrief sheet explaining the nature of the research, how you can find out about the results, and how you can withdraw your information if you wish. It is estimated that the total time to complete this interview will be 45 to 60 minutes.

The interview will be taped, so I can listen to it and transcribe it. If you agree, audio clips from the interview may be used in future presentations. This will be discussed with you in detail both before and after the interview when a second consent form will be signed. If you do not agree to this then you are still very welcome to take part in the research.

4. What are the exclusion criteria (i.e. are there any reasons why I should not take part)?

Mothers who are under the age of 18 will not be included in this research. Mothers who do not have a child who is under one year of age will also not be included.

Appendix G: Information Sheet (Continued)

5. Will my participation involve any physical discomfort?

You will be interviewed for around 60 minutes. If you feel that this is too long please let me know. Please also tell me if you would like a break or would like to stand, stretch or change your sitting position at any time.

6. Will my participation involve any psychological discomfort or embarrassment?

During the interview, you may be asked questions about your relationships with family and friends and how you feel they may have supported you during your experiences with feeding your baby. If you do not want to answer any of the questions (for any reason), please let me know that you wish to move onto the next question.

7. Will I have to provide any bodily samples (i.e. blood, saliva)?

No

8. Will my information be private?

A number of procedures have been put into place to protect the privacy of participants. The information you give will not be printed alongside your name or any of your identifiable information.

You will be allocated a participant number that will always be used to identify any information that you provide. Your name will not be associated with your information, for example the consent form that you sign will be kept separate from your information.

Only the research team will have access to any identifiable information; paper records will be stored in a locked filing cabinet and electronic information will be stored on a password-protected computer. This will be kept separate from any information and will be treated in accordance with the Data Protection Act.

9. Who will have access to the information that I provide?

Any information gathered during this research study will only be available to the research team identified in the information sheet. Should the research be presented or published in any form, then that information will not include your name or a false name may be used. (i.e. your personal information or data will not be identifiable).

10. How will my information be stored / used in the future?

All information gathered during this research will be stored in line with the Data Protection Act and will be destroyed 3 years following the conclusion of the study. During that time the information may be used by members of the research team only for purposes appropriate to the research question. Insurance companies and employers will not be given any individual's information, nor will we allow access to the police, security services, social services, relatives or lawyers, unless forced to do so by the courts.

11. Has this investigation received appropriate ethical clearance?

Yes, the study and its protocol have received full ethical approval from Northumbria University's Faculty of Health and Life Sciences Research Ethics Committee. This means that a panel of experts from Northumbria University have agreed it is safe for you to take part in this research.

12. Will I receive any financial rewards / travel expenses for taking part?

No.

13. How can I withdraw from the project?

The research you will take part in will be most valuable if few people withdraw from it, so please discuss any concerns you might have with me. During the interview itself, if you do decide that you

Appendix G: Information Sheet (Continued)

do not wish to take any further part then please inform me as soon as possible, and I will stop the interview and discuss with you how you would like your information to be treated in the future. After you have completed the interview you can still withdraw your information by contacting me and giving me your participant number or if you have lost this give me your name.

If, for any reason, you wish to withdraw your information please contact me within a month of taking part. After this date, it may not be possible to withdraw your individual information as the results may already have been published. As all information will not include your name, your individual information will not be identifiable in any way.

14. If I require further information who should I contact and how?

If you would like to ask any further questions, register a complaint, or to withdraw your data, please contact;

Named Researcher

Justine Gallagher
Graduate Tutor
Faculty of Health and Life Sciences
Room G210
Coach Lane Campus East
Benton
Newcastle upon Tyne
NE7 7XA
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Principal Supervisor

Deborah James
Reader in Child and Family Communication
Faculty of Health and Life Sciences
Room H021
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Benton
Newcastle upon Tyne
NE7 7XA
Tel 215 6287
deborah.james@northumbria.ac.uk

15. Who can I contact if I am unhappy with the conduct of the research?

If you are in any way unhappy with that conduct of the research, you may approach

Associate Dean for Research and Innovation

Professor Olivier Sparagano
Northumbria University
Coach Lane Campus
Benton
Newcastle upon Tyne
NE7 7XA
Tel: 0191 215 6044
olivier.sparagano@northumbria.ac.uk

Thank you for taking the time to consider taking part in this research.