Being the 'good' mother: A discursive study of breastfeeding women's experiences of accessing early childhood education in New Zealand

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Abstract

A majority of women in New Zealand will attempt breastfeeding, return to employment, and access early childhood education (ECE) care within the first year of their child's life. There is a great interest in promoting and increasing national breastfeeding rates, yet little research exploring how normative ideals of motherhood influence breastfeeding women once they return to employment. Psychological studies that explore breastfeeding and employment often locate the issue at an individual level, constructing breastfeeding as a personal 'choice'. Such research ignores the significant influence that structural barriers and societal pressures have on breastfeeding women's ability to freely choose an infant feeding method. This research seeks to remedy this limited focus.

In the current study, I was interested in examining how discursive constructions of breastfeeding shape women's subjectivities as mothers, and the ways in which these subjectivities enable or constrain women's ability to breastfeed. I utilised a poststructuralist approach to highlight how women's constructions of breastfeeding influenced their accounts of infant feeding in ECE and workplace settings. I conducted qualitative interviews with seven women living in Auckland who had experienced combining breastfeeding with employment and I applied a Foucauldian discourse analysis to make sense of the data collected. Through my analysis I discovered that the participants worked to align themselves with the subject position of 'good' mother. Participant's discursive constructions of breastfeeding worked to strengthen their subjectivities as 'good' mothers through three primary discourses; breastfeeding as best for the child, a natural and easy part of motherhood, and a difficult journey. The subjectivity of the 'good' mother had significant implications for how women navigated ECE and workplace settings. Participants often placed themselves under considerable stress to ensure they continued breastfeeding, despite structural difficulties. In the workplace the 'good' mother had to manage disruptions caused by breastfeeding, navigate poor management, and mitigate stigma. In ECE settings women had to manage tensions between public and private spheres and deal with low structural support. Women's ability to uphold their status as 'good' mother in these contexts was often dependent on the level of privilege each participant held. Western constructions of motherhood compel women to be 'good' mothers regardless of the strain introduced. Therefore, I argue that by unpacking women's constructions of breastfeeding and motherhood, in relation to ECE care and employment, the negative impacts of such discourses are highlighted and avenues to address these can become apparent.

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Chapter 1: Introduction

Despite a continued interest in promoting and increasing breastfeeding rates, both in New Zealand and internationally, little is known about how normative ideals of motherhood influence breastfeeding women, particularly in relation to their ability to access early childhood education (ECE) care (Dombrowski et al., 2018). Many studies construct breastfeeding as an individual decision made by 'rational' parents, with little regard for the influence introduced by societal pressures and structural barriers (Wolf, 2010). In a bid to address the former, critical research has studied women's accounts of breastfeeding. Research suggests breastfeeding is far more than a health behaviour; it is a value-laden, conspicuous performance of motherhood that has direct implications for how women are judged as mothers (Faircloth, 2017; Ryan, Bissell, & Alexander, 2010; Spagnoletti, Bennett, Kermode, & Wilopo, 2018). Western discursive constructions of mothering place immense pressure on women to mother in alignment with strict parenting ideals, which often entail large quantities of emotional, physical, and financial labour, including breastfeeding (Wolf, 2010). Yet, many of the structural institutions mothers interact with, namely workplace environments and ECE care, are poorly equipped to accommodate breastfeeding women (Dombrowski et al., 2018). Normative ideals of motherhood, combined with establishments that provide poor support, mean many women face significant stress when trying to mother and breastfeed in these contexts.

Employment is a well-researched area in breastfeeding literature. Evidence suggests that employment is a crucial factor in determining whether women are able to continue breastfeeding, with significant drop-out rates both internationally and locally upon returning to work (Appelbaum & Milkman, 2011; Bai & Wunderlich, 2013; Kozhimannil, Jou, Gjerdingen, & McGovern, 2016; Lubold & Roth, 2012). For example, nineteen percent of mothers sampled in the Growing Up in New Zealand cohort study reported they had ceased breastfeeding upon their return to work (Morton et al., 2012). Part of the reason for these statistics may be related to a lack of support for breastfeeding women in paid employment, including childcare arrangements.

ECE centres are prevalent in New Zealand, yet there has been little research conducted on how they influence breastfeeding practices, and the experiences of women who must make decisions in this context (Bartle & Duncan, 2009). In 2003, Bartle and Duncan explored support for breastfeeding mothers within New Zealand childcare centres and found that "breastfeeding within the context of childcare is not well-established in New Zealand" (p. 27) and that "little progress appears to have been

made towards the establishment of breastfeeding-friendly early childhood services" (p. 27). They argue for improved policy within the sector, yet to date this has not been addressed. There is only one recent study examining women's experiences in this context. Conducted in Scotland, Dombrowski et al. (2018) found that ECE centres played a considerable role in women's experiences of infant feeding, childcare, and employment. What little research exists of mother's experiences in this context suggests ECE centres have been an unjustifiably forgotten factor in breastfeeding research. This project seeks to fill this gap by illuminating women's experiences of attempting to combine breastfeeding with accessing ECE services.

It is important to note that a majority of research in this field sits at an individual level, discussing ideas of personal choice and responsibility. Such research locates the issue as individualistic despite evidence suggesting that structural barriers may be more influential (Wolf, 2010). Constructing breastfeeding as an individual issue contributes to a societal discourse that blames women for not reaching 'correct' parenting standards, rather than considering the wider social context which greatly constrain many women's ability to parent how they wish (Wolf, 2007). A potential outcome of such research is the judgement of mothers, rather than the judgement of society for failing them.

Shame, guilt, and stress are highly correlated with motherhood, as women attempt to reach parenting standards in a society that provides little structural support (Ryan et al., 2010; Spagnoletti et al., 2018). An emerging body of research has responded to this issue by providing a critical exploration of breastfeeding and employment. Maintaining a critical approach provides an investigation of how societal influences enable or limit certain behaviours, in most cases focusing on workplace settings and women's ability to breastfeed. This project aims to deepen the work in this field by continuing to explore employment and breastfeeding, while adding the new dimension of early childhood education (ECE).

The relevance of this project is its ability to build upon critical research conducted on employment and breastfeeding. This will provide further understanding of the structural barriers that working mothers face, highlighting how mothers are held unfairly responsible for parenting 'choices'. This works to shift the narrative from individual blame to an appreciation of how mothers' available options are greatly constrained by societal pressures and structural barriers.

In this chapter I begin by situating this issue in context, providing the background against which this research is set. I explore breastfeeding, employment and ECE care, and then go on to discuss my research aims and provide an outline of chapters included in this work.

Background

In this section I provide context for my research project by discussing the potential benefits of breastfeeding, including issues relating to class, culture, and societal pressures. I then consider the current state of employment and motherhood in New Zealand, examining statistics and policies that are relevant to breastfeeding. Finally, I turn my attention to the ECE sector, exploring attendance rates and defining the type of ECE care my research focuses on.

Breastfeeding

The World Health Organization recommends that women exclusively breastfeed until their child reaches 6 months of age, then continues breastfeeding until aged two years and beyond in combination with solid foods (World Health Organization, 2009). Despite 97 percent of New Zealand mother's attempting to breastfeed, exclusive breastfeeding rates in New Zealand have plateaued over the last decades (Morton et al., 2012; Plunket, 2017). Data from Plunket (2017) demonstrate that at six weeks old 52 percent of New Zealand infants are exclusively breastfed, with a further 34 percent receiving a combination of formula and breast milk. By six months the rate of exclusive breastfeeding has dropped to 21 percent, however a further 48 percent are receiving breast milk alongside formula and solids (Plunket, 2017). The median age for breastfeeding cessation in New Zealand is four-months-old, which interestingly corresponds with previous paid parental leave provisions (Morton et al., 2012). While rates of exclusive breastfeeding are lower than intended, a majority of infants in New Zealand do receive some breast milk. This means a significant portion of mothers with children under the age of six months are engaged in some form of breastfeeding.

There are many reasons to support women's breastfeeding in New Zealand. Culturally, there are many shared understandings of breastfeeding's value (Wolf, 2010). Claims of illness reduction, increases in intelligence, heightened mother-infant bonding, and a lessened risk of obesity are often touted as the benefits of breastfeeding (Wolf, 2010). Recent research suggests these benefits may be more modest than those claimed, yet strong evidence suggests breastfeeding may lower the incidence of

gastroenteritis (stomach flu), ear infections, and dental malocclusion (misalignment of teeth) (Wilson & Wilson, 2018). Furthermore, breastfeeding is free and readily available, potentially saving families thousands of dollars in feeding supplies (Bartle & Duncan, 2009). Moreover, breastfeeding is directly linked to the ECE curriculum, 'Te Whariki', promoting educational outcomes in infancy (Ministry of Education, 1996). In a New Zealand context, cultural factors relating to Māori are of equal value. For Māori, breastfeeding is a traditional and respected practice, fitting with each of the Māori health cornerstones; physical, spiritual, mental/emotional, and whānau health (National Women's Health, 2011). In New Zealand, breastfeeding is considered a human right and is a key Ministry of Health goal (Human Rights Commission NZ, 2005; National Breastfeeding Advisory Committee of New Zealand, 2009). Finally, continued breastfeeding support is significantly correlated with a successful return to employment (Farquhar & Galtry, 2003).

It is important to note that while breastfeeding has many benefits, the diverse range of situations that influence the choices and opportunities available to women must be considered. Most research in this field defaults to the assumption that 'breast is best', however this project will sit in an emerging field which challenges this view. Motherhood can be a tumultuous time, and breastfeeding can be an experience associated with guilt, shame, and worthlessness, leading to poor self-worth, negative self-assessment, and thoughts of failure around motherhood (Taylor & Wallace, 2012). For example, if a woman is placing herself under immense pressure to express milk for her infant, the immediate stress of this may prove more harmful than the possible health benefits that the infant is receiving (Wolf, 2010). Moreover, socio-economic status and culture are greatly influential (Nickel et al., 2014). A liberal pākehā woman may feel comfortable visiting an ECE centre to breastfeed, however the same privilege may not exist for a woman with more conservative cultural or religious views. Additionally, while workplaces legally have to provide breaks to express milk, the practicality of this will differ. Women working in low-level service jobs may find it unfeasible to express, compared to women working in corporate settings with designated breastfeeding break rooms (Nickel et al., 2014). Furthermore, there are some mothers who simply do not wish to breastfeed, and they should be afforded the autonomy to be supported in this decision too. There are a multitude of social factors that may determine whether breastfeeding truly is 'best' for a family, which highlights the importance for allowing women to account for their own infant feeding choices. Understanding how women account for their infant feeding choices provides valuable insight into how these decisions are constructed, highlighting discourses that feed stressful aspects of breastfeeding and mothering. Such accounts can lead to a greater understanding of how to support mothers judgement-free.

Employment

In the past decade, New Zealand has seen significant improvements in breastfeeding policy due to advancements in parental leave and employee rights. Paid parental leave is a significant contributor to the success of developing strong breastfeeding practices (Nandi et al., 2018). The OECD average duration of paid parental leave is 18 weeks, which was previously in line with New Zealand's provisions (Adema, Clarke, & Frey, 2015). However, as of July 1st 2018 parental leave in New Zealand has increased to 22 weeks, and is set to change again to 26 weeks in July 2020 (Ministry of Business, Employment, & Innovation, 2017). This moves New Zealand above the European average, and places us at seventh out of the 34 OECD countries. In addition to 22 weeks of paid parental leave, women in New Zealand are entitled to a further 30 weeks unpaid parental leave. However, current evidence suggests the availability of unpaid leave has little impact on women's breastfeeding practices (Nandi et al., 2018). Unpaid leave is often only utilised by women in comfortable financial positions, as most families cannot afford the loss of income. Therefore, overall access rates to unpaid financial leave is low and does not significantly raise breastfeeding rates (Nandi et al., 2018).

Nevertheless, whether a woman establishes a strong breastfeeding practice during parental leave is of little importance if she enters an unsupportive workplace. Consequently, New Zealand has regulations to ensure that employers uphold their responsibility to protect breastfeeding. In 2008, The Employment Relations (Breaks, Infant Feeding, and Other Matters) Amendment Act included a clause requiring employers to provide staff with appropriate breastfeeding facilities and breaks (Department of Labour, 2008). This was followed in 2010 by the Department of Labour's publication, 'Code of Employment Practice on Infant Feeding', which provides specific recommendations for breastfeeding arrangements (Department of Labour, 2010). The code clearly defines unacceptable provisions (e.g., requiring employees to breastfeed or express in toilets) and offers examples of best practice (e.g., providing a comfortable chair in a private, lockable room). New Zealand's employer obligations mirror those of similar countries (Heymann, Raub, & Earle, 2013).

Workplace policy is important as New Zealand mothers participation in the workforce has continued to increase over time (Flynn & Harris, 2015). In New Zealand 30 percent of sole mothers, and 55 percent of partnered mothers, with children under the age of two are employed (Flynn & Harris, 2015). Employment is equally split between full-time and part-time workers, and 47.4 percent of women report that their jobs offered flexible hours (Flynn & Harris, 2015). Increasing rates of employed mothers mean that ECE services are frequently accessed.

Early Childhood Education

ECE centres influence breastfeeding practices, decision-making, and women's experiences around infant feeding (Bartle & Duncan, 2009). ECE centres are defined as "premises used regularly for the education or care of 3 or more children under the age of 6" (Shukla, 2010, p. 133). This encompasses both parent-led facilities such as playgroups and some kōhanga reo (te reo Māori immersion) groups, as well as teacher-led services including kindergarten, education and care services, licenced kōhanga reo centres, and in-home carers. This research will focus on teacher-led services, primarily looking at those accessed by younger children. Such childcare centres are required to have 50 percent of teachers qualified and registered and are usually purpose-built centres which accommodate for children aged three months to six years. 2,584 centres in New Zealand fit these criteria, and they are the most frequently accessed ECE services (Ministry of Education, 2018).

New Zealand infants spend a considerable amount of time in ECE settings as their mothers return to employment (Ministry of Education, 2018). Children 0-2 years of age spend more hours than any other age group in ECE centres and may be spending an upwards of 40 hours a week when parents are in full-time employment (Ministry of Education, 2018). 17 percent of infants (0-12 months of age) access ECE care, along with 38 percent of toddlers in the 12-24-month age bracket (Ministry of Education, 2018). Asian and NZ European/Pākehā families are most likely to access ECE care. Māori families participate the least, but have higher participation in kōhanga reo programs, with 17 percent of Māori families opting for these (Ministry of Education, 2018). Economically deprived areas have had historically lower rates of ECE attendance, yet in recent years they have shifted to be in line with national standards (Ministry of Education, 2018). Overall, 200,588 children in New Zealand accessed ECE care in 2018, accounting for 65.5 percent of all children aged 0-4 years-old (Ministry of Education, 2018). ECE participation is high in New Zealand, therefore likely influencing working mothers return to paid employment, particularly in relation to breastfeeding.

Research objectives

My research aims to illuminate the context in which women make breastfeeding decisions, and the various ways their choices are constrained or enabled upon their return to work. I will investigate women's construction and negotiation of breastfeeding, with the following aims guiding the project, focusing specifically on the role of ECE.

1. Which discursive constructions do women deploy when discussing breastfeeding and motherhood?
2. How do women use breastfeeding and motherhood discourses to inform the subjectivities they construct and negotiate?
3. What are the power relations and possibilities for action enabled by these particular discursive constructions and subjectivities?

This research will gather the unique accounts of women who are combining employment, childcare, and breastfeeding. By focusing on these goals, I aim to provide insight into how constructions of breastfeeding and motherhood influences women's subjective experiences of infant feeding. I will explore the implications of these constructions, attending to how they impact women's ability to negotiate ECE and workplace settings, therefore facilitating or limiting their ability to breastfeed. Through exploring these goals the project will illuminate the social inequities, norms, and power relations, which shape the choices and experiences available to these women.

This research is useful for multiple parties at various levels, with the potential to provide valuable insights into how ECE and employment shapes women's experiences of breastfeeding, and the choices they are able to make. On a practical level, this is beneficial for ECE workers, who can gain an understanding of how to best support women, based on the opinions of women themselves. This can be used to form centre guidelines, facilitate discussion, and provide theoretical underpinnings to centre practice in regard to breastfeeding. Additionally, these understandings could be used to inform current and future policy/interventions for employment. On a more theoretical note, the research will have significance to women as it will provide a platform to share grievances and/or praise toward current practice, and an opportunity to hear other women's experiences. Ultimately, the project will highlight the social discourses which constrain or support the decisions these women are able to make around infant feeding and may work as a catalyst for future research.

Outline of chapters

In chapter 2 (Literature Review) I provide an overview of current research into breastfeeding, employment, and ECE care. I begin by exploring common discursive constructions of breastfeeding, focusing on common motherhood discourses, the moralization of infant feeding, and autonomy and

self-surveillance as a mother. I then discuss recent research on how employment and ECE care constrain women's infant feeding choices.

Chapter 3 (Methodology) specifies the theoretical perspective I have used in this project: poststructuralism. I explore the theories key tenets and examine the benefits of using such an approach. I then outline the methods used in this project, including participant recruitment and selection, ethical considerations, the interview procedure, my chosen method of analysis (Foucauldian discourse analysis), and evaluation criterion.

In chapter 4 (Analysis) I analyze and report on my findings. I discuss how participants attempted to align themselves with the 'good' mother subjectivity, and how this subject position influenced their discursive constructions of breastfeeding. I then turn my attention to the implications of such constructions, examining the effects these have on employment and ECE care.

In the final chapter of my thesis (Chapter 5: Conclusion), I draw my research to a close by providing a summary of my findings. I also consider the research relevance and the implications of this project. Finally, I highlight methodological considerations.

Chapter 2: Literature Review

Breastfeeding mothers face a multitude of potential barriers while breastfeeding. Research has well documented the significant challenges breastfeeding women face when returning to work, demonstrating its potent influence on women's breastfeeding practices. Alongside material and practical issues is a morally-loaded debate, producing often conflicting discourses about 'good' mothering, womanhood, infant health, and the ideal worker. Due to its intimate nature, breastfeeding has been a hotly contested issue within literature, with researchers attending to the influences of social support and employment on women's experiences while breastfeeding. However, a third significant influence has been long neglected within the field. Research indicates that early childhood education (ECE) centres have a marked effect on breastfeeding practices and women's experiences around infant feeding (Bartle & Duncan, 2009). In New Zealand, infants spend a considerable amount of time in ECE settings as their mothers return to employment (Ministry of Education, 2018). The little research investigating ECE's impact on infant feeding has demonstrated its importance and highlighted the need for further research to support the small existing base of literature.

I start this literature review by examining common ideas about breastfeeding circulating in contemporary Western settings, exploring in particular how these contribute to the moralisation of infant feeding practices. These breastfeeding discourses provide discussion for the socio-political background that influences breastfeeding choices and practices within Western society. Following this, literature investigating the two primarily researched barriers of breastfeeding is discussed, namely: (1) a women's return to employment, and (2) social support. I then go on to discuss the role that ECE has played in working mother's breastfeeding practices, drawing on the little research that has been conducted internationally and locally, to make a case for increased attention to ECE's impact when considering breastfeeding barriers.

Discourses of Breastfeeding

Breastfeeding is constructed as one of the most important contributions to a child's health a mother can make (Lubold & Roth, 2012). In a society preoccupied with mapping individual health choices to ideas of morality and subjectivity, breastfeeding is a valued practice due to its potential to influence infant

health. In this section, I explore how a cultural emphasis on the personal responsibility of health has moralised infant feeding practices, creating high levels of surveillance around breastfeeding. Ultimately, these discourses ignore wider socio-cultural influences, and may have a marked negative impact on many women's self-esteem and subjectivity as mothers.

"Breast is best": The moralisation of breastfeeding as a health practice

Western, neoliberal society places a great emphasis on maintaining healthy behaviours (Defossez, 2016). The dominant ideology of neoliberalism celebrates independence and autonomy. It requires all citizens to be personally responsible for their own health, removing accountability from institutions such as the state (Defossez, 2016). This ideology rests upon the assumption that individuals may freely make health choices. It is presumed that all individuals have the ability to make 'good' choices. This dominant ideology benefits those in power, as it removes their responsibility and places the focus on the individual (Defossez, 2016). Our preoccupation with personal responsibility for health has led to what many scholars deem 'risk consciousness' (Beck, 1992). Risk consciousness refers to the idea that risks, particularly in relation to health, can be minimised by following certain ideal health practices. Each citizen is expected to anticipate future health risks, adapting their current behaviours in an attempt to lessen the probability of becoming ill (Beck, 1992). One of the most successful ways this has been achieved is through the moralisation of health (Crawford, 1980). When health choices become measures of morality, people are open to judgements that police their behaviour as these judgements become internalised. In addition, as morality is strongly linked to identity health behaviours have the power to influence individual's subjectivities. Consequently, those who fail to perform socially acceptable health behaviours face persecution from both themselves and others (Crawford, 1980).

Breastfeeding is a health behaviour that is heavily tied to morality because it impacts on infant welfare. The primary concern for infant welfare is reflected in the ideology of 'intensive motherhood', an ideology of mothering which permeates Western parenting. Intensive motherhood is a dominant cultural framework which defines Western society's obsession with women investing in their children physically, emotionally, and financially, in order to be deemed 'good' mothers (Hays, 1998). Within this overarching framework, there are three core components to ideal parenting; (i) the mother assumes the role of primary caregiver, (ii) children are innocent and require parental protection, and (iii) raising children properly involves high quantities of physical and emotional labour, along with financial

investment and expert guidance (Hays, 1998). Within this framework infant feeding practices are arguably the most conspicuous choices (Faircloth, 2009). Breastfeeding fulfils each intensive mothering criterion: it is the mother's responsibility, breast milk is thought to provide psychological and physical protection to children, and the labour-intensive choice to breastfeed sits within a medical discourse which has scientifically 'proven' its benefits.

Wolf's (2007) idea of 'total motherhood' furthers the notion of intensive motherhood by combining the concept with risk consciousness, Total motherhood explores the moral code inherent in mothering discourses, in which women are held personally responsible for optimising their children's lives and anticipating and managing all potential risks, particularly in relation to illness. As Wolf (2010, pp. 72, 73) explains:

> Total motherhood stipulates that mothers' primary occupation is to predict and prevent all less-than-optimal social, emotional, cognitive, and physical outcomes; that mothers are responsible for anticipating and eradicating every imaginable risk to their children, regardless of the degree or severity of the risk or what the trade-offs might be; and that any potential diminution in harm to children trumps all other considerations in risk analysis as long as mothers can achieve the reduction. … total motherhood assigns individual mothers unique responsibility for their children's welfare.

Consequently, any disadvantages experienced by children becomes the personal failings of their mother. When a mother does not feed her infant the 'right' food source (breast milk), she is choosing to expose her child to a range of physical and psychological risks. Breastfeeding is thought to be linked to a wide array of health outcomes across the lifespan. From gastrointestinal illnesses in infancy to poor attachment styles as an adult, a lack of breast milk can be issued as the culprit. Indeed, several of breastfeeding's supposed benefits may be more modest than many assume (Wilson & Wilson, 2018; Wolf, 2010), however, despite uncertainties in research total motherhood stipulates women must still breastfeed based on the possibility that they may be lowering their child's risk.

In total motherhood Wolf highlights how "mothers have *wants…* but children have *needs"* (Wolf, 2007, p. 615). When children's 'needs' are constructed as concrete and necessary it generates a sense of responsibility for the mother, and may induce feelings of guilt if she fails to fulfil the need (Woodhead, 2015). Anything a woman provides that is less than optimal is fabricated as a risky choice, reflecting her own selfish desires rather than the best interest of the infant. By not breastfeeding mothers face blame when their offspring inevitably develops one of the myriad of psychological and physical health issues that are inherent in the human condition.

Additionally, attachment parenting, a psychological discourse that has filtered into the popular domain in the west through parenting advice literature, is increasingly becoming a key aspect of total motherhood. Attachment parenting relies on a vague evolutionary discourse which encourages women to trust their motherly instincts and dedicate extensive energy and resources to parenting (Wolf, 2007). Much of this is built on traditional Christian ideals promoted by American paediatrician 'Dr. Sears', and lacks scientific backing (Tuteur, 2016). Nevertheless, the concept is increasingly popular within Western society and is a necessary lens for understanding total motherhood. Many of the practices promoted by attachment parenting, dubbed 'The 7 Baby B's' have become conflated with the pursuit of 'good' motherhood. One of these tenets is breastfeeding, which Dr. Sears claims "gives your mothering a boost" (Sears, n.d, p. 1). Total motherhood, currently influenced by attachment parenting, works to police and control women's parenting decisions, particularly in relation to breastfeeding.

In a total or intensive motherhood society, breastfeeding is the obvious choice if a woman wishes to be a 'good' mother. Western society values 'science', and people are quick to draw on this powerful discourse when discussing breastfeeding (Faircloth, 2010a). Medical evidence is thought to have demonstrated a multitude of breastfeeding's benefits (Wilson & Wilson, 2018), therefore providing a trusted discourse to employ when arguing for the benefits of breastfeeding. Because society values biological evidence, breastfeeding is taken up as an integral aspect of total motherhood. Consequently, breastfeeding women are seen as selfless and moral, and their counterparts vice versa. The moralisation of breastfeeding can lead to feelings of guilt, shaming women who formula feed (Benoit, Goldberg, & Campbell-Yeo, 2016; Ryan et al., 2010). These beliefs may become internalised by women and create negative self-assessments in bottle-feeding women (Benoit et al., 2016). Benoit et al., (20016) emphasise that shame, which is experienced by many women who do not breastfeed, is an overwhelmingly negative emotion, with the potential to affect self-worth and esteem greatly.

The double bind of ideal mother vs. autonomous woman

Ideally, women should women be able to make infant feeding decisions free from moral persecution, yet due to the moralisation of breastfeeding, women are subject to judgement whichever choice they make. Accompanying the moralisation of breastfeeding is the notion that women who choose formula are uneducated, selfish, or simply do not try hard enough (Hausman, 2014). Conversely, breastfeeding women face a different onslaught of judgement. Women are told to breastfeed, but punished when

breastfeeding impedes their ability to attain societal ideals of autonomy and employment. Women, therefore, must negotiate an array of judgements regardless of the infant feeding method they choose.

Even though breastfeeding is social valued, it is a highly regulated practice and women may face judgement or criticism for straying from ideal practices. In a society that values personal autonomy, women who let their infants suckle their breasts for comfort are accused of being 'human pacifiers' and chastised for not maintaining clear personal boundaries (Hausman, 2014). Women are expected to preserve their personhood throughout mothering, passing down a sense of independence to their children (Wolf, 2010). This issue is particularly prevalent for women who extend breastfeeding beyond infancy, who are then accused of breastfeeding for selfish reasons rather than the benefit of the child (Faircloth, 2010a). Furthermore, breastfeeding goes against many hegemonic ideas of independence and productivity in Western societies (Hausman, 2014). Infant development is measured through methods of regulation which include striving toward long stretches of sleep during the night, scheduled naps and feeds, and little time being held or comforted (Hausman, 2014). Generally, breastfed infants will not be able to adhere to these parenting standards. They will need more frequent feeds, including during the evening, which creates difficulty when attempting to follow a schedule (Koerber, 2013). They will have greater interdependence with their mother, especially physically. Although breastfeeding is celebrated as the 'correct' infant feeding choice, breastfeeding women are often held to impossible standards.

Once a woman returns to employment, breastfeeding may further be problematized. Williams (2001) explores the 'ideal worker norm', which examines how workplaces are set up for the 'ideal worker', who is male, available at all times for work, has no housework or childcare obligations, and does not have deviations from their career due to pregnancy or breastfeeding. If women are to succeed as equals to men in their career paths, then they are encouraged to follow the path of an 'ideal worker', which does not provide room for the potential interruptions breastfeeding may incur (Lubold & Roth, 2012). Breastfeeding women's bodies are thought of as a site of problems. Constructions of leaky breasts, which are at risk for mastitis, could leak at the sound of an infant crying, and need regular pumping to alleviate swelling, may interfere with a women's ability to participate in a productive, neoliberal market (Hausman, 2014).

Breastfeeding culture: surveillance & self-regulation

Many scholars have employed the Foucauldian idea of surveillance when exploring breastfeeding culture (Alianmoghaddam, Phibbs, & Benn, 2017b; Duncan & Bartle, 2014; Hausman, 2014; Payne & Nicholls, 2010). Western, neoliberal society values the idea of choice in relation to health, and decisions pertaining to health are constructed as individualised, autonomous choices, with each citizen responsible for maintaining their own good health (Defossez, 2016). These choices are subject to surveillance and regulation from both others and the self.

Institutions play into this regulation as they uphold dominant ideology, and apply a 'normalising judgement'. Foucault's (1977) theory of disciplinary technologies states that normalising a practice gives it power, coercing others to fit within these dominant practices. Hospitals, health-care professionals, and health promoters exercise normalising judgement by posing breastfeeding as the natural way of things, and othering women who decide to bottle feed (Alianmoghaddam et al., 2017b; Payne & Nicholls, 2010). This leads to self-surveillance, in which women internalise normalising judgements, monitoring and judging their own behaviour to fit the dominant practice of breastfeeding (Foucault, 1977). This works as a form of control, removing the need for an external 'punishment' for not complying with breastfeeding recommendations. Rather, the 'sentence' arrives in the form of guilt, shame, and a negative self-identity as a mother (Benoit et al., 2016; Duncan & Bartle, 2014). Alternatively, women who meet societal expectations of breastfeeding will fail other normalised practices, such as being an ideal worker or maintaining full autonomy from their child, which may equally cause emotional distress (Hausman, 2014). It is important to note that there are also real social consequences for 'bad' mothers, including the constant threat of state intervention, although these are unlikely to be exercised in the case of breastfeeding. In a culture that surveils women's every mothering choice, there are no winners.

Constraints to 'choice': Barriers to breastfeeding

It is crucial to note that when discussing breastfeeding practices, 'choice' may be too freely an applied concept. Knaak (2010) draws attention to the myriad ways women's choices are constrained. On one hand, women feel socially pressured to breastfeed, even if it goes against their wishes (Benoit et al., 2016). Additionally, representing breastfeeding as an individual choice implies that all options are equally available. This is often not the case as there are a multitude of barriers to breastfeeding (Lee, 2011). Ultimately, if a woman's choice to breastfeed is not socially or structurally supported, she has no

option but to turn to formula. So, did she truly choose to bottle feed? Given that many women feel passionately about breastfeeding (Hausman, 2014), society should ensure all women are able to choose breastfeeding if they wish, while simultaneously withholding value-laden judgements of infant feeding choices.

Two of the most commonly explored barriers that constrain women's breastfeeding choices, which I discuss below, are: (1) returning to work and (2) a lack of social support. Numerous qualitative and quantitative studies have found that both of these factors significantly contribute to the initiation, exclusivity, and duration of breastfeeding. It is important to understand these primary barriers as they influence the options available to women and their subsequent experiences in relation to infant feeding.

Return to work

Women returning to work face many obstacles that may impede their ability to breastfeed. Working mothers are most likely to cease breastfeeding upon beginning their return to employment, suggesting there are multiple barriers during this crucial time (Lubold & Roth, 2012). At a policy level, paid parental leave and employer obligations will impact the choices that are structurally available. These are further impeded by psychosocial factors, which are primarily influenced by perceived employer support and workplace culture (Lubold & Roth, 2012). Moreover, attention must be paid to the intersections between, class, culture, and race, which will heavily alter the experiences women may have within the same structural landscape (Nickel et al., 2014).

Structural influences on return to work

Paid parental leave has been identified as a primary factor for establishing a resilient breastfeeding practice, which greatly increases the likelihood of continued breastfeeding. Research suggests extended paid parental leave is a necessity for the initiation and success of breastfeeding (Appelbaum & Milkman, 2011). Multiple survey-based studies suggest extended paid parental leave increases maternal attachment and that increases in provisions strengthens women's ability to develop their breastfeeding practices (Cooklin, Rowe, & Fisher, 2012; Ogbuanu, Glover, Probst, Liu, & Hussey, 2011; Rossin-Slater, Ruhm, & Waldfogel, 2013). Compelling evidence comes from California's paid parental leave program. Upon establishing paid leave, the median duration women breastfed for doubled (Appelbaum & Milkman, 2011). While there is a lack of qualitative research examining breastfeeding and paid parental

leave, one 2008 study interviewed women from Australia and New Zealand on their experiences. Women with no access to paid leave described the need to quickly return to paid employment, which adversely impacted on the establishment of their breastfeeding practices (Brough, O'Driscoll, & Biggs, 2009).

Psychosocial influences

Policy can provide a general framework to support a breastfeeding woman's transition to employment. However, research has found various psychosocial factors that influence the potential benefit of these schemes. Breastfeeding can be a contentious issue within workplaces, therefore many women are cautious of perceived judgement and a lack of support (Lubold & Roth, 2012). Combining breastfeeding with employment may create stress as is, placing further pressure on the already difficult negotiation between motherhood and employment. When this is compounded by a perceived lack of support from employers it can become taxing for women to navigate, leading to high rates of breastfeeding dropout (Lubold & Roth, 2012). Multiple studies suggest that workplace culture plays a large role in women's success of maintaining breastfeeding through employment (Bai & Wunderlich, 2013; Payne & James, 2008; Weber, Janson, Nolan, Wen, & Rissel, 2011). For instance, an Australian survey found just thirteen percent of women returning to work perceived their organization as supportive, and only eight percent had received information on the company's breastfeeding policy (Weber et al., 2011). Many women feel their workplaces promotion of breastfeeding is passive, and therefore support is not perceived as genuine (Anderson et al., 2015; Zhuang et al., 2018).

This lack of support may be due to ideal worker norms, where breastfeeding women are seen as an interruption to workplace productivity. A Foucauldian analysis with 20 women from New Zealand who breastfed while employed revealed that women performed a delicate and taxing negotiation between their duties as a mother and worker (Payne & Nicholls, 2010). Many women felt they were a disruption to their workplace, and therefore engaged in high levels of discipline to ensure they remained invisible as a breastfeeding employee. These factors can greatly increase the psychosocial stress women face when managing a balance between work life and motherhood. Additionally, this may greatly impact the success of workplace regulation, as ideal worker norms may discourage women from advocating for their rights.

Inequalities

Supportive workplaces theoretically improve a women's ability to breastfeed, however race and socioeconomic status also constrain the choices that are truly available to women. Disparities in socioeconomic status and race greatly impact breastfeeding, with white and Asian women breastfeeding at higher rates than black women (Jones, 2018; Lucas & McCarter-Spaulding, 2012; Nickel et al., 2014). It is well documented in recent literature that white, middle-class, educated women working in professional or managerial roles have significantly more success in maintaining breastfeeding while employed (Lucas & McCarter-Spaulding, 2012). Women of this class status are more likely to have accommodating jobs, private spaces to breastfeed or express, and/or on-site ECE facilities. In contrast, women of colour are overrepresented in low-wage service jobs, and may have less access to breastfeeding facilities (Hardison-Moody, MacNell, Elliott, & Bowen, 2018). Women who work in low-skill jobs are often replaceable to companies, therefore there is less incentive for employers to provide breastfeeding support and it may be difficult for female employees to defend their rights (Lucas & McCarter-Spaulding, 2012). Furthermore, working class women often have no choice in returning to work, and when this return occurs. Women in high-skill jobs are in a better position to work flexible hours and have the power to negotiate a supportive environment. Thus, employment status plays a key role in the breastfeeding inequalities caused by socioeconomic status and race (Lucas & McCarter-Spaulding, 2012).

Social support

Social support beyond the workplace is important for breastfeeding women, and greatly influences breastfeeding practices. Support works as a buffer for many breastfeeding barriers, and can come from a variety of sources, from close familial relations to wider-context support networks such as coffee groups, events, or social media (Alianmoghaddam, Phibbs, & Benn, 2018a).

Support from partners and other family members has been shown to impact women's breastfeeding decisions. Men have traditionally been thought of as being outside the realm of breastfeeding, but research suggests that many men are now actively involved in supporting their partners breastfeeding practices (Alianmoghaddam, Phibbs, & Benn, 2017a). Qualitative research has revealed that men provide highly effective support to their partners, and despite a general lack of knowledge and experience, are able to help both emotionally and practically (Alianmoghaddam et al., 2017a).

Wider family support is also effective, particularly when received from women's mothers. A qualitative analysis exploring breastfeeding women in New Zealand found that an intergenerational breastfeeding culture and support from the maternal grandmother were key support systems (Alianmoghaddam, Phibbs, & Benn, 2018b). Furthermore, they found that emotional support was more important to women than instrumental support. This has been found in various studies, which demonstrate how women with low support are less likely to breastfeed (Alberdi et al., 2018; Hinic, 2016; Ogbo et al., 2016).

Community support is also a powerful influence on women's ability to breastfeed, and coffee groups, social media, and organizations such as La Leche League provide strong support networks for many women. Research has shown that support from strangers online can work as an effective form of support, both providing practical information and emotional encouragement (Alianmoghaddam et al., 2018a; Tomfohrde & Reinke, 2016). Community initiatives and events such as 'baby cafes', La Leche League, and 'The Big Latch On' can help women relate those in similar positions (Fox, McMullen, & Newburn, 2015). 'The Big Latch On' is a prominent breastfeeding event, run annually in New Zealand by Women's Health Action, which sees breastfeeding women come together to share support and education. The initiative is run country-wide, including remote areas, and takes place in a variety of locations, such as cafes, maraes, and community halls (Women's Health Action, 2019). Community events like 'The Big Latch On' provide an important source of support for women, particularly those who may not receive active support from their partner, friends, or family (Fox et al., 2015). Social support is a strong predictor of breastfeeding and works as an important buffer to many emotional and practical difficulties women may experience.

I have thus far reviewed the literature indicating that workplace support and social support are two crucial factors that influence breastfeeding. As I have shown, a wide variety of literature has examined workplace and social supports potential to constrain women's breastfeeding choices. Less researched however, is the role of early childhood education, which is the focus of my research, and which I turn to in the following section.

Early childhood education: an intersection between employment & support

Early childhood education's impacts on breastfeeding women's experiences has been largely neglected in research. This is unfortunate, as ECE rests at an important intersection between employment and

support. ECE is largely accessed by working mothers, directly linking it to barriers faced by women who are returning to work (Bromer & Henly, 2004). Alongside this lies the powerful support network ECE centres provide. Centres are sites of active engagement, consider themselves to act as a whanau, and work to create links between teachers, families, and the wider community (Bromer & Henly, 2004). Many families see centres as a supportive extension of their family, and trust the advice and guidance centre staff may provide (Gupta, Shuman, Taveras, Kulldorff, & Finkelstein, 2005). Therefore, ECE centres may hold significant potential to support women in their breastfeeding choices. As with employment, ECE centres can introduce a powerful institutional influence on what is usually thought of as a private decision (Hill, 2010). They have the opportunity to accommodate women through constraints imposed by employment, both practically and emotionally. Conversely, if a lack of cooperation exists then ECE risks becoming one of the multitude of barriers women already face. Despite the powerful influence ECE centres may have, there has, as mentioned, been little research in this area. There is a limited selection of recent international research and only three key New Zealand works investigating its effects. I discuss each of these bodies of work in turn.

International research on ECE and breastfeeding

There is a small pool of current international research examining ECE and breastfeeding, mostly emerging from the United States, as well as Australia, Scotland, and Korea. Researchers have focused on staff support, although one recent study has focused on breastfeeding women's experiences.

Staff support of breastfeeding

Survey research has focused on measuring ECE staff knowledge related to breastfeeding, often finding low to moderate knowledge (Batan, Li, & Scanlon, 2013; Garth, Messer, & Spatz, 2016; Lucas et al., 2013; Souza, Prudente, Silva, Pereira, & Rinaldi, 2013). Lucas et al. (2013) found a majority of the staff members across the 11 centres that they surveyed underestimated their potential role as health promoters and educators. Staff reported that they had little influence on infant feeding decisions, therefore miscalculating the weight that centre support and policy plays in women's breastfeeding practices. Batan, Li, and Scanlon (2012) found that an increase in ECE centre support was directly correlated with increases in breastfeeding duration. Recent quantitative research suggests a need for improved staff education.

A number of studies in a range of countries, predominantly Western, have used qualitative interviews to investigate breastfeeding practices in ECE centres. These interviews have revealed large variations in knowledge and support between centres. Most centres are supportive of breastfeeding, but many lack the necessary training to support women. In terms of support, Hill (2010) conducted interviews with nine ECE centres in the United States and sent surveys to a further 93. The data revealed many differences between individual centres approaches to breastfeeding, and showed that centres with personnel who had breastfed their own infants provided more support to breastfeeding women. Javanparast, Newman, Sweet, and McIntyre's (2012) Australian study, found that while centres have good intentions, their support is generally passive and places the onus on women themselves to manage breastfeeding while accessing ECE, including staff education on how to handle breast milk. Interviews conducted at 15 ECE centres showed that most centres were without a breastfeeding policy, and while most stated they were supportive of breastfeeding their knowledge was low (Javanparast et al., 2012). Staff members thought it was important to focus on breastfeeding within workplaces rather than on centre practice and shifted the responsibility to breastfeeding women rather than institutions.

In terms of staff knowledge and training, recent qualitative data suggest that there is a lack of education and responsibility from within the ECE sector. Interviews with ten Korean ECE workers revealed highly positive attitudes towards breastfeeding, but low knowledge, little policy, and insufficient staff training (Suan, Ayob, & Rodzali, 2016). Calloway, Stern, Schober, and Yaroch (2017) found similar results in the United States. They report that staff motivation to promote breastfeeding was indicative of the level of support provided. Staff members who were interviewed expressed that they were underprepared with the education they had been given on breastfeeding, and in line with New Zealand research discussed below, had to research and form policy on their own. Participants also perceived parents as indifferent towards infant feeding choices, and cited this as major reason for not promoting breastfeeding within centres (Calloway et al., 2017). Likewise, Marhefka et al. (2018) found comparable attitudes in their sample of 28 centres also in the United States, with many centres pinning this indifference on the formula feeding norm within childcare settings. Clearly, staff members are aware that they are lacking breastfeeding knowledge, however despite this it appears that many centres are falling short of working towards providing genuine, active support for women who are breastfeeding.

Parental perceptions

Nearly all qualitative research in this field has been gathered through interviews with ECE staff, rather than breastfeeding women themselves. While this has provided important evidence regarding the association of ECE centres and breastfeeding, it only tells half the story. Self-reported levels of support provided by staff may not be predictive of whether breastfeeding women truly feel supported within this setting. Therefore, there is a need to investigate the experiences of women themselves, as ultimately women and their children are the most affected parties.

To address this gap, a 2018 small scale feasibility study in Scotland conducted two focus groups, which included one with four breastfeeding women who were accessing ECE services, and another with two ECE teachers (Dombrowski et al., 2018). The researchers, using grounded theory, revealed a large disconnect between how women wished they were supported, and the reality of the ECE services actions. They expressed extreme difficulty locating nearby centres who catered for breastfed or express-fed children and were left with severely limited options (Dombrowski et al., 2018). The women interviewed discussed how responsibility for feeding was placed on them, including for staff education on storage, preparation, equipment, and differences between breastfed and formula fed infants. One woman felt that her centre was only accommodating her wish to feed her child expressed milk due to her insistence. All four women interviewed expressed a need for greater education and support amongst ECE centres and felt that the lack of supportive centres had greatly constrained their childcare options (Dombrowski et al., 2018).

Alongside investigating breastfeeding women's perspectives, Dombrowski et al (2018) interviewed two senior staff members working at ECE centres independent of the breastfeeding participants discussed above (Dombrowski et al., 2018). With over twenty years' experience, both teachers were yet to come across a woman who continued breastfeeding within the ECE setting. Therefore, their interview data can be considered purely speculative and not reflective of actual encounters with breastfeeding women (Dombrowski et al., 2018). This is important, considering that this research field has focused on staff-reported data, despite the possibility that many participants do not have real-world experience to draw on. The teachers interviewed reported that while they would support a breastfeeding woman, it was not their role to engage in active breastfeeding support and promotion. When asked how they encouraged breastfeeding within their centres they discussed having posters and pamphlets. One teacher stated that if a woman wished to bring expressed milk to the centre then they would "*deal with that*". These results are in line with previous research, which suggests ECE centres provide passive support

(Dombrowski et al., 2018; Javanparast et al., 2012). The breastfeeding women interviewed picked up on the passivity of support in their interviews and discussed its negative consequences, including no written guidance and policy, and a lack of verbal communication from staff. Dombrowski et al. (2018) have provided an important first step into examining women's experiences of breastfeeding upon ECE enrolment. However, this research only interviewed women who continued breastfeeding. Women who discontinued breastfeeding may present different experiences, leading to a richer and more comprehensive picture. It is also necessary to consider specific contexts in which social and cultural norms may shape experiences differently.

New Zealand research on ECE and breastfeeding

There has been little research on the ECE setting and breastfeeding in New Zealand, with three key works, which include a case study, a literature review, and a survey. A 2003 case study was funded by the Department of Labour and the Ministry of Women's Affairs. This study examined two ECE centres in New Zealand and theimpacts they had on families' breastfeeding choices. Researchers gathered a variety of qualitative data, using observations, questionnaires, and interviews with parents, staff and managers. Both centres were working to be supportive towards breastfeeding women, although one centre had no breastfeeding infants attending, and both facilities agreed that breastfeeding was the exception rather than the norm. One centre had no written policy, and the other had recently written one based on information they had researched themselves. The researchers concluded that ECE has a considerable impact on infant feeding decisions and were able to identify a number of key factors that supported the continuation of breastfeeding (Farquhar & Galtry, 2003). These factors included:

- Staff members who are willing to learn how to practically support breastfeeding women
- Welcoming spaces for women to breastfeed in, both physically and attitudinally
- Written breastfeeding policies
- Working alongside families' requests to support their specific breastfeeding requirements
- Written and verbal communication between staff and parents on infant feeding schedules
- Staff and managers who are able to provide evidence-based guidance as needed
- Supporting women who may have difficulties with breastfeeding
- Withholding judgement and providing equal support to families whether they decided to breastfeed or not

- Offering information on relevant health care professionals to families who may need them (Farquhar & Galtry, 2003).

While the centres had some idea of how to support breastfeeding women both centres felt they were left to create guidelines and policy without support, as no national standards are available. This means that there can be great variation in how centres approach breastfeeding. Many centres may create their own guidelines on an ad hoc basis, rather than implementing evidence-based best practice (Farquhar & Galtry, 2003). Farquhar and Galtry (2003) used their case study to inform a set of guidelines for ECE centres to best support breastfeeding women. These guidelines outline four issues relating to facilities, storage and handling, communication, and policy. Within each issue, guidelines are provided and labelled as either essential or desirable. These recommendations provide a clear, achievable framework for centres to use when creating breastfeeding policies. However, it is still widely up to the individual centre to decide whether they will utilise guidelines and implement a breastfeeding policy.

In 2009 research on ECE and breastfeeding was conducted again, in the form of a literature review prepared for the Ministry of Health. This report built upon Farquhar and Galtry's (2003) research, providing more evidence for the necessity of ECE breastfeeding guidelines. Bartle and Duncan (2009) examined international research on breastfeeding policies, mother's return to work, and early childhood environments. The findings reiterate the guidelines set forth by Farquhar and Galtry (2003), and conclude that breastfeeding is a human's rights issue that has been continuously overlooked within the ECE sector (Bartle & Duncan, 2009) .

Lastly, in 2012, Manhire, Horrocks, and Tangiora (2012) conducted a survey of 32 ECE centres in New Zealand. Drawing on a nursing perspective, they sampled 31 managers and 55 staff members, and were focused on investigating the number of breastfed children attending ECE, and attitudes and knowledge among staff members. The findings revealed that nine percent of infants 6-12 months old attending ECE services were exclusively breastfed, which is well below the national average of thirty five percent. Levels of staff support were high, though education, policies, and resources appeared low. Staff reported that they had not been trained to support breastfeeding but expressed an interest in attending training programs. This research demonstrates low rates of breastfeeding infants attending ECE, and that while staff are willing to improve in relation to breastfeeding, they are failed by a lack of institutional knowledge, resources, and policy. Manhire et al. (2012) conclude with a call for further research within this field, and the recommendation that future policy should focus on including ECE

centres within strategies to support breastfeeding. Again, their research did not include mother's perspectives on the issue.

All three studies indicate a need for further local research to support the small existing base of literature demonstrating ECE's impact on infant feeding. Despite this call the area has seen little advancement. With an ever-increasing number of women returning to work, improved breastfeeding employment policy, and advancements in breast pump technology, updated research is necessary to continue relevant work in this field (Employment New Zealand, 2010; Flynn & Harris, 2015; Shu, 2017). Moreover, there is a clear need to include mothers in such research.

Conclusion

Many women feel judged and unsupported in relation to infant feeding, regardless of the breastfeeding choice they have been able to make. Dominant discourses of personal responsibility have moralised breastfeeding and placed too much emphasis on individual-level choices. The negative impact of this is wide reaching, affecting women's self-esteem, identity, and experience of motherhood, and may expose mother's to intervention from official and non-official sources. It is important to shift the focus away from individual choices, and instead critique the wider socio-cultural context that constrains infant feeding options. As it currently operates, the ECE setting may either be a powerful barrier or a positive influence for many women. Researching women's experiences of breastfeeding within this context will illuminate the various ways ECE centres may limit and/or open women's available choices.

Therefore, using Foucauldian discourse analysis (FDA) to examine the experiences of women within this setting will provide rich data. FDA, utilising interviews, will allow women's voices to come to the fore. FDA grants access to study how power operates within a context, highlighting how people's available options are either constrained or enabled by wider sociological barriers. This removes the emphasis on individual choice, which many current studies in this field have focused on, and will contribute a detailed look at the restrictions that ultimately shape infant feeding decisions. This research is unique because instead of simply identifying barriers, FDA will allow me to explore participant's constructions of breastfeeding and the implications of this on their subjectivity. This will provide a nuanced account of how women experience the various ways breastfeeding is shaped in relation to employment and ECE care.

Chapter 3: Methodology

I have argued for the need to attend to women's own accounts of their breastfeeding practices in ECE settings. My approach to these accounts, which I outline in this chapter, is from a broadly social constructionist orientation that emphasises the importance of language in our experiences of the world. Importantly, based on this perspective, language is not seen as simply a communicative medium used to describe the world in a neutral way. Instead, a critical view is taken of language as constructing rather than reflecting reality. In this view, language is understood as making available sets of culturally shared meanings (or discourses) that people draw on in their accounts and in so doing they construct particular versions of reality (e.g., breastfeeding as natural or as an obscene act) (Burr, 2015). Reality is therefore constructed through a dynamic process, in which language shapes our world, including our thoughts, personhood, experiences, and the social structures we exist within (Gannon & Davies, 2014). Therefore, social constructionism stands in opposition to mainstream psychology's preferred objectivism. Our knowledge is seen to be historically and culturally specific—that is, contingent on the time and place in which it is produced (Burr, 2015).

In this chapter I begin by discussing the key tenets of social constructionism, which provide a blueprint for Foucault's poststructuralist theory, the theoretical lens that I apply in this research. I then go on to explain key aspects of poststructuralism, including language and discourse, power/knowledge, subjectivity, and agency. Following this, methods, including participant's recruitment and selection, ethics, and the interview procedure, will be considered. This leads way to an exploration of the chosen method of analysis, Foucauldian discourse analysis (FDA). Finally, researcher reflexivity is considered in relation to quality assurance and evaluation criteria to assess that the project is of good quality. This includes an exploration of my own assumptions as a researcher, which are central to acknowledge within qualitative approaches as they aid in reflexivity and help contextualise the research in relation to the researcher.

Social constructionism

No singular definition of social constructionism exists, however many scholars accept a framework of assumptions that broadly support a social constructionist approach (Burr, 2015). In this regard, Burr (2015) outlines four key assumptions. Research grounded upon one or more of these assumptions is

drawing on constructionist epistemology. Firstly, research must provide a critical stance to common knowledge. Social constructionists reject the idea that our current understandings are objective and unproblematic, therefore challenging taken-for-granted knowledge. This is important as mainstream psychology prides itself on unbiased, empirical knowledge, often disregarding assumptions that influence both the research process and its interpretation. Social constructionists will tease these out, highlighting the assumptions that shape our knowledge, and opening new possibilities for understandings. Secondly, social constructionism does not seek universal knowledge about 'human nature'. Instead, historical and cultural specificity is highlighted. Ways of understanding are relative to the historical, cultural, economic, and social influences of the time. Consequently, there is no inherent 'human nature', as all humans are inextricably linked to their time and space. As a result of this, researchers may not impose their own understandings on other cultures. Thirdly, social constructionists assume that knowledge is a social process. There is no universal 'human nature' or objective 'truth', therefore knowledge is produced through language and shared by people. This is a dynamic process in which daily social interactions create reality. The sharing of knowledge leads to collective understandings of the world, which become accepted as truths. This is why knowledge is highly dependent on the culture and time in which it is produced. What is spread as a shared understanding varies greatly with time and place. Finally, a key assumption of social constructionism is the connection of knowledge to social action. Socially constructed knowledge generates acceptable behaviour and actions. Therefore, how a culture understands an issue will shape the actions accompanying it. For example, in nineteenth-century UK alcoholics were personally responsible for their drinking, and the accepted action was imprisonment. However, today the dominant social understanding is based on a disease model of alcoholism, and consequently the accepted response is to provide medical and psychological treatment. The social construction of concepts and ideas inevitably effects action. Accepting this assumption allows social constructionists to highlight power relations within society, since those who shape and control knowledge in turn shape and control society.

The four assumptions outlined above are key to social constructionism, and inform a variety of approaches, each with their own slight differences of understanding. FDA, my chosen method, is informed by social constructionism. FDA views research as subjective and context-dependent, and sees knowledge as a shared and social process. Power is an important aspect of FDA, as the method aims to contest and challenge dominant discourses in order to promote social change. Specifically, FDA falls within poststructuralism, which is one of the approaches falling under the umbrella of social constructionism, as discussed further below.

Poststructuralism and Foucault

Poststructuralism is an approach that stems from social constructionism. This approach questions understandings of truth, meaning, and reality. It states that no singular 'truth' exists. Instead, concepts are constructed relative to a specific context, and are only given meaning through their relation to other constructs. Foucault was a key figure within the poststructuralist movement, and his ideas on language and discourse, power/knowledge, subjectivity, and agency are fundamental to understanding both poststructuralism, and the methodology used in this thesis. I therefore unpack each of these key concepts below.

Language and discourse

The notion of discourse is fundamental to Foucauldian theory, which assumes that human experience is textually constructed (Gannon & Davies, 2014). Discourses may refer to any text that can be read, including written and spoken language, and images (Burr, 2015). Under a Foucauldian, approach discourse refers to 'a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events' (Burr, 2015, p. 64). Any one phenomenon will therefore have various discourses surrounding it, each offering a unique perspective, or construction, of the phenomenon.

Discourses function as a way of understanding the world, and operates primarily through language (Gannon & Davies, 2014). For example, when discussing breastfeeding multiple discourses may be employed. One woman may discuss breastfeeding as being a natural and essential part of parenting, drawing on a 'total motherhood' discourse in which the child's needs are met above all else. A second mother may construct breastfeeding in a different way. She may draw on Western discourses of individuality and productivity, focusing on 'negative' aspects of breastfeeding such as workplace interruptions or interdependence between the infant and mother. Each of these accounts construct a phenomenon (breastfeeding) in entirely different ways, which has implications for what we believe the 'true' nature of the object to be and the actions people can take. These ideas are supported by dominant discourses, and are further shaped by intersections of ethnicity, identity, socio-economic status, and social position. Consequently, people's words cannot be seen as a reflection of 'true' reality,

but rather the result of multiple competing discourses, expressed and constructed through our language (Macleod, 1994). Multiple versions of reality therefore emerge.

Discourse shapes our reality, and as intimated earlier can shift across different groups, times and places. Therefore, under this approach language has no inherent meaning of its own (Burr, 2015). The active, shared process of using language creates knowledge as understandings circulate throughout a culture (Willig, 2013). Therefore, language may either reinforce or lessen current shared understandings or generate entirely new ones. Through this social process different forms of knowledge generate organically and appear as taken-for-granted truths (Gannon & Davies, 2014). However, language and meaning are transient, constantly shifting based on a range of contextual factors shaped by the historical and cultural knowledge of the people using it, and by the person interpreting it (Weedon, 1997).

Discourses influence the practices, power relations, and social processes accepted by a society (Gannon & Davies, 2014). Dominant discourses are taken up as the norm, positioning other discourses as lesser. For example, in Western society we have a dominant biomedical discourse, which focuses almost purely on biological and medical causes of health. Due to this, psychosocial, cultural, or environmental health discourses are largely overlooked. Dominant discourses such as the biomedical discourse are held up by those in power, while alternate discourses are discredited, as they serve their own interests (Gannon & Davies, 2014). For example, a focus on individual physical health choices shifts responsibility from those in power and may therefore be preferred. Often these discourses become invisible as they get reinforced through social processes, such as language, which make them appear as simply the natural order or as the way things are (Weedon, 1997). This can make it difficult to step outside of dominant discourses and offer new perspectives to produce social change (Gannon & Davies, 2014).

For this reason, FDA aims to examine how participants use various discourses in order to discuss their choices and experiences. By illuminating the various discourses researchers are able to demonstrate how power and knowledge operates within a particular context, and the implications of this on people's subjectivity and agency (i.e., their ability to act in certain ways).

Power/Knowledge

Power and knowledge are also central concepts to poststructuralism. Knowledge generates power, and in turn exercising power creates knowledge (Burr, 2015). Foucault describes power as relational, in that

it operates between people and institutions. Through discourse we generate knowledge about our world. This knowledge becomes the basis of society, shaping the meanings, categories, and practices that either constrain or enable the choices available to those within a particular society (Burr, 2015). This is in opposition to a top-down approach, in which there is a divide between those who have power and those who do not (Braun & Clarke, 2013). Rather, power is diffuse, operating through and from all of society. Power may not appear to be being constantly created, yet through language, discourse, and everyday practices people within a society consistently exercise, shape, and define power. Power and knowledge are therefore seen as inextricably related. Knowledge, formed through discourse, creates certain social realities and perceptions. These social realities have implications for power as they influence how people conduct themselves, shaping their thoughts, feelings, and actions (Burr, 2015).

Subjectivity

As part of making sense of the world, discourses help shape social identity, known as subjectivity, and experience. Within poststructuralism the 'self' is considered fluid and defined in relation to multiple discourses. Discourse provides people with social identities, or 'subject positions'. For example, within Western society we have a 'total motherhood' discourse, in which women are expected to place their children above their own needs or desires, and optimise every aspect of their offspring's lives (Wolf, 2010). This dominant discourse creates the subject position of the 'good' mother, and allows for the othering of the 'bad' mother, who does not meet ideal parenting standards.

Taking up or accepting a subject position is more than simply an identity label, as it involves seeing the world through the lenses of the various subject positions one inhabits (Burr, 2015). It is important to acknowledge that multiple subject positions exist alongside one another for the same person. This is because across time and space, we take up different subject positions for different purposes. The 'good' mother may also be a Christian, a vegan, a Māori woman, or middle-class. These subject positions work together to create an individualised self, open to change throughout the life span. This is in opposition to an essentialist view of the self, as it demonstrates how individual's subjectivities are dynamic, ever-changing, and multiple. They are a reflection of the available dominant discourses. Therefore, they are open to change as new discourses can create new possibilities for experience. For example, in the 1950s, formula feeding was the norm and it would be unlikely for a woman to feel like a 'bad' mother for not breastfeeding. However, in today's society, breastfeeding is a central tenet of 'good' motherhood, and experiences of guilt and shame are common amongst women who are unable to do

so. Subject positionings “facilitate and limit, enable and constrain what can be said, by whom, where and when” (Willig, 2013, p. 102). By taking on the world views of particular subject positions, we limit available possibilities by narrowing our scope to what fits within our current positions. This has implications for agency, as detailed below.

Agency

Agency refers to the capacity each individual has to make choices freely and independently. As discussed above, subject positions influence which options are available to most individuals. When someone has a narrow field of options due to their subject positions, their choices become highly constrained. For instance, a poor breastfeeding woman who works in the fast-food industry may find it difficult finding time and space to express milk at work and could be accessing an ECE service that is uneducated on providing expressed milk. In this scenario, the woman has little agency to continue breastfeeding despite her intentions. However, because dominant discourse assumes people are able to make logical choices, she may be considered a failure for weaning her infant. Therefore, these ideas affect the woman’s sense of maternal identity. Subject positions impact the extent to which people have agency in specific contexts, with many positions constraining their subjects available choices (Burr, 2015; Gannon & Davies, 2014).

The theoretical concepts explored above are central to understanding research conducted within a poststructuralist framework. Each of these concepts are illuminated through using Foucauldian discourse analysis. This allows for the exploration of discourses employed by participants, the subject positions they construct and negotiate, and the possibilities for action enabled by these particular discursive constructions and subjectivities.

Methods

Participants, recruitment and selection

Recruitment

For the purpose of recruitment, a working figure of 5-10 participants was set, with the aim that the final sample size would fall within these limits. This flexible goal was set to ensure there would be an appropriate sample size to yield sufficient data for analysis, depending on the richness of the data

generated (Gannon & Davies, 2014). In terms of selection criteria, participants needed to be Auckland based, as it was not feasible to travel to other cities for interviews. There were no age restrictions in place, however participation was limited to women who currently, or within the past three years, had an infant or child in ECE care. This was to ensure recent experiences were gathered, as these are the most relevant to explore due to changes in paid parental leave and workplace legislation. Women from all backgrounds were encouraged to apply, whether they continued or discontinued breastfeeding. This was to ensure a range of experiences were represented, as women who make either decision likely have unique experiences and perspectives. Additionally, there were no limits for the age of their child, meaning the child could be as young as three months, or as old as five years.

Participants were recruited through both ECE centres and Facebook. Initially, a site-based approach was used. A letter to ECE centres (Appendix I) was emailed to four centres in Auckland, however only one responded. The email called for centres to assist recruitment by displaying a flyer (Appendix II) and the participant information sheet (Appendix III) for their families to view. This was done by uploading a PDF of the flyer to 'Storypark', a widely used ECE portal, and pinning a hard copy to their centre notice board. As only one ECE centre displayed the advertising material, the advert was then placed on the Facebook page of 'The Big Latch On'. The Big Latch On is an initiative organised by Women's Health Action, which aims to promote public breastfeeding, and has a large online following. This led to the recruitment of a wider range of women.

Selection

Prior to contacting centres, I researched the various ECE services within Auckland. Most ECE centres upload their Education Review Office report to their websites. Due to this, I could find demographic data on ethnicity, centre participation, and children's ages. I selected a wide variety of centres, ensuring I targeted large centres catering for a range of ages and ethnic groups. I also ensured I contacted a variety of socioeconomic status areas, as determined by the decile ratings available on the Ministry of Education's website. I utilised this demographic data in an attempt to garner a diverse sample with a range of perspectives. I accepted the three women who contacted me based on the one ECE centre who advertised my material. Following the advertisement being placed on The Big Latch On Facebook page I received a further four participants.

Participants

Seven women participated in this research. Demographic data were collected as part of the interview and can be seen in Table 1: Participant demographics, below. Participant's ages ranged from 29 to 41. Four women identified as NZ European, one woman identified as British, one identified as North American, and a further one woman identified as South African/European. The women had children who ranged in age when starting ECE, from three months to 13 months. Six women were in full time employment, and one was employed part time. Six women had continued breastfeeding upon ECE enrolment, and one had stopped. All participants self-identified as middle class. Despite my attempt to garner a diverse sample the participants were all white, middle-class women. This was likely to because half my sample came from the ECE centre which displayed my advert, which services a majority of NZ European/Pākehā families. The demographic characteristics of the participants would have shaped data as women with greater economic privilege have more available options in relation to breastfeeding (Nickel et al., 2014).

Table 1: Participant demographics

Name	Child's age at time of ECE enrolment	ECE Status	Breastfeeding Status	Infant feeding method
Hailey	8 months	Part-time enrolment	Exclusively breastfed	Child refused bottled breast milk. Hailey worked shorter shifts to compensate for her child not getting milk during their time at ECE.
Olivia	13 months	Full-time enrolment	Exclusively breastfed	Did not want to ask new employer about pumping breast milk so provided cow's milk at ECE care and breast milk at home.
Madison	4 months	Part-time enrolment	Exclusively breastfed	Child refused bottled breast milk. Madison worked shorter shifts to compensate for her child not getting milk during their time at ECE.

Elly	3 months	Full-time enrolment	Exclusively breastfed	Visited centre during her work day to breastfeed, eventually switched to providing pumped milk.
Emma	7 months	Part-time enrolment	Exclusively breastfed	Pumped breast milk at work and supplied this to her ECE provider.
Sophie	7 months	Full-time enrolment	Exclusively breastfed	Pumped breast milk at work and supplied this to her ECE provider.
Charlotte	8 months (twins)	Full-time enrolment	Partially breastfed	Ended breastfeeding in preparation for her return to work, switched to formula.

Ethical considerations

Researchers have the responsibility to ensure they practice their research safely and ethically. The research processes were considered using the 2018 Code of Ethical Conduct as dictated by Massey University, along with the New Zealand Psychological Society guidelines. These issues were discussed in-depth with my supervisor, and I sought cultural advice from Lisa Stewart. A full submission of ethics was approved by the Massey University Human Ethics Committee. This section will discuss the key ethical considerations for this project, including possible harm to participants, researcher protection, and cultural safety.

Protection of participants

Research participation must be voluntary. This includes ensuring participants choose to participate and that this choice is made without coercion or undue influence, and with full knowledge of the risks and benefits of the research (New Zealand Psychological Society, 2002). To ensure participation was voluntary people were able to nominate themselves by emailing an address on the flyer. Therefore, no one was chosen or felt obligated to participate. Coercion refers to the pressure people may feel to participate in research, for example facing retaliation from an employer or authority figure. It is unlikely women accessing the ECE centre utilised felt coerced into participating. While organisations such as ECE

centres do hold power, it is highly doubtful that the centre had a vested interest in pressuring women to participate, and that the women would meet harm by not taking part.

To further ensure voluntary participation researchers must be aware of the influence financial incentives may introduce. If an excessive reward is offered certain participants may not be able to afford to refuse the offer to participate, potentially causing them to agree to research they would not otherwise feel comfortable with (Head, 2009). To negate this the incentive was kept small and fair, with participants receiving a $20 voucher. The vouchers were given at the start of the interview, respecting participant's right to withdraw. Finally, participants were made aware of the risks and benefits of the research. These were detailed on the participant information sheet (Appendix III), which was sent to participants prior to agreeing to participate. This was to ensure there was sufficient time to think through the research process and its implications before volunteering.

Informed consent was obtained from each participant through a signed consent form, which further reminded participants of their right to ask questions about the study, and withdraw at any time. Participants also consented to having their interview recorded on a voice recorder, with the understanding that they could request for it be turned off at any time. Furthermore, participants were provided with a transcript of their interview, and given two weeks to make edits or withdraw their data. The editing window was limited to two weeks due to the difficulty of removing data once analysis had begun. No participants made changes to their data.

Data were kept private and confidential. Interviews limit the possibility for anonymity, therefore, whilst researchers will know the identity of their participants, they must ensure no identifying information is available to the public (New Zealand Psychological Society, 2002). Throughout the data collection process all information was securely stored in mine and my supervisor's password protected computers. Hard copies of the consent forms were stored in a locked drawer. Upon transcription the voice recordings were deleted, and the written transcriptions and consent forms will be stored securely for five years, then destroyed. In the write up pseudonyms are used for the participants to prevent identifiable information. These appear in Table 1.

Interviews may be an intense experience for participants, as they may feel they have to confront or justify sensitive information. However, harm due to the interviews was expected to be minimal, particularly because participants self-selected. Nevertheless, breastfeeding is an intimate issue which may be sensitive for some women to discuss. As a result of its delicate nature it was important to ensure

a non-judgemental, empathetic tone was used. Women who discontinue breastfeeding often feel they have to justify their choice to others. It was made clear to participants that the research goal was not to persecute those who discontinued breastfeeding, but rather highlight the structural factors influencing women's decisions. Therefore, it was important to emphasize that there were no 'right' and 'wrong' answers or choices. No participant showed visible distress during the interviews; however, they were still made aware of the breastfeeding service La Leche League, whose contact details were available on the participant information sheet. They were reminded of this service both before and after the interview was completed.

Using ECE centres to recruit participants introduced the potential to damage relationships between staff and participants if the data were not used responsibly. The centre who aided this research by distributing advertising materials and providing interview spaces may have placed themselves at risk if any identifying information had been released. Women were honest and open when discussing their experiences with the centres they accessed, and even well-meaning centres may have unintentionally constrained women's choices. To avoid damaging the reputations and relationships of the participants, staff, and centre who assisted with this research it was ensured the descriptions of the centres were kept vague to avoid identifiable information. Additionally, because centres and participants were able to request a final copy of the project it increased the importance of protecting participant's privacy. Information provided by the participants could be recognisable to centre staff, therefore special attention was paid to removing unnecessary identifiable information. However, because many experiences are highly individualised it is still possible participants could be identified by staff who knew their story well. This was explained to participants in both the information sheet and at the time of the interview, ensuring they had a full awareness of this risk. It was particularly important to thoroughly consider and negotiate this risk throughout all stages of the research process, as causing tension between women and their ECE providers would likely cause psychological harm.

Despite the potential risks, discussing their experiences with a non-judgemental listener may have been beneficial for many participants. Breastfeeding can be associated with high levels of stress, shame and guilt, and reflecting on their experiences may have helped women make sense of their breastfeeding journeys. Throughout motherhood women's individual thoughts and preferences are often subject to harsh judgement, and this research may have provided an experience to have their opinions valued and validated. Many participants expressed that they had enjoyed the interview experience. For example, one participant said it had been therapeutic for her to revisit her experiences, as she had not had a

chance to reflect on breastfeeding despite it being a defining presence in her life the past few years. Participants were eager to help with the project, often offering to pass my details on to their friends for recruitment, or in one participant's case, a Stuff.co.nz reporter.

Cultural consideration

Even though no Māori women volunteered, research conducted in New Zealand needs to be Te Tiriti o Waitangi responsive (New Zealand Psychological Society, 2002). I sought cultural supervision from Lisa Stewart, who is a professional clinician and lecturer at Massey University, and specialises in Kaupapa Māori research. Lisa provided in-depth information on how to conduct research with Māori participants, and together we formed a plan for ensuring cultural safety if any Māori women participated. I attempted to encourage participation through ensuring the research was advertised at centres attended by Māori women (this information is available through the Ministry of Education), and including a phrase suggested by Lisa Stewart on my flyer (Appendix II) 'women of all walks of life welcome'. Although no Māori women participated, Lisa had prepared me with both practical suggestions, such as appropriate kai (food) to share and a karakia (prayer), and the offer of cultural supervision during my analysis.

Interview procedure

Interview setting

It was predicted most women who participated would have busy, working schedules and might find it difficult to find childcare outside of working hours. Therefore, it was decided participants could have the option of having the interview in their home, causing the least disruption to their children's schedules. Additionally, if women preferred the interview to take place outside of the home, there was the option of using a reserved room at the Massey University Albany campus library. One interview was conducted at the library and the others took place in the participants homes, all with children present. I believe doing the interviews in-home with children around worked to build rapport, as in most cases conversation naturally flowed from being in a homely environment.

Interview process

The interview process involved arriving at the participant's house and thanking them for allowing me to interview them. As I entered the house I made sure to build rapport through sharing whakapapa, natural

conversation, and providing food and drinks. This allowed me to create connections and a comfortable environment between the participants and me. Following this, we went over the information sheet and consent form together. Participants were reminded again of their right to withdraw and given an opportunity to ask questions. I brought participants attention to the contact details which were provided on the information sheet, and emphasised they could contact me, my supervisor, or the ethics committee if there were any questions or concerns. I also highlighted the contact details for La Leche League, as they could provide support if participants became distressed. At this point, participants were given their $20 voucher and reminded they had no obligation to continue with the interview if they changed their mind.

Once participants felt ready, we began the interview. I brought an interview guide (Appendix IV) that was used in an unstructured manner. The interviews were conversational, driven by what the participants felt was important to them, and minimal encouragers were used to reassure the participants they could keep speaking. Broadly, the interviews focused firstly on collecting basic demographic data and their breastfeeding history. We then discussed what breastfeeding meant to them, and if there were any cultural, spiritual, or philosophical values implicated within their practice. Following this, we talked about their experiences of breastfeeding (or not) while accessing ECE, both at a practical and an emotional level. This included workplace factors, ECE staff support, partner support, the ECE environment, and any other challenges they wished to touch on. These were broken down into a series of planned questions, as per the interview guide, but each factor was often discussed organically throughout our conversation.

Once the interview questions were finished, we discussed anything else the participant wanted to add, or felt we had missed. When given this opportunity many participants used the time to express their gratitude that this research was being conducted. Following this, we reviewed the interview together, and ensured I had understood their thoughts and experiences correctly. They were reminded of their right to withdraw data within the next two weeks, and reminded they could contact La Leche League if they felt any distress. This concluded the interview process, upon which I expressed gratitude to the participants for giving me their time and sharing their stories with me.

Analysis

Transcribing

Accurate and thorough transcription is essential when conducting a discourse analysis. Interviews were transcribed in a style consistent with the requirements of Foucauldian discourse analysis, such as including pauses, laughs, and changes in tone of voice. The transcription conventions used are detailed in Table 2: Transcription.

Table 2: Transcription conventions

Notation	Feature
((laughter))	Laughter from the speaker
((general laughter))	Laughter from both speakers
((pause))	Significant pause
((word?))	Unsure exactly what the word was
umm, ahh	Non-verbal utterances
?	Signals rising intonation of a question
'inverted commas'	Inverted commas to signal reported speech
…	Person trailing off

Foucauldian discourse analysis

Foucauldian discourse analysis (FDA) was used to examine women's accounts of infant feeding in ECE centres . Through this method we can observe how women position themselves within relevant discourses, and how these limit or enable the decisions they are able to make (Burr, 2015; Gannon & Davies, 2014). This allowed for theorisation on the experiences and subjectivity of women who make choices around breastfeeding infants in ECE. The analysis utilised Willig's (2013) six stages of FDA, which provided a framework for interpreting data, and are detailed below.

The first stages of FDA involve exploring the discourses within the interviews. Firstly, the discursive objects relevant to the research question are identified through the text (e.g., breastfeeding, choice). This includes looking for key words, as well as both implicit and explicit references to the phenomena. During this stage, it is important to take note of how participants are constructing these objects. This is followed by the second stage, which locates the discursive object within wider discourses. People rarely

draw on one discourse at a time, and different discourses can be used to explain the same issue. For example, a woman may draw on a biomedical discourse when talking about the biological effects of breastfeeding, and a total motherhood discourse when discussing her emotional experience breastfeeding. Therefore, stage two involves taking the identified discourses and fitting the discursive object into the multiple available constructions, and examining how this fits into wider discourses. The third stage questions why participants are constructing the object in this way. There are multiple ways to construct each object, so it is important to examine what is gained through the constructions used, and what this construction enables the participant to achieve within their language. For example, the breastfeeding woman discussed above may feel validated by breastfeeding's biological evidence. She may draw on a total motherhood discourse to proudly claim responsibility for her 'good' choice to breastfeed. Understanding this clarifies how people employ these discourses to rationalise their choices, beliefs, and experiences.

The next set of stages allows us to examine the implications these discourses have on subjectivity. Alongside objects, discourse creates subjects, and the fourth stage of FDA identifies these. This stage highlights the role a participant's discourses allow them to assume, and the rules, rights, and duties this position includes. This is followed by the fifth stage, practice, which inspects how a person's subject positioning supports or constrains their available choices. For example, the woman discussed above may feel pressured to continue breastfeeding despite difficulties, as this is constructed a 'bad' choice within a total motherhood discourse. Therefore, for her to see herself as a 'good' mother she must persist, thus constraining her ability to quit. Finally, the sixth stage highlights links between discourse and subjectivity. This is an important step in FDA, as now we have examined the available options from within participant's discourses and subject positions, we can now make inferences about the experiences, thoughts, and emotions these positions allow (Braun & Clarke, 2013).

Evaluation and quality of the research

Positivist, quantitative research has set a standard of proving data's reliability and validity based on statistical output and 'objective' scientific rigour (Burr, 2015). Due to its nature, qualitative research cannot meet these standards, leading to criticism from many quantitative researchers. Therefore, qualitative researchers must ensure they critically reflect on the quality of their work using appropriate criteria. Qualitative researchers can utilise quality assurance and evaluation criteria to ensure the research is of good quality, and meets expectations of rigorous conduct (Burr, 2015).

Henwood and Pidgeon's (1992) seven attributes of good qualitative research provide useful evaluation criterion. Those criteria relevant for this research are reflexivity, documentation, importance of fit, and transferability. In terms of reflexivity, the researcher's role needs to be considered, which is an important criterion, considering that I currently work in the ECE field. I reflect on my own identity and position in the research below and any potential influences from this position will be acknowledged throughout the research process, including the analysis and discussion of findings. Documentation is important to the research process, as it means the research must be well accounted for and rationalised. To achieve this, I have kept a research diary documenting field notes, reflections on my role as a researcher, and accounting for each decision made. Furthermore, qualitative research has the potential to elicit unexpected responses. In the case of unforeseen data, it is important to continually assess the fit of any applied categories or themes, ensuring the data are well represented. This process has been included as part of my documentation. Finally, I will provide a level of transferability by demonstrating the research's implications outside of the project. Maintaining these attributes will help uphold a high standard of academic rigour in my research.

In addition to ensuring the quality and rigour of the research in these ways, is the task of ensuring qualitative research is relevant and meaningful (Weedon, 1997). Finlay (2006) has proposed five dimensions, termed the '5 Cs', which aids researchers in this effort. Clarity, ensures the research is coherent and systematic, which has been achieved through the documentation described above. Credibility examines whether our claims fit the evidence and are plausible. I have done this by reflecting on how the research relates to current findings in the field. Contribution looks at social relevance, which has been continually reinforced by the enthusiasm and meaningfulness of this research, as communicated to me by my participants. Communicative resonance asks whether the research challenges or effects those reading it, which has been a continual process of discussing my findings with my supervisor and peers. The fifth and final step, caring, analyses any impacts to participants, and the wider social consequences of the research. I have ensured my research is caring by keeping my participant's needs in mind, as well as the potential social impacts. Using Finlay's (2006) 5 Cs has made sure the significance and value of the findings were considered throughout this research project.

Reflexivity

Traditionally, psychology has favoured positivist, empirical research (Gannon & Davies, 2014). Within this framework, researchers are seen as objective observers, impartial and free from bias, and it is

believed controlled research will unearth reality. Therefore, with scientific rigour any information can be conducted and interpreted neutrally. This leads to the belief that researchers can reveal 'truths' about the world, unaffected by the assumptions, expectations, or baggage they bring (Willig, 2013). Social constructionist and poststructuralist approaches stand in opposition to this, arguing that researchers are central to their projects procedures and interpretations (Burr, 2015). Meaning is context dependent, therefore, certain information may be interpreted differently across different times and places (Braun & Clarke, 2013). Because of this, a social constructionism stance cannot accept research data as a 'truth' in the way positivist researchers do (Burr, 2015). A researcher cannot be free from their context, therefore they inescapably shape the researcher process and findings based on their assumptions and values. These permeate the research at every stage, from the initial problem definition, to the methods chosen, to any final conclusions. While positivist researchers make attempts to lessen or hide researcher bias, social constructionists reject objectivity (Burr, 2015). Bias is inevitable. Rather than downplaying its significance, social constructionists wish to illuminate it, making it transparent to readers. Being open about the assumptions researchers bring to their projects does not lessen the projects validity, but rather allows readers to make informed judgements about the research and understand the researcher's perspective. Therefore, I must be honest about my own subjectivity and assumptions, as my presence undoubtedly affects the way I engage with this field.

As a (very happily) childless woman in my mid-twenties, people are often surprised to hear I am conducting research in breastfeeding. Presumably many people seek to do research in areas where they have a personal involvement with. Despite not having personally breastfed a child, and therefore not experiencing the range of emotions, constraints, and judgements accompanying it, I do have a level of involvement in many women's infant feeding choices. As an early childhood teacher, working with infants aged 3 months to 18 months, I have witnessed many women experience distress while trying to settle their child into ECE. As it turns out, breastfed babies are often very resistant to accepting a bottle. This has led to stress for both us teachers, and the child's mother as there is joint concern over making sure the baby is getting enough nutrition. However, I believe no one feels this stress more than the infant themselves. In my experience it is extremely common for infants to refuse feeds while settling into day care. This means they are not only in a new, overwhelming environment, and likely away from their parents for the first time, but they are also probably very hungry.

Admittedly, in the past I never thought of this as being an issue I was involved in. I turned a blind eye to women's infant feeding choices, and alongside my co-workers I provided a very passive level of support.

It wasn't until 2017, when I interned for Women's Health Action that I began to notice breastfeeding. I was placed on their breastfeeding team, working to create a summary report for their yearly event 'The Big Latch On'. Additionally, my manager there was expressing milk during the work day to send to her daughter's day-care. Being immersed in breastfeeding literature, and talking with my manager who would pump milk during our meetings, I began to realise the potential role I may have unknowingly played in many women's infant feeding experiences.

Looking back on my experiences within just the past year, I have seen every breastfeeding mother who has walked through our door struggle. Three women tried unsuccessfully to get their infant to accept a bottle, and resorted to leaving the infant with their father/grandparents until they got so hungry they had no choice but to accept it. Two women tried to breastfeed during their work breaks, but these attempts were short-lived. Shockingly, my centre is an on-site facility for hospital employees, and on-site facilities are touted as the gold standard for breastfeeding success during employment. We always offer the choice to provide expressed milk, however none of our families have taken up this offer. To be completely honest, none of the staff know how to handle expressed milk, including myself (prior to undertaking this research). Despite my manager's best intentions we had no breastfeeding policy, and there is not a metre of unused space within our small centre where we could create a breastfeeding room. I feel disheartened thinking about the lack of breastfeeding success within my centre, and the stress mothers have experienced trying to navigate infant feeding upon ECE enrolment. My experiences at Women's Health Action have made me reflect on infant feeding practices within the ECE sector, and made me critically consider the influence ECE settings may have.

Therefore, while I am not a mother, I do have a high level of involvement with breastfeeding in ECE centres, and my work as an ECE teacher over the past few years has certainly impacted my interest, engagement, and interpretation of this issue. My position as an ECE teacher has encouraged me to dig deeper than concentrating on teacher support, to also focus on the structural influences which poorly impact both teachers and mothers. My role as an ECE teacher was raised across most interviews, which I believe helped build rapport with participants as we both shared insider knowledge of the ECE system.

In this chapter I explored the theoretical underpinnings of my project. The key tenets of social constructionism were defined, which provided context to discuss Foucault's poststructuralist approach. Language and discourse were situated as fundamental to both constructing and experiencing reality, which has implications for power, knowledge, subjectivity, and agency. Following this, I reviewed the recruitment, ethics, and interview procedure used. I then turned my attention to FDA, the chosen

method of analysis for this project. Finally, I considered the quality and reflectivity of my research, including identifying my own subjectivity within breastfeeding and ECE care. In the next chapter I provide the analysis and discussion of my research findings.

Chapter 4: Analysis

Three broad discursive constructions were evident across all interviews and were drawn on by the participants to rationalize their choices and beliefs. Breastfeeding was constructed as the best choice for the child, and an easy and natural part of motherhood. Alongside this, breastfeeding was also paradoxically constructed as a difficult and stressful "journey". Each of these three discursive constructions will be examined in turn, including an exploration of how they attend to the subjectivity all participants attempted to align themselves with: the 'good' mother. I begin with a brief discussion of this subjectivity as it provides important context for participants discursive constructions of breastfeeding. The practical implications of attending to this subjectivity are also discussed in relation to ECE settings and workplace environments.

Being the 'good' mother

Women must engage in high levels of performance when parenting in order to be considered 'good' mothers according to societal expectations. This is often referred to as total (Wolf, 2007) or intensive (Hays, 1998) motherhood and is a common paradigm used by researchers to describe current Western parenting trends. Total motherhood specifically provides the discursive backdrop for the participants talk in this section. Total motherhood combines the principles of intensive mothering (i.e. high levels of financial, emotional, and physical resources devoted to child-rearing, an expectation that the mother is the primary caregiver, and the notion of children as vulnerable and in need of special protection) with risk conscious ideas of the personality responsibility for health. In the analysis I utilise total motherhood because of its focus on health behaviours. I have provided a detailed account of this concept in chapter 2 (Literature Review).

Lowe (2016) argues that dominant Western understanding of motherhood acts as a disciplinary norm in that they regulates women's choices and practices, as they strive to live up to their ideals. Total motherhood, currently informed by attachment parenting, provides the subjectivity of being a 'good' mother, which inherently creates the possibility of being a 'bad' mother. Important to note is the anti-essentialist view of the 'self' employed by the poststructuralist lens used in this research. Within this framework one's subjectivity is not concrete but highly open to change across time and space.

Consequently, women must continually work to ensure they are still 'good' as their place in this difficult to inhabit position is constantly under threat.

The idea of the 'good' motherhood was evident throughout all interviews, with participants continually aligning themselves within a total motherhood discourse. The participants used three primary discursive constrictions to situate breastfeeding as the appropriate choice and to position themselves as 'good' mothers in relation to total motherhood while simultaneously avoiding the negative position of 'bad' mother. These discourses include discussing breastfeeding as the best choice for the child, as a natural and easy part of motherhood, and as a difficult, stressful journey. I will examine each of these discourses in turn, analysing how they informed the participant's subjectivities of being a 'good' mother.

Breastfeeding as the best choice for the child

Providing breast milk was constructed as the gold standard for infant nutrition, and formula a poorer, or even dangerous substitute for breast milk. This common construction of breast milk echoes the breastfeeding advocacy and health promotion literature which frequently "emphasises the developmental problems likely to befall children who are not breastfed" (Spagnoletti et al., 2018, p. 17). Participants were quick to emphasize the positive health outcomes associated with breastfeeding, and often positioned these benefits in relation to a biomedical discourse that supports risk consciousness. Such talk emphasised a mother's personal responsibility to ensure her children are not only healthy, but achieve optimal physical and psychological development. Consequently, breastfeeding was positioned as a moral imperative. Within this construction women who do not breastfeed were positioned as placing their infants in mortal danger.

Breastfed babies are healthy, formula fed babies are sick

Breast milk is widely believed to have protective factors for infant health. These are often advertised as far-reaching health benefits which improve the child's resistance to illness across their lifetime (Lee, 2011). When asked what their reasons for breastfeeding were, health benefits were presented as paramount to the participants. Breastfeeding was constructed as a health practice, drawing on a biomedical discourse as support as demonstrated below.

> Ellie: *Hmm, I know that there are health benefits for him and me, and the number one reason [I chose to breastfeed] is that I know it's healthier*

Ellie discusses breastfeeding as implicitly "*healthier*" than formula feeding. While she does not provide specific examples of the health benefits, she understands that by breastfeeding her child she is providing a healthier option than formula. Constructing health benefits as *"the number one reason*" implies that the child's physical health had received more attention than other potential motivators such as cost or closeness, or demotivators such as pain, stress or time intensity. Furthermore, this extract illustrates how participants placed their child's health above the physical and mental strains that may accompany breastfeeding for many women, aligning with a plethora of research that suggests women commonly place the perceived needs of the child above their own (Woodhead, 2015).

Like Ellie, the women interviewed all strongly emphasised breastfeeding's potential to prevent illness, and often discussed this in relation to the immune system. For instance, Charlotte stated that "*immunity development, general health outcomes are a million times better, and yeah…*". Her use of hyperbole emphasises the importance and benefits of breastfeeding. It is unlikely Charlotte truly believes this claim ("*a million times better*"), yet it serves as way for her to position infant feeding as highly influential on infant development. Making the claim that breastfeeding improves a child's health by a million implies their bottle-fed counterparts must have health a million times worse. Such claims allowed participants, like Charlotte, to demonstrate their mothering abilities by proving their commitment to avoiding the risk or illness and bettering their children's health. This is a cornerstone of 'good' motherhood in Western society (Wolf, 2010). Emma and Sophie also discussed breastfeeding in terms of immunity development.

> Emma: *Oh well his immune… I wanted him to have a really good immune system, and I definitely think that that is true. I've only had to pick him up from day care once! For a kid, usually they get a lot of sicknesses in their first year, and he didn't come home at all in his first year.*
>
> Sophie: *I just knew for all her health benefits, her digestive set up, everything from the colostrum and the breast milk. She's been at day care, she's nearly 2, for well over half of her life, and she's been so healthy and I've been healthy too.*

These extracts demonstrate how constructions of breastfeeding were associated with avoiding future risks. Here, Emma and Sophie construct breastfeeding as responsible for their children's good health. Their children are presented as an exception to the norm ("*usually*"), and the evidence for this is their lack of illness despite being in an ECE setting where they might be exposed to other children's illnesses. The participants construction of breastfeeding as preventative of illness was particularly important as they had work commitments and could not attend to ill children. By providing breast milk to their infants the participants positioned themselves as having successfully lowered their risk for sickness. This is relevant within current neoliberal society, which many scholars deem as being overly 'risk conscious'

(Beck, 1992).The idea that we can minimise health risks by following certain practices was common among the participants. This is a key aspect of total motherhood, as within this discourse predicting and managing illness is an important display of 'good' motherhood (Wolf, 2007). Emma and Sophie have visible evidence of their 'good' mothering through their children's high attendance at ECE, and attribute this to their decision to breastfeed, a common construction among the participants.

Breastfeeding was constructed as the superior choice, while formula was constructed as inherently worse for children's health. Mothers who use formula are not following expert health advice, which therefore places their child at risk and secures them a place as 'bad' mothers. In this vein, participants regularly discussed the visible formula feeding norm within centres, as demonstrated by the following excerpt.

> Madison: *And also I realised those kids are going to all get sick! They're going to get sick because they're not breastfeeding. Of course she's going to get sick anyway, but there's no immunity there.*

Madison acknowledges that her daughter would get sick in ECE regardless of her breastfeeding status, but describes the formula-fed children as having *"no immunity*". She describes "*those kids*" as lacking in immunity and health, which positions them as disadvantaged when compared to her breastfed daughter. This serves Madison's subjectivity of being a 'good' mother, placing herself in opposition to the mothers of "*those kids*" who have allowed their children to have no immunity.

Many participants were aware that they were the only breastfeeding mother in their child's centre. Their experiences of this were raised frequently, and often served as a means to compare their child's health to formula fed children. For example, Sophie discusses her thoughts on this below.

> Kaitlin: *And how did you feel about being the only mum who was doing that?*
> Sophie: *I felt proud, but also sad. A lot of the kids who go to day care have runny noses and look all kind of… raggedy. Like they've been at day care. I felt quite proud that Daisy was really healthy.*

Sophie describes formula-fed children as constantly ill and "*raggedy*", something worth being *"sad"* for. Her sadness implies the belief that the formula fed children at her daughter's centre do not have mothers who are willing to provide the best for them. The use of the word "*raggedy*" emphasises this. To describe a child as ragged paints a picture of an unkempt child, perhaps even an uncared for one. Sophie juxtaposes her daughter against these children, distancing Daisy from the stereotypical runny-nosed day care child. She is proud of this distinction, and her pride signals the moral superiority deep-

rooted within breastfeeding ideology. Her comparison provides proof of her status as a 'good' mother. Such talk about children's immunity, as Lupton (2011) also identified among Australian mothers, constructs "the infant body as highly vulnerable and requiring protection from contamination" (p. 637) and positions the mother as responsible for providing this protection from the *risk* of disease.

Breastfeeding as the educated choice

Breastfeeding was constructed as the superior choice, in relation to the positioning of educated women as those who breastfeed. A total motherhood society dictates that a 'good' mother will rely on scientific information to avoid risks. This relates to neoliberal understandings of citizens being rational decision-makers, as discussed in the literature review (Wolf, 2010). Therefore, total motherhood assumes that people will take scientific knowledge and directly apply it to their lives. Such expectations neglect the reality that people are often not rational decision-makers, nor do all people have the resources or ability to follow expert guidelines (de Souza, 2013). As a result, the idea that women may have different needs or priorities that could lead to an informed decision not to breastfeed is refuted. By aligning themselves with following expert advice the participants worked to construct breastfeeding as the only choice for the intelligent, well-researched mother, who they were then able to self-identify with. In the following excerpt, for example, Charlotte discusses her sister-in-law's decision not to breastfeed.

> Charlotte: *And she said to me 'I don't want to be just stuck on the sofa all day feeding. I'd rather not do that'. And umm… I was really surprised because she's smart, she's educated, but she had very different beliefs to me around breastfeeding?!*

Charlotte expresses disbelief here on the basis that her sister-in-law is intelligent ("*educated*") and should therefore know better than not to breastfeed. This implies that knowing better will automatically mean performing better. There is no critical exploration of why this woman may truly have decided to use formula. Rather, Charlotte gives the reason behind her sister-in-law's decision as related to her desire not to be "*stuck of the sofa*". Other possible reasons, such as time constraints, are not discussed. Instead, in a total motherhood society the child's needs come before the mother's wants, therefore her sister-in-law's choice to use formula for her own benefit gives her a point towards 'bad' motherhood.

This quote from Sophie further illustrates these ideas.

> Kaitlin: *So kind of a norm that you'll send your kid with a tin of formula?*
> Sophie: *I think all the advertising on TV about having a healthy strong boned kid with all this zinc, and calcium, and iron… There's none of that in breast milk so why do you have to give it to a*

> *kid in formula? It's so bizarre. It proves how naive a lot of mums are, and they haven't researched and aren't educated on it.*

The sub text here is that women choose formula due to a lack of personal research as they have not educated themselves. Of course, drawing on expert knowledge is a hallmark of total motherhood. Describing these mother's as "*naïve*" positions them as ignorant and as duped by formula advertisers. It implies that if women simply did their due diligence they would arrive at the conclusion to breastfeed. In addition, the use of the word "*bizarre"* makes women who use formula seem so abnormal and strange to Sophie that she is able to firmly position herself in opposition to them. By constructing the behaviour of not carefully researching and following expert guidance as outlandish she is able to secure her reputation as an educated mother and to position herself within the framework of total motherhood. This construction was employed continuously throughout the interviews, and allowed participants to position themselves as having the 'truth' about breastfeeding. Discussing breastfeeding in this manner undermines the real-world experiences of many mothers who do not have access to the time, resources, or ability required to breastfeed their children (Nickel et al., 2014). Furthermore, this issue is highly classed and raced (Lowe, 2016). Women at each intersection of privilege and/or disadvantage may experience a different set of stressors that impede their capacity to breastfeed. The assumption that improving breastfeeding rates is as simple as providing education disregards the various reasons women may make an informed decision to not breastfeed, based on other needs and priorities. Education is often associated with breastfeeding, however its effect may be over-stated. For instance, Mauri, Soldi, Cortinovis, Bertora, and Contini (2017) sampled 192 women in Italy who had decided not to breastfeed. Education was not correlated with the outcome of the participant's breastfeeding decisions, yet anxiety, employment, relationship status, and the need to care for the infant's siblings were. Constructing breastfeeding as a non-negotiable for the educated mother fails to acknowledge the true range of influences that impact infant feeding decisions.

The idea that breastfeeding is 'the educated choice' arises from both scientific and cultural consensuses. This was often discussed through medical understandings of breastfeeding's superiority being expressed by participant's mothers, friends, or heath care professionals. For example, Emma stated, "*I've grown up with my mum saying whenever someone was sick or had ear infections, a poorly person, 'Ah! I bet they weren't breastfed!' That was her saying. Breastfeeding fixes everything. It was drummed into me*". Breastfeeding is promoted fiercely and women will often experience breastfeeding material from a range of trusted sources, both medical and familial (Mauri et al., 2017). The biomedical discourse is powerful within Western society. Great trust is put into medical knowledge, and biomedical

explanations of health are privileged (Mauri et al., 2017). These biomedical understandings are culturally reinforced by shared beliefs, such as Emma's mother's claims, and often ignore the wider structural influences which affect biomedical processes. Within our neoliberal society, educated citizens are expected to follow these biomedical understandings of health, and personal responsibility is placed on individuals to uphold this (Mauri et al., 2017). In this context the model citizen follows expert advice to maintain their health status, and failure to do so is seen as a personal fault. Consequently, society focuses on individual health 'choices', ignoring the multitude of structural barriers that inhibit or remove the ability for many to choose freely. Maintaining an individual focus removes responsibility from organisations or those in power as society becomes occupied with tracking personal choices, such as the 'choice' to breastfeed or not, rather than the systemic inequalities which impact these decisions (Mauri et al., 2017). As Murphy (2000, p.295) has pointed out:

> This narrow focus on women's behaviour choices serves to distract attention from the conditions under which women carry out their feeding work. Contemporary pro-breastfeeding discourses are highly selective and individualistic insofar as they cast maternal behaviour as the source of future disease and disadvantage, ignoring the determinants of health that are embedded in the social structure and placing responsibility on the mother for future outcomes.

This oversight can be seen in the examples above, where participants simply expect that if women are educated they will choose the 'most educated choice' to breastfeed, without considering wider barriers that impact women's ability to make choices without constraint.

The moral mother

A common construction in the data tied to health was of breastfeeding as virtuous. The personal responsibility to strive for optimal health has become conflated with morality (Mauri et al., 2017). This is particularly applicable to mothers, who hold responsibility over their children's health, as children are granted a special status as vulnerable (Woodhead, 2015). When breastfeeding is constructed as *the* way to ensure a child's optimal health, Lowe (2016) argues that it becomes a moral imperative that is difficult for women to reject, and something that they should strive against all odds to achieve. Intensive mothering views investments such as breastfeeding as one of a mothers last defences against the negative effects of the modern world, leading to Western society's preoccupation with ensuring that mothers follow breastfeeding guidelines (Mauri et al., 2017) Faircloth (2010a) states that breastfeeding is "one of the most conspicuously moralised elements of mothering" and that "feeding is a highly scrutinised domain where mothers must counter any charges of practising unusual, harmful or morally

suspect feeding techniques" (p. 2). Infant feeding decisions, while often thought of as part of the private domain, are regularly exhibited in public spaces. Breastfeeding and bottle-feeding alike become visible practices when performed or discussed publicly, and breastfeeding's revered status works as a virtue signal for breastfeeding mothers, who can be visibly seen practicing 'good' motherhood (Murphy, 2000).

The construction of deciding to breastfeeding as a morally correct choice was evident across all interviews. For example, here Madison discusses why she is happy to continue breastfeeding despite finding it time intensive.

> Madison: *I'm not the most maternal mum ever, I'm very pragmatic –"yes, I'll breastfeed you 'til you're two because I think it's the right thing to do, and I'm happy to do that".*

This is an example in which breastfeeding is constructed not only as a good choice, but explicitly given moral status as it is constructed as "*the right thing to do*". It is worth noting that even though Madison admits that she is not the "*most maternal mum ever*" she is still able to construct a positive maternal identity based on having made the proper choice to breastfeed her daughter. Madison is not maternal, but even she is able to do what is right for her child. She specifies she will do this until age two, likely reflecting the World Health Organisation's (WHO) recommendations. The idea of breastfeeding until aged two was a pattern across most interviews, demonstrating the participants' internalisation of the WHO guidelines as most correct, and therefore moral to follow. Above, Madison's pragmatism allows her to put aside her own interests or traits, enabling her to make parenting choices in line with best practice, thereby ensuring optimal health benefits for her child. The implication of the construction of breastfeeding as a moral imperative is that women who do not breastfeed are 'bad' mothers. They are not doing the 'right' thing, putting them at odds with 'good' motherhood. The following quote from Hailey further illustrates the effort expected of women to achieve this.

> Kaitlin: *And how about the people who quit?*
> Hailey: *It depends on the reason. If it's just because it's too 'hard', as in, getting up at night and feeding the baby and they just don't want to deal with it, it's a bit like 'yeeeeeeah… you could be putting in a bit more effort'.*

Hailey takes a moral stance against those who decide not to breastfeed for what she deems superficial reasons. Hailey placed the word "*hard*" in air quotes, signifying that she was contesting the validity of these women's claims. A mother's decision not to breastfeed becomes a lack of "*effort*", reflecting total motherhood ideals that correct child-rearing should be difficult and require great effort (Wolf, 2010). Additionally, mother's desires are positioned as 'wants' which should come after the child's perceived need to receive breast milk ("*they just don't want to deal with it*").

Research suggests women are aware of moral judgements such as these. Ryan et al. (2010, p. 951) analysed interviews with 49 breastfeeding women in the United Kingdom, finding that breastfeeding "women's embodied experience and sense of self are disciplined within current, limiting, often punishing discourses, by undertaking painful moral work in order to maintain or repair their subjective positions". If a mother decides not to breastfeed for unjustifiable reasons she is not performing motherhood correctly, and will likely be seen as a 'bad' mother. This is enough of a motivation for many women to continue breastfeeding despite difficulty to be seen as a 'good' mother within this moral framework.

Apparent in Hailey's example and also Charlotte's story of her sister-in-law (above), is the idea that mothers breastfeeding decisions are open to judgement. Mothers judge, compare and assess other women's situations and decisions, keeping score of the mothering statuses of those around them. Indeed, breastfeeding becomes constructed as a measure of motherhood (Lowe, 2016). Across all of the interviews, breastfeeding was touted as the best—if not the only—choice for the infant and choosing to breastfeed was used as a signal for 'good' motherhood. This construction was justified primarily in relation to presumed health outcomes via a biomedical discourse. The participants emphasised that they had chosen breastfeeding for its positive health benefits, and highlighted that breastfeeding is the educated choice. To be a 'good' mother, women must be risk averse and accept sole responsibility for their child's health and wellbeing and will consequently place the needs of the child above their own wants. The 'good' mother takes the moral path of following expert, child-centred advice to promote healthy outcomes for her children, despite the cost (de Souza, 2013). Whether or not the health advantages of breastfeeding outweigh other issues, especially the impact on women, is rarely considered (Lowe, 2016). Accordingly, constructing breastfeeding as the best choice for the child allowed participants to secure themselves the position of being a 'good' mother.

A natural, easy part of motherhood

Participants commonly drew on evolutionary and attachment parenting paradigms to construct breastfeeding as not only biologically superior, but as a natural, and therefore easy, practice. Aligning themselves with the natural worked to bolster their health-related, scientific arguments. Breastfeeding's naturalness was continually raised, providing evidence for the practice's as a result of maternal instinct. These ideas echo Faircloth's (2017) work with European women who relied on the concept of the 'natural' to support their claims of breast milks superiority. Emphasising the naturalness of breast milk

allows women to position it as the *only* way to feed an infant. Many of these ideas tie into the concept of attachment parenting, a popular mothering framework focusing on a strong attachment within the mother-infant dyad and requiring constant attention and availability (Hays, 1998). As mentioned earlier, attachment parenting rests on an unfounded evolutionary paradigm of parenting which has become popularised due to Western society's current focus on the psychological wellbeing on children (Faircloth, 2017). These constructions of breastfeeding as a natural and instinctive part of motherhood were visible in two common ways of speaking. First, breastfeeding was often related to the risk conscious idea of the natural being pure and uncorrupted. Second, breastfeeding was constructed as a natural part of motherhood, which served to strengthen mother-infant bonding, therefore bolstering children's psychological development. Each of these are detailed below.

The natural way

The participants emphasised that breastfeeding is a natural aspect of motherhood, and highlighted that because breasts biologically exist for breastfeeding, feeding a child breast milk is the preferred practice. This was achieved by drawing on both evolutionary and biological discourses to naturalise breastfeeding and consequently normalise the practice and reinforce its status as the universally preferred method of infant feeding. To illustrate, Sophie and Madison, below, achieved this by emphasizing the evolutionary and biological aspects of breastfeeding.

> Sophie: *I am just all, sort of, the priority for me is as little medical and artificial intervention as possible, doing it 'a la natural' as much as possible. So that's why breastfeeding is an important thing for me.*
>
> Kaitlin: *How would you say breastfeeding relates to your parenting philosophy?*
> Madison: *If we look at history, no other mammal feeds their offspring anything besides the breast milk of the mammal of its lineage. And we even see elephants wet nurse another elephant if they need to. So that's my background, it's always what my thinking was.*

Sophie contrasts "*a la natural*" with the "*artificial*", creating a binary opposition between nature and synthetic, with breast milk the preferred option. Madison draws on an evolutionary ("*history*") and biological ("*mammals*") discourse to support her claims of breastfeeding as natural. Here humans are positioned as mammals and she compares us to other animals. By drawing on mammals feeding practices she is able to demonstrate breastfeeding's special status as organic and part of nature. Participants commonly used these discourses to account for their preference for little intervention or reliance on outside sources. In this talk there is no acknowledgment of women who decide to use mixed

feeding methods, which in New Zealand accounted for twenty-three percent of infants under six months of age, and forty percent above six months of age, in 2017 (Plunket, 2019). Rather, a strong dichotomy was formed within which mothers either perform naturally or artificially. Only one participant, Charlotte, resisted this idea, stating she was "*all for top-ups*" of formula when her twin daughters were born, although breast milk was still considered their primary food source.

Within this context what is natural is considered superior, and the idea that humans have evolved to depend on breast milk has been a common theme raised by mothers in recent research (Faircloth, 2017; Marchesi, 2018). Attachment parenting relies on assumed evolutionary practices to substantiate its claims, despite many of these being either unfounded or irrelevant to modern society (Faircloth, 2017). The evolutionary root of this conceptualisation is evident in a claim made by Sophie, in which she stated that breastfeeding is *"part of what cave women would have done, and we should be doing it now too".* Hausman (2014, pp. 124, 125) states that "the idea that specific, supposedly traditional, mothering practices are really evolutionary adaptations – rather than cultural constructions that emerge at a specific historical juncture – is a persuasive rhetoric, delineating natural and unnatural maternal practices within a speculative evolutionary paradigm". In a rapidly changing and increasingly 'unnatural' world an appeal to nature provides a strong rationale for many mother's decision to breastfeed (Faircloth, 2017).

Normalising breastfeeding as a natural practice gives the impression that motherly instinct will ensure breastfeeding is easy and trouble-free. This sentiment was expressed across a majority of the interviews, and can be seen through Ellie's excerpt below.

> Kaitlin: *Cool, and when you started breastfeeding did you have any difficulties?*
> Ellie: *It was super easy. It felt like he was showing me what to do, but no never had any problems at all. I felt for whatever reason (I don't really know why) but I felt it would be something that I'd find quite easy. No basis for that whatsoever.*

Many participants said they had expected breastfeeding to come naturally to them. Ellie states she had "*no basis*" for why she assumed breastfeeding would be easy. Her assumption is likely a reflection of the evolutionary and attachment discourses discussed above. Despite this perception many women, both in this research and other studies, struggle with breastfeeding (Lowe, 2016). Emphasising breastfeeding's ease may have negative impacts for women when they face difficulty. For example, Williamson, Leeming, Lyttle, and Johnson (2012) conducted a study with first-time mothers, finding many were

struggling to pair a positive mothering identity with their difficulty breastfeeding, largely due to their cultural perception that breastfeeding is natural and therefore trouble-free.

Appeals to evolution and biology allowed participants to shape breastfeeding as a common sense practice, emphasising the construction of breastfeeding as an obvious choice because it is fabricated to be a simple and available option. This further individualises breastfeeding as it obscures the social context. Breastfeeding is a 'natural practice', but we no longer live in a natural world. To draw on how "*cave women*" mothered their children is irrelevant in many ways to modern society. Reliance on these discourses means the influences that current society introduces are overlooked, and further reinforces the focus on individual choice. However, by emphasising how natural and easy breastfeeding was for them the participants were able to use this experience as an example of their innate mothering skills.

Furthermore, emphasizing the natural nature of breastfeeding also reinforced the construction of breast milk being as best for the child. An appeal to nature allows society to brush over the scientific uncertainty present in breastfeeding's claims (Wolf, 2007), and the participants used this to distance themselves from potentially harmful formula. In their excerpts below, Madison and Sophie further the construction of formula as harmful.

> Madison: *Formula? Oh my god… It's a pharmaceutical grade drug. I don't want to give my kid something when I don't even know what's in it*.
>
> Sophie: *I'm so anti all the intervention through societal pressures, medical and artificial and synthetic, and made in a lab kind of things that people think are better for some reason. I just find that so bizarre, because it's really the complete opposite.*

Madison describes formula as a drug, stating she would not give her child unknown substances. Her exclamation of "*oh my god*…" shows her resistance to formula, constructing it as something unimaginable to provide. Sophie has a similar view, forgoing what she deems artificial intervention, stating natural is better. This pattern of statements made by participants worked to demonise formula and can be understood in the context of risk consciousness. When there is scientific disagreement over a behaviour society will default to what is natural (Crawford, 1980). Nature is pure and therefore untainted by risk. The result of this is that the natural takes on a special quality which makes it difficult to contest. Consequently, formula, an unnatural and human-made substance, is constructed as risky, and breastfeeding remains unchallenged as the preferred infant nutrition source. Formula may involve a level of risk, and 'good' mothers vehemently avoid risk, and will therefore avoid formula.

An implication of this talk is that breastfeeding women are considered to be parenting 'naturally', which is in line with many total motherhood ideals. Alternatively, formula-feeding mothers are performing 'unnatural' motherhood. This form of motherhood is villainised through the threat of formula exposing children to a range of toxins, or forcing children to forge essential nutrients and proper emotional development (Wolf, 2007). These claims are unsubstantiated (Wilson & Wilson, 2018), yet this ideology is consistently found in studies of this nature (Faircloth, 2010b; Knaak, 2010; Murphy, 2000). Knaak (2010) conducted interviews with 33 Canadian women who discussed the choice to use formula as a discursive formality rather than a true option, overstating the artificial, and therefore "horrible" (p. 348) and risky nature of formula. Within a risk conscious society there is no leeway for the introduction of potential danger or uncertainty, therefore women must rely on breast milk to ensure they maintain their identity of being a 'good' mother.

Improved bonding and psychological development

In attachment theory, a central idea is that the mother-child dyad is crucial to infant development and all the child's future relationships (Hays, 1998). Women are expected to provide maximum empathy and responsiveness to their children and be continuously physically available. Breastfeeding is an important part of this, expressed as "bonding". This extends the benefits of breastfeeding from nutritional benefits to include the optimal psychological development of the child. This argument positions breastfeeding as a developmental need in order to ensure the child reaches their full emotional potential. Mother-child bonding, achieved through breastfeeding, is constructed as the best way women can ensure that their children have secure attachments and healthy mental wellbeing throughout the lifespan. This furthers breastfeeding's moral imperative as the issue becomes not only about physical health, but psychological wellbeing too. Lowe (2016, p. 183) states that in bonding discourse breastfeeding is constructed as "a measure of (proper) maternal devotion, and, potentially, a way to ensure the production of 'better' future adults". Consequently, breastfeeding becomes a great moral responsibility for women, falling solely on mothers themselves.

Many participants discussed their pride in having achieved bonding through breastfeeding, which speaks to the moral code inherent in infant feeding choices. This was particularly salient as it provided a method for participants to successfully combine physical separation due to employment with 'appropriate' bonding. This is evident in Sophie's following statement: "*It's a really special time and being away from her so much for work I really love it. For her and me, it's beneficial for our bonding I*

think". Breastfeeding was constructed as a natural way to form a strong mother-child attachment. Attachment parenting supports constant mother-child attachment, and when this cannot be achieved due to employment, breastfeeding is one way women may navigate their ability to provide a 'good' attachment. For instance, Sophie was still able to provide that "special time" despite being apart most days.

Bonding, attained through breastfeeding, was constructed as a natural process provided it was not interfered with. This is particularly well illustrated by Charlotte's account below. She was only able to breastfeed one of her twin daughters and explains how she was able to form a stronger bond with her breastfed daughter.

> Charlotte: *I just couldn't solely breastfeed Isla and not give anything to Ivy. It would be so unfair if Isla continued to get me and Ivy didn't get anything from me – not just the milk but the closeness. I thought I could develop a very strong bond with Isla, and Isla and I have had a very close bond from the start because of the breastfeeding… I was mindful if I carried on breastfeeding that that would divert that relationship. Would one become even stronger? With Ivy, would I become even more distant? So I didn't. I wanted to do a straight finish.*

Here Charlotte describes breastfeeding as a bonding activity which motivated her choice. Her account resonates with the Canadian and Norwegian women in Andrews and Knaak's (2013) study who felt they were under immense pressure to breastfeed, emphasising bonding as a primary motivator. Here we see Charlotte construct breastfeeding as involving more than simply providing nutrition as she explicitly states that the practice is not "*just about the milk*" but about promoting bonding through physical closeness. This is reinforced by her references to breastfeeding as giving of herself ("*get me*"). Moreover, Charlotte was providing expressed breast milk to her bottle-fed daughter, so her guilt was focused on the bonding associated with breastfeeding. Interestingly, the attachment theory on which ideas about bonding are based emphasises the mother-child dyad, which in this instance a second child (the twin) interrupts. As Wall (2001) points out, breastfeeding is often constructed as reunifying mother and child as one as during pregnancy. As a result, the twin is positioned as deprived (she "*didn't get anything*") in comparison to her sister who was breastfed.

Charlotte's reference to "*closeness*" echoes attachment parenting sentiments, constructing breastfeeding as essential to a child's emotional wellbeing and psychological development (Wall, 2001). This extract shows how, supported by the total mothering discourse, mothers were positioned as chiefly responsible for healthy child development. This reinforces traditional gender discourses that position women as best suited to meet infants' needs (Wolf, 2010). By conflating/integrating the physical

practice of breastfeeding, which can only be performed by a mother, with the process of bonding the mother is positioned as uniquely equipped to bond with the infant. Indeed, Wall (2001, p. 602)—who deconstructed breastfeeding education materials—argues that "such understandings draw on, and perpetuate, deep-seated cultural beliefs about maternal instinct, natural motherhood love, and exclusive motherhood, beliefs that also have their basis, in part, in the science of attachment and bonding". This is reflected in Charlotte's experience as she later explains that her husband had formed a stronger relationship with her daughter she had not breastfed, ultimately leading to her decision to wean both girls to make things "*fair*". Implicit in Charlotte's account of her experience is the idea that her bottle-fed daughter was lacking a proper show of maternal devotion, and that the primary attachment figure for her children should be herself rather than her husband.

Thus, participants drew on attachment parenting ideals to naturalise breastfeeding, which allowed them to demonstrate their natural mothering ability. A 'good' mother provides natural, caring responses which privilege bodily contact. Therefore, the 'good' mother will ensure her breasts are readily available for feeding when the child pleases. Ideas of natural motherhood, cave women, and the risk of artificial ingredients in formula were positioned in such a way that breastfeeding was constructed as superior to formula. This links the argument to the previously discussed discourse of 'good' mothers providing the best for their children. It also further individualises this issue, as it ignores many barriers introduced by the modern world that interfere with mothering the 'natural' way. Furthermore, discussing breastfeeding as an irreplaceable bonding experience firmly secures the mother's role as primary caregiver, reinforcing the pressure on women to ensure their children's healthy psychological development (Wall, 2001).

A difficult journey

Despite the participant's emphasis on the ease of breastfeeding, they simultaneously constructed it as difficult, as shown in the words of Madison: "*I always thought breastfeeding is easy, and it is, even though it is challenging".* Physical pain and discomfort were discussed by all but one participant. Additionally, the sacrifices and restrictions women experienced were continuously explored throughout the interviews and appeared to have great impacts on the participant's daily lives. Participant's also signalled that the age they breastfed their child to had implications for their subjectivity of being a 'good' mother.

Breastfeeding's difficulties

All but one participant reported that she had experienced pain and discomfort associated with breastfeeding. These ranged from minor difficulties to extreme sensitivity and encompassed both physical and emotional strain. For instance, Charlotte said that "*it is a really tough journey for some women. Very, very hard. For me, harder than giving birth*". In this excerpt Charlotte is predominately referring to the emotional stress breastfeeding had caused her. For Charlotte breastfeeding was a practice greatly associated with guilt. This is line with a recent Canadian study which found that guilt was the primary emotion associated with a strained breastfeeding relationship, regardless if the mother continued feeding or stopped (Jackson, Mantler, & O'Keefe-McCarthy, 2019). Here, Charlotte describes breastfeeding as a "*journey*", which was a term repeatedly used across the interviews. The use of the world journey may convey breastfeeding's recurring nature. Often breastfeeding is discussed as simply a choice made by a mother, yet we know breastfeeding is not a one-off decision. Indeed, mothers must continue to choose breastfeeding in each new moment and scenario. Describing breastfeeding as a journey was one of the few indications given by participant's that their breastfeeding practices were not born from a singular decision. This echoes Jackson et al.'s (2019) study, who found that women who continued breastfeeding despite pain experienced guilt due to the habit of regularly considering stopping breastfeeding .

The idea of breastfeeding being a journey has a clear end goal; successfully breastfeed your child until the age of two, as per World Health Organisation recommendations. Any breastfeeding practices falling short of this may be categorised as failing to reach the desired outcome. Consequently, breastfeeding becomes a personal mission in which the 'good' mother will persevere through a strained breastfeeding relationship to ensure she fulfils her "*journey*".

Physical pain associated with breastfeeding, particularly in the early days, was a common account among the participants. Below, Sophie discusses her first month of breastfeeding.

> Sophie: *The sensitivity. It was simply excruciating pain when she would latch on. It felt like transference pain, toe curling and it would make me sweat. It was this unusual pain even though there was no cracking or damage to cause it.*

As this account shows, Sophie continued breastfeeding, determined to push past the "*excruciating*" pain. Emma had a similar story, in which a month of "*horrific*" breastfeeding occurred before a Plunket

nurse noticed her son's tongue-tie. [1]As Sophie and Emma's stories show, many of the women used strong language to describe their difficulties, with the terms excruciating and horrific invoking images of intense pain. Pomerantz (1986) has written about the phenomenon of 'extreme case formulation' in which people use severe imagery to legitimatise their experience, in this case, the decision to stop breastfeeding before the 'right' time. Pain is not simply sore, it is torturous. This works to validate claims and constructs the issue as worthy of complaint and action.

Using an extreme case formulation also allowed women to frame their experiences as a display of maternal devotion. Excruciating pain would likely create a desire to end breastfeeding, yet a 'good' mother can place the needs of her child above her own wants. These stories allowed Sophie and Emma to signal their maternal devotion and was a consistent theme across a majority of interviews and is demonstrated in the following excerpts.

> Madison: *It was really tough. Really hard. And you have to be so committed, and most people aren't. And that's okay, but I was, so I was like this is what I need. It's hugely stressful, it takes time.*
>
> Emma: *It was hard at the start. Every latch was like starting again because once he had the cut he had to relearn everything all over again because his tongue could move. It was really hard but I'm a pretty determined person so I stuck at it.*
> Kaitlin: *What kept you going?*
> Emma: *Stubbornness. I'm just stubborn.*

Madison acknowledges that while most people are not committed to battling breastfeeding's difficulties, she is. This comparison allows Madison to position herself as morally superior to women who do not breastfeed. Similarly, in Emma's account her "*stubbornness"* and determination allowed her to continue despite adversity. She also uses an extreme case formulation, explaining how with each latch her son had to learn "*everything all over again*", signalling the level of persistence she had needed to endure the early days of breastfeeding. Madison and Emma were able to use their described traits of stubbornness and commitment to demonstrate their dedication to ensuring their children's perceived needs were met. Furthermore, these traits allowed participant's to continually choose breastfeeding, despite many points of resistance along their breastfeeding "*journey*". In this way, they make reference to "a 'good maternal body' which is able to produce breast milk through the management of pain and discomfort" (Williamson et al., 2012, p. 906).

[1] A tongue-tie is a small membrane which connects the tongue to the mouth, limiting movement. Most infants born with a tongue-tie struggle to breastfeed (Health Navigator NZ, 2018)

Attempting to reach the health behaviour ideals that assuming a personal responsibility for health produces requires diligence and perseverance. Consequently, these are valued traits within a neoliberal, and thereby total motherhood, society. Highlighting instances in which they had overcome hardship due to their determination fed participant's subjectification of themselves as good neoliberal mothers. It signals the high level of devotion the participants provided to their children and their willingness to be self-sacrificial, as discussed in the following section.

The sacrificial mother

The participants commonly spoke of needing to sacrifice their own needs in order to continue breastfeeding. Sacrifices were positioned within a framework where infant's 'needs' take precedence over mother's 'wants', a consistent theme across this field of research (Lowe, 2016; Woodhead, 2015). This construction is illustrated in the following excerpt.

> Madison: *So… How do I manage it? I don't know. You just get on with it, and in my mind I never thought about giving up breastfeeding. I'd always give something else up. It was always 'how do we make this work? Where are we going to, where's this going to, what's going to give here?'. The exterior stuff.*

Here, Madison describes the sacrifices she would make in order to continue her breastfeeding relationship, stating that she would give up the "*exterior stuff*" before risking her breastfeeding practice. Breastfeeding is constructed as a priority for Madison; therefore she is willing to drop other commitments in order to maintain it. Later in the interview, Madison stated she would have been willing to quit her job if she could not successfully combine it with breastfeeding. Here, Madison has clearly placed the 'needs' of her daughter (receiving breast milk), above her own 'wants' (to return to work in a bid to improve her mental health). Madison depicts her own mental state as less important than her child's presumed need to receive breast milk. Also, important to note is Madison's ability to consider relinquishing paid employment in favour of breastfeeding. Such talk clearly signals her class status, reminding us that total motherhood is highly class dependent.

Across the interviews, it was apparent that the participants had often scarified their own health in order to preserve breastfeeding. The extract below occurred as Charlotte explained how she was depleted from breastfeeding and pregnancy. Pumping and breastfeeding took a huge toll on her, and she explained she had an awful winter in which she was sick for nearly six months straight.

> Charlotte: *I had the flu, I had everything. Loads and loads of stuff. I was giving everything to them, I was just unwell all the time. Just depleted of lots of stuff and I kind of thought the breastfeeding and the pumping… having two of them is taking it out of me and I need to build my health back up as well… I was already quite depleted from the pregnancy.*

Charlotte's story demonstrates the moral imperative to breastfeed and how this restricts women's choices. We see an extreme case formulation as she explains that she was "*giving everything*" to her children, and therefore was ill and "*depleted*" ("*had everything*"). Here, Charlotte distances herself from selfish mothers who end breastfeeding based on their own desires, and paints the picture that there was no chance she could have continued despite wishing to. Her talk echoes the accounts of British mothers in Murphy's (1999) study. They accounted for their decision to stop breastfeeding by emphasising circumstances beyond their control, recounting the ways that "their desire to breastfeed was thwarted by the inefficiency of their bodies" (p. 311), thereby highlighting physical rather than volitional reasons for changing to formula feeding. Likewise Charlotte characterises herself as having had nothing left to give, therefore her choice to end breastfeeding is rendered reasonable and justified and cannot affect her position as a 'good' mother. Such talk clearly rests on ideals of self-sacrificial motherhood. As breastfeeding receives a privileged status it becomes a 'need' for children, and the physical and mental wellbeing of the mother slips into being deemed a 'want', worthy of sacrifice in order to protect breastfeeding (Ryan et al., 2010). This makes it difficult for women to stop breastfeeding without risking being seen as selfish. To avoid this they have to justify their choices, citing 'valid' reasons for stopping breastfeeding.

Women are commonly found to experience pain due to breastfeeding, with a recent cohort study finding 30 percent of 223 mothers in Australia experienced a 'high burden' of breastfeeding problems (Faircloth, 2017). This was significantly correlated with poor maternal mood, however, a 'good' mother will sacrifice her own desires, even her own health, in order to meet their child's perceived needs. By participant's discussing the sacrifices breastfeeding has necessitated they are able to portray themselves as sacrificial mothers, worthy of being deemed good and compliant with the demands of 'good' motherhood.

Living with restriction

Sacrifices inherently introduce a range of restrictions, and participants usually explored this is relation to their physical bodies. Here, Madison talks about wanting her "*body back*".

> Kaitlin: *Are you still planning on weaning her at two?*
> Madison: *Yep. I'm tired. I'm 42. No but like I think too, the time where I'm like okay, I'd like my body back, this is mine now. My body is in here somewhere… It's much tighter than this, the exterior is my daughter's mum's body. So I'd just like to wean her and then feel like my fitness is back.*

Madison describes her body as being not her own but rather as her "*daughter's mum's body*". Her body's sense of identity is formed in relation to her daughter, rather than what she perceives to be her true self. Interestingly, Madison depicts these two bodies as distinct entities. Her own bodily identity does not coexist alongside her body's identity as a mother. Her body as a mother is in the foreground, indicating she has supressed her true body. This finding forms a pattern across research in this field, in which women feel constrained by their decision to breastfeed (Lupton & Schmied, 2016; Marshall, Godfrey, & Renfrew, 2007). Madison explained she can get her "*body back*", a sentiment echoed throughout many of the interviews, which is shown in the following two excerpts.

> Charlotte: *I think it was a mixture of me wanting my freedom back, wanting my body back, wear the work clothes I've got.*

> Kaitlin: *And are you planning on weaning him?*
> Hailey: *Yes, nights. I'm working on weaning him (laughter). I want my bed back. I want my body back.*
> Kaitlin: *And how come you want to wean?*
> Hailey: *Oh, it's just… He's almost 2.5 years, it's a bit… The bed is getting full. He still doesn't realise that the breasts are part of mummy. They can't stretch. Sometimes I just feel like I've had enough of him touching me, so we'll work on it.*

By describing their bodies as something that can be received "*back*", it reinforces the idea that their breastfeeding bodies do not belong to themselves, but to their children. These findings align with a recent sample of 25 Australian women, with the majority of participant's echoing the sentiment of wanting their body "back" (Malatzky, 2017). Medical discourses construct women's bodies as an ecosystem existing to serve the child, alienating and erasing the mother from her own body (Crawford, 1980). This construction is evident in the above excerpts, as the participants describe that in their current form, their breasts, and by extension their bodies, exist to serve their children. This language also echoes previously discussed ideas of breastfeeding being an act of 'giving'. Providing breast milk inherently involves giving something away, which in this case involves sacrificing bodily autonomy and independence. However, there is a point of resistance wherein once their child reaches a certain age, generally two years old, it is within the mother's rights to take her "*body back*" from the child, guilt free. At this point the mother has fulfilled her obligation to breastfeed for the 'right' amount of time

according to expert guidance, and is therefore able to wean her child without being seen as a selfish mother.

Breastfeeding duration as an indicator of 'good' motherhood

Women work hard to be considered 'good' mothers, and often this means walking a tightrope in which one slip up will lead to being classed too good, or not good enough (Pederson, 2010; Faircloth, 2010). This is particularly true for breastfeeding, which is a sacred practice and a key tenet of 'good' motherhood, yet once the child reaches a certain age it shifts into a transgression. For instance, in her UK study of the negotiation of the ideal of 'good' mother in mothers' online discussions, Pederson (2010, p. 33) concluded the following:

> Mothers come to understand that a 'good' mother should persevere with breast-feeding no matter how inconvenient or painful it might be for her, selflessly putting her baby's needs above those of her own. However, mothers who breastfeed beyond the baby years or embarrass others by public breastfeeding might be deemed morally deviant

When the child is considered 'too old' to be breastfed by Western standards the breastfeeding mother is positioned as strange, feeding the child for her own benefit more than that of the child (Pederson, 2010). Many of the participants were aware of where their performance fell on this continuum as shown by the following responses to my question about whether the participant had a preconceived idea about how long she would breastfeed for.

> Hailey: *I was just going to go until one of us gets sick of it, so I didn't really have a date. I used to say around 2ish, but I think I'll probably go up to till 3 ((Laughter)). As long as he doesn't still feed when he goes to school. That's a bit too far… But ((Laughter)) I might actually change my mind… it depends. I just go with the flow.*
>
> Emma: *Yeah, I was kind of like, I'd always said my brush off comment to how long are you going to do it is was I'd stop when he could walk up and ask for it 'ha ha ha', and then he'd be like 'more?' and pulling at my top, and I'd be like 'okay you can ask for a bit it's okay, we won't tell anyone' ((Laughter)). But I didn't want to like, do it for too long.*

Evidently, Hailey and Emma understand there is a point within which breastfeeding is socially acceptable, and understand where their behaviours fit within the continuum of 'good' mothering. As the first quote shows, Hailey is aware that she had been feeding her child for longer than what many consider 'normal'. At two-and-a-half, she was having trouble weaning her son. Hailey nervously laughed as she stated it would be a "*bit too far*" if he was still feeding up until school age, but then admits she may do so regardless. She was aware that feeding a child until school age positions her as an over-

performer. However, Hailey is able to rationalise this to me by saying "*I just go with the flow*". Hailey, is able to negotiate her over-performance by deferring to the child-centred framework common within attachment parenting discourse in which the child decides when they want to stop breastfeeding thus necessitating going "*with the flow*" (Wall, 2001). Similarly, Emma fed her child until age one-and-a-half, and while this is still younger than the WHO recommendation of two years, she felt she had slipped into the territory of over-performance.

The trouble then that such talk points to is that the acceptable amount of time to breastfeed for must not be too short or "*too long*". As Pedersen (2016) argues acceptability around the duration of breastfeeding is usually determined by the wider social context:

> Mothers thus glean from the media and wider society how easy it is to tip over into delinquent or 'bad' motherhood. …a 'good' mother knows that she should breastfeed her baby, but not for too long or in too obvious a way (p. 33).

Above, Emma jokes that breastfeeding her son can be their secret. In this statement she constructs their breastfeeding practice as needing to be invisible to hide her perceived transgression. It also suggests that she views this issue as imposed by external forces, in which other people's judgement is constructed as the problem. This may also have been why Hailey lists school age as being "*too far*", perhaps reflecting her child's shift into being a more public member of society. Participants were aware that their 'good' mothering status may be negatively influenced by extended breastfeeding and took precautions to preserve their identity when breastfeeding beyond what they considered 'normal'.

In contrast to those who had breastfed for too long, women who do not feel they have successfully breastfed because they feel they stopped prematurely or sooner than they would have liked to may be concerned they have underperformed, as intimated above (Wolf, 2010). For example, Charlotte had stopped breastfeeding while her daughters were eight months old and was aware she had fallen short of breastfeeding targets. Charlotte rationalized this by explaining that breastfeeding is difficult with twins. She said, "*a lot of the twin mums I've met have stopped early. Maybe 5/6 months? 7? I don't really know any twin mums who have gone past a year".* In addition to positioning herself as having persevered longer than other mothers of twins, she also stated that if she had not had twins, she would have continued breastfeeding. These disclaimers provide justification for Charlotte's perceived underperformance, guarding against negative positioning (as selfish, lazy, or not dedicated) and preserving her status as a 'good' mother. Within this sample Charlotte was the only mother who discussed what could be seen as underperformance. This suggests women who felt they had performed

motherhood correctly through breastfeeding to an appropriate age may have been more motivated to participate in a study of this nature.

Ultimately, a 'good' mother does not simply follow expert advice and mothering traditions, she must also be self-sacrificial. Most of the women, while constructing breastfeeding as easy, also admitted their struggles. This could be perceived as contradictory to attempts to align with being a 'good' mother, but ultimately it provides stronger evidence than having an easy experience. The 'good' mother makes sacrifices for her children and will give up anything to ensure they reach their full potential. A difficult journey provides a platform to demonstrate maternal devotion. It is part of the narrative of 'good' motherhood, not antithetical to it, as it creates the idea that certain women are *such* 'good' mothers that they were able to overcome great hardship due to their dedication to their children. Anyone can be a 'good' mother to an easy-going child in a stress-free situation, but it takes a great mother to persevere and still reach what is considered a high standard of parenting. Therefore, by acknowledging their breastfeeding difficulties participants were able to validate their status of being 'good' mothers. However, by ensuring they met this standard they were faced with significant practical implications which greatly shaped their experiences of ECE and their re-entry into the workforce.

Negotiating the practical implications for working and mothering

Combining breastfeeding with employment has a well-documented history of being difficult (Hausman, 2014). Women must fulfil their responsibility to be both a 'good' mother and household manager, and a productive employee (Lubold & Roth, 2012). Many scholars have dubbed this working the 'double shift' (Hochschild & Machung, 2012). Participant's described being placed in an impossible position where they cannot be both a 'good' mother and a good worker. Women are expected to adhere to standards of 'good' mothering, including following breastfeeding recommendations. However, mothering, in particular breastfeeding, belongs to the private domain. Stigma associated with breastfeeding, and women's bodily functions as a whole, are expected to be both regulated and discreet (Turner & Norwood, 2014). This conflicts with the reality of most women in the 21st century who need to combine motherhood with employment. Employment demands that women discipline their bodies to fit into the workplace, therefore making breastfeeding women's employment conditional on their ability to hide aspects of their role as a mother (Hausman, 2014). This may be further reinforced through an ECE environment where mothers who are attempting to blend breastfeeding and outsourced childcare are in the minority (Farquhar & Galtry, 2003). This section will explore how participant's subjectivity of being a

'good' mother influenced their infant feeding possibilities while navigating these tensions, including discussion on how many were able to resist stigmatised positions and treatment.

The participants shared stories of both success and hardship when combining employment with breastfeeding. Madison, Hailey, and Olivia continued breastfeeding outside of ECE hours after finding it too difficult to integrate pumping or ECE centre visits. Hailey had trouble getting her son to accept a bottle, Madison experienced difficulties pumping and workplace resistance, and Olivia found she was able to make up for missed daytime feeds at night to avoid the hassle of pumping at work. Sophie and Emma managed to pump during their work days and provide the breast milk to their ECE centres. Ellie found an ECE centre nearby her work and was able to take multiple breaks daily to visit her son for feeds, then switched to pumping as her son grew older. Charlotte made the decision before returning to work to wean her twin daughters for a variety of reasons. Each of the participant's experiences highlight different barriers faced by breastfeeding women returning to work as they attempt to uphold their status as 'good' mothers. This section will explore the practical implications of breastfeeding, examining the structural barriers introduced by the ECE and workplace settings.

Navigating the early childhood education setting

A majority of children in ECE care are formula fed, therefore breastfeeding women may have unique experiences when accessing care. In this section I will explore how participants attended to their subjectivity of being a 'good' mother, within the constraints introduced by the ECE setting. Firstly, this section explores how participants attempted to use ECE centres as a substitute for the 'good' mother, followed by a discussion of their experiences of pumping breast milk. I will then turn my attention to examine ECE's problematic intersection between the public and private spheres, which had implications for the visibility of formula and the women's perceptions of those around them. Finally, support from both teachers and structural influences are considered.

The ECE centre as the 'good' mother

Participants chose centres aligned with their parenting values, with a majority of participants discussing attachment figures. They worked to choose centres that could provide a consistent teacher with whom their child could form a secure attachment. Hailey discussed how she explicitly sought a centre that would "*baby-wear*" her son during the day:

> Hailey: *One of the things I did ask was if they were willing to baby-wear him if needed. That was his comfort. The kindy that I did find, as soon as I walked in I felt at home. All the kids were happy; it was a nice relaxed atmosphere. I've walked into some other kindies where the kids are all upset, crying, rigid…Not aligned with my parenting style.*

Hailey's emphasis on baby wearing supports the attachment parenting style that is synonymous with 'good' motherhood, in which infants are thought to need one primary attachment figure and unrestricted physical contact (Wolf, 2010). Most participants explained they had been "*picky*" when choosing a centre, and described some centres as chaotic, without key attachment figures, and as having a cold environment. Above, Hailey used an extreme case formulation to explain how in these centres "*the kids are all upset*" and distanced herself from this by saying it is not "*aligned*" with her parenting style. Similarly, Emma described these centres as having a "*herd*", where she could not be sure who was looking after her child each day. The notion that children need one secure attachment figure in order to promote developmental wellbeing (Sears, n.d) is challenged within an ECE environment as centres take a collective approach to child-rearing. A team of teachers is assigned to each age group in an ever-rotating fashion due to sick leave, non-contact hours, and break times. Participants resisted this by ensuring they selected small centres where their child could have a primary teacher to bond with. In this way, the child's teacher becomes a stand-in for the secure attachment figure that the 'good' mother usually provides. A majority of participants had children enrolled full-time in ECE care, and consequently their child spent most of their waking hours in the care of the ECE centre. Participants had to be confident that the centre would support the practices associated with 'good' motherhood in order to feel comfortable with outsourcing a large portion of their child-rearing.

Alongside seeking secure attachment figures, homeliness was raised as an important factor for all participants. For this reason, Madison sent her daughter to an in-home carer, as discussed in the following excerpt.

> Madison: *I looked at the day cares and I saw all of the things of formula, and the kid's names on them. I was just like 'No. I'm not taking her… She can't come here". Because this is their norm, and I don't feel comfortable with that being their norm. It's not going to work for me. I just felt like… If for some reason I couldn't provide milk they would just automatically give that to her, even though there was food there and it was other children's, I was just like yeah no. Too commercial for me… So yeah, when it came to looking around different day cares I realised I just couldn't put her in that.*

Madison described centres as "*too commercial*". Her use of the word commercial connotes the antithesis of what participant's said they were looking for – a homely environment. Taken further this could imply an unnaturalness to the ECE environment. This is a common critique of the ECE setting,

which is becoming increasingly industrialised in New Zealand with large chain corporations owning a large share of the trade (Collins, 2017). The idea that ECE centres are 'factory farms' for children is often raised in public media, with many centres operating as profit-driven businesses (Collins, 2017). Within a total motherhood society this idea is vehemently rejected. Children are special treasures who need individualised care and attention, not a means of financial gain (Wolf, 2010). Indeed, the ultimate individualised care is a devoted stay-at-home mother, but in an economy where few can inhabit this position the best alternative is a small centre which feels like home. The participants could not, either financially or without cost to their mental health, be stay-at-home mothers. Therefore, they sought centres which they felt aligned with the ideals that a total motherhood society promotes, particularly focused on seeking key attachment figures and a homely feel. Participants could not provide an experience of 'good' motherhood to their children during working hours, so they ensured their ECE centre could stand-in for these values.

'A cow in a milk shed': Pumping

Participant's relied on pumping to provide breast milk to their children. Pumping introduced a great workload for the participant's and was often a source of stress or discomfort. Many participants reported that pumping demanded large quantities of time, both in waiting for their breast milk to pump and cleaning the equipment. Emma described this constant cycle as "*draining*", while Madison said it had caused her "*daily stress*". Ellie initially visited her son for feeds, then switched to pumping, which she described as "*equally exhausting*". Pumping introduced a new mental load for participants in addition to their already busy schedules. These findings are consistent with Stearns' (2009) research, and Avishai's (2011) study, which found pumping was perceived as an exhausting challenge. Stearns argues for the need to consider breastfeeding "as time-consuming and labour-intensive maternal body work" (2009, p. 76). Pumping makes this labour visible, as it does not fit with the 'natural' narrative most women employ, in which breastfeeding seems to "happen simply" (Stearns, 2009, p. 76). Pumping also removes an enjoyable aspect of breastfeeding (physical closeness) and leaves women with considerably more labour. In the excerpt below Sophie discusses how she felt during pumping sessions.

> Sophie: *And sitting with the pump going is just the most… It's the hardest part of breastfeeding. It's quite a degrading process, you feel like a cow in milk shed.*

Sophie describes pumping as "*degrading*", which evokes a sense of being demeaned. Her claim "*you feel like a cow in a milk shed*" supports this portrayal. One of the main ways women take pleasure from

breastfeeding is the physical closeness it provides (Avishai, 2011). Pumping does not allow for this closeness, hence the demotion to being "*a cow in the milk shed*". In this case, breast milk becomes a transactional exchange rather than a bonding moment.

Therefore, women who seek to fulfil the breastfeeding obligations imposed by total motherhood may place themselves under significant stress. When a woman decides to pump, the onus falls on her alone which leaves little incentive for employers to interfere. Attempting to be a 'good' mother and manage the labour-intensive workload of pumping placed a sizeable burden on participants. Participants discussed this responsibility negatively, yet their commitment to ensure their child's perceived needs were met took precedence over their "*daily stress*".

Early childhood education: A strained bridge between the public and private

ECE centres occupy a unique position that rests between the public and private sphere (Vandenbroeck, Coussée, & Bradt, 2010). Traditionally childcare has existed in the private sphere, a practice reserved for the family home. Within the private sphere mothers assumed responsibility for childrearing with relatively free domain. Now, childcare centres involve much of the intimate labour associated with private childrearing, yet this labour takes place within the public realm. A result of this is that private family practices, including infant feeding, become subject to the norms and values that govern the public (Vandenbroeck et al., 2010). Society has the expectation that breastfeeding sits firmly in the private sphere, rendering it invisible in public spaces such as ECE centres (Smyth, 2012). The invisibilisation of breastfeeding was noted by all participants. For instance, Sophie stated:

> Sophie: "*Some women sit and talk to me while I'm breastfeeding, other's scurry away. I've never felt embarrassed or disrespected in any way, but I think some may think I want privacy… I would love there to be more welcoming chit chatter".*

In this extract, Sophie implied that her daughter's teachers assumed she wanted privacy, whereas what she truly wanted was to be welcomed and engaged with. The teachers reactions rest on the cultural assumption that breastfeeding is a private act, which Western society justifies with concern over the sexualisation of breasts and the taboo of bodily contamination. By performing a supposedly intimate practice in a public space women challenge the idea of modesty (Murphy, 1999). Western society has sexualised female breasts to a point where their natural function is hidden beneath sexual connotations. Murphy (1999, p. 202) states that breastfeeding women not following standards of modesty are seen as

violating Western boundaries of decency and are therefore "open to the charge that they are brazen women". The risk of this is often enough to make many women hide breastfeeding from the public eye.

Alongside the visual offence of breastfeeding lies physical disgust over women's bodily secretions. Women's bodies are a highly stigmatised site, with women's bodily products treated as a source of public contamination (Chrisler, 2011). Cook (2016) states that public breastfeeding is often conflated with public sex, masturbation, and urination. At most breast milk, a 'private' substance, is treated as a public health risk, and at least the general public has social permission to feel squeamish about it (Cook, 2016).

Participants were aware of breast milk's stigmatised position and had considered that they were asking their children's teachers to handle a private part of themselves. Emma said she could see how the teachers could think this was "*gross*", particularly as the milk may "*get all over them*". Sophie expressed a similar point, noting that she was asking the teachers to handle "*what someone else's body has created*". Miller (1998, p. 82) states that by bringing a private act (breastfeeding), or a private substance (breast milk), into the public realm it "forces bystanders to look and notice, or to suffer self-consciousness about not looking or not *not* looking". This can be seen in Sophie's earlier quote, in which she hypothesised that the teachers assumed she wanted privacy ("*scurry away*"). ECE centres, sitting at an intersection between public and private spheres, could have the opportunity to resist stigma associated with breastfeeding. Nevertheless, deep-rooted cultural norms of modesty and bodily contamination still appear to have an influence, and ECE centres appear to unsuccessfully bridge this divide for many participants. Consequently, navigating these tensions becomes yet another responsibility for breastfeeding women accessing ECE care, placing women in an impossible position. The 'good' mother is pressured to breastfeed, then simultaneously condemned when the practice becomes too visible.

An added burden that breastfeeding women face, introduced by ambiguity between the public/private realms, is managing value-judgements made by others. An ECE setting forces mothers to openly share their private parenting choices in the public realm, which may open them to critique and stigma. This can be seen in Charlotte's story of seeing another mother breastfeeding a toddler at their centre.

> Charlotte*: I don't see any mums breastfeeding if I'm honest, apart from that one last week which made me go 'Ohh…!'. She was actually walking around with the toddler – quite a big toddler. Probably the first time I've seen anyone breastfeed there…. Yeah… he was… big.*

This was the first time Charlotte had seen a mother breastfeeding at her centre, and she was intrigued by the age of the child ("*quite a big toddler*", "*he was… big*"). She emphasised the age and size of the child twice, which suggests that these details have an important impact on the story. This could be read as Charlotte passing judgement on the woman. As well as a potentially a positive assessment, it is also an observation of an over-performance of motherhood which Charlotte thought was unusual. Her judgement may also reflect the stigma associated with breastfeeding. The age of the child is significant as women breastfeeding older children are likely to face more shame, as discussed above (Cook, 2016; Stearns, 1999). The discomfort associated with breastfeeding becomes multiplied by a perceived over-performance of motherhood, while people are generally more accepting of mothers feeding small infants (Stearns, 1999). If Charlotte was passing judgement, she is not alone. Women frequently judge mothering choices, and tension between the private and public realm may exacerbate this (Murphy, 1999). Women are made to believe their mothering choices are personal and private, yet within the ECE sector's semi-public environment these behaviours are open to scrutiny.

A result of breastfeeding's private nature is its visibility in ECE centres, which was portrayed as signalling a lack of support by many participants. The absence of a visible breastfeeding culture highlighted that participants were in the minority. Some spoke of this as an opportunity to resist by ensuring they emphasised feeding in shared spaces in the centre, while others explained how it pushed them out of the ECE sector. In the following excerpt Madison describes the visibility of breastfeeding as unwelcoming, meaning she did not feel comfortable in the ECE centres she toured.

> Madison: *But the norm… oh just seeing all that formula! You'd never see a breast pump or breast milk right there, so this is what we're always looking at, so everything else is hidden. Where is it? Obviously milk needs to be in the fridge so it's not as advertised. So I just… For me I was like oh yep. Okay. Yep... No.*

Madison portrays the lack of visibility as difficult. In contrast the high visibility of formula is depicted as making her uneasy. Her anti-formula sentiment recalls the previously explored repudiation of formula within a total motherhood framework. Madison's claims that breast milk is "*not as advertised"* alludes to an impression that formula is. This echoes her previous statement on ECE centres being "*too commercial"*, and reinforces the discomfort present with centres using public, business-driven models. It points to the tensions that exist due to ECE centres strained relationship between both the public and private realms. These findings align with Dombrowski et al.'s (2018) study of Scottish mothers who found breastfeeding's hidden nature discouraging. Unprompted, many participants speculated as to whether their centres had ever given their child formula without their knowledge. This possibility was

not a worrying concern for most participant's, but to bring it up within the interview suggests they may have felt there was a chance that it had happened. A lack of visible breastfeeding support meant many participants were suspicious of the centres commitments to support exclusive breastfeeding. Accordingly, the 'good' mother must work against the ECE provider to ensure her targets are met.

Teacher support

Teacher support was constructed as an important factor for participants comfort within their centres. Most participants reported that teachers were welcoming of breastfeeding mothers, likely because they had inquired about breastfeeding before enrolment and had factored this into their decision when choosing a centre. Despite the teacher's support, however many participants were the only breastfeeding mother attending the centre. One participant had some difficulty working with her child's teachers, while a majority of participants were pleased with the level of support provided by staff.

Sophie found herself tasked with educating her daughter's ECE centre on how to handle breast milk. She had not brought up breastfeeding before enrolling her daughter, so was initially unaware she would be the only breastfeeding mother. However, the staff's reactions meant she quickly realised once her daughter started attending, as the quote below shows.

> Sophie: *I could tell by the look I got that that was kind of like… 'okay….?'. I was aware about how they asked a lot of naive questions about what to do with it, and how to heat it, clearly they weren't used to the idea.*
> *[…]*
> Kaitlin: *So they were fine with following your lead?*
>
> Sophie: *I think so, but I think at the same time it was a bit weird for them handling someone else's… what someone else's body has created. I'm sure there was a bit of that, but I didn't let it become thing and had to keep positive about it.*

The above except suggests that the teacher felt Sophie had made an unusual request ("*okay*…?), and the confused "*look*" positions Sophie as performing an exceptional practice. Therefore, she has positioned herself as the 'other', which places her as having to request special treatment from staff members. Women could risk being constructed as picky or difficult if they demand too much for themselves or their children, constraining their ability to negotiate a supportive environment. At this ECE centre breastfeeding was treated as not normal, perhaps even a nuisance. Sophie had maintained a cheery attitude despite this, possibly to avoid causing a hassle ("*had to keep positive about it*"). This was evident as Sophie laughed about how she discovered that the staff were discarding large quantities of

her breast milk before it would have expired. She would have been well within her right to be upset over the product of her painstaking, "*degrading*" pumping going to waste, yet she laughed it off. This may be an attempt to minimise the perceived burden she already placed on staff by expecting them to provide her breast milk. Sophie had spent months supporting and educating her daughter's teacher with information on breastfeeding and breast milk, demonstrated in the excerpt below.

> Sophie: *I just had to educate them. But as a new mum, my first child, my one and only child, I was learning at the same time. It was actually quite nice to know the information and be able to then pass that on. I didn't see it as a negative at all*

Sophie reported that she enjoyed taking on a leadership role and providing education on breastfeeding so that the teachers would be able to better support herself and highlighted how she felt she had also helped future breastfeeding mothers. This is potentially a moment of resistance for Sophie. She is the "*new mum*", still learning, yet she positions her knowledge-base as superior to the teachers ("*they asked a lot of naive questions*"). The ECE teachers, predominantly university-trained, are positioned as needing to be educated. This gives Sophie power within the situation, leading her to construct this experience as not "*negative at all*" and allowing her to feel proud for having advocated for future breastfeeding mothers within the centre.

Sophie left her experience of combining breastfeeding and employment feeling positive, but it is possible many women may have sensed the initial discomfort from the teacher's "*look's*, and not had the confidence to continue. Sophie, a well-spoken, educated, middle-class, white woman may have had the upper-hand in this scenario. Indeed, Johnson, Williamson, Lyttle, and Leeming (2009) found that women of a similar demographic in their study had a greater sense of agency in regards to breastfeeding. Consequently, the ability to perform 'good' motherhood in this context is partially dependent on privilege. This further marginalises women with less privilege, as they must work harder to meet the same standards of 'good' motherhood that their privileged counterparts can. As a result, the level of support provided by a teacher may greatly influence women's ability to perform 'good' motherhood within an ECE context.

Overwhelmingly, participants described their children's teachers as great sources of support. Participants commonly conceptualised this support in relation to getting their child to accept bottles. Every participant struggled to get their infant to take bottle, and most had become quite distressed over their child's refusal to take a bottle, leading to it becoming a primary stressor when preparing for ECE. For instance, Emma explained how her son refused feeds for the first couple of days at his centre, which

she described as "*horrible*" and "*stressful"*. Emma became panicked during her first few days back at work, but said her son's teacher was "*fantastic"*, kept her calm, and eventually her son started accepting pumped breast milk. The participants trusted the teachers approaches and experience. Due to the lack of mother's perspective in this field there is little direct comparison for these findings besides Dombrowski et al's (2018) research, in which the mother's interviewed reported greater challenges than the women in the present study. Interestingly, Dombrowski et al's research was conducted in an ECE centre located in "one of the top ten most deprived areas of Scotland" (2018, p. 3). As explored above, privilege impacts on women's agency (Williamson et al., 2012). In contrast to Dombrowski et al's (2018) research, the women interviewed in the present study were all in positions of social and economic advantage, which may have shaped their perceptions and experiences of teacher support. Nevertheless, the participants accounts suggest teachers are able to play a unique role in supporting breastfeeding mothers return to work, removing a burden that had caused significant stress and worry for nearly all participants. Teacher support is an important factor, however this only accounts for a small portion of potential aid. Teachers alone cannot be expected to help breastfeeding women.

The absence of structural support

Evident throughout all interviews was the lack of structural support provided to ECE centres. No participant knew of their centre having a breastfeeding policy despite the extensive evidence of their benefits of these (Marhefka et al., 2018). Private breastfeeding spaces are a key aspect of providing a supportive environment (Farquhar & Galtry, 2003). The fact that no centre had a designated breastfeeding space is alarming, particularly as many participants were attending new, purpose-built centres. Moreover, Sophie and Emma both noted there was only enough space in the fridge for one women's breast milk. It was pure chance that the centres had available facilities. Just as the responsibility for upholding breastfeeding should not be centred on women, teachers must not be liable for the ECE sectors shortcomings. Without sufficient education, policy, and resources teachers cannot be expected to uphold the burden of supporting women in their attempts to continue breastfeeding. In 2003 Farquhar and Galtry provided guidelines for supporting breastfeeding friendly ECE care in New Zealand. Over 15 years later, there has been no structural change to ensure ECE centres are supporting women 's choices. Farquhar (2006, p. 235) states that "breastfeeding support is being intentionally ignored by the early childhood education community". Indeed, this lack of support means the onus is placed first and foremost on breastfeeding women, then secondly on individual teachers. It is important

to consider that just as breastfeeding women need structural support, teachers do too. Low industry standards mean much of the labour involved with supporting breastfeeding women falls on individual teachers, who are likely overworked and underpaid. The pressure of mothers attempting to uphold standards of 'good' mothering are not isolated to the mothers themselves. These expectations are then placed on their children's teachers as well, who are lacking the structural support necessary to fulfil this role. Many teachers were able to act as key support figures for mothers, but structural change is needed to support the joint labour that teachers and mothers undertake in infant feeding.

ECE centres played a marked role in participants experiences of returning to work while breastfeeding. The participants had to negotiate the ideals of total motherhood within the practical constraints of the ECE setting. Accessing ECE care meant they had to either compromise aspects of their parenting or engage in large quantities of labour in a bid to maintain their subjectivity of 'good' mother. For instance, due to practical constraints many participants were sending pumped breast milk to the centre with their children. This meant that they had to forgo the psychological and bonding benefits that breastfeeding promises, whilst expending large quantities of labour managing pumping. Within the private sphere there is the expectation that women can make mothering choices individually. This is interrupted when a portion of the labour involved with childrearing is transferred to the public, as childrearing therefore becomes more subject to the norms and values that dictate the public realm. Participants had to work around this constraint in order to perform this 'abnormal' practice in the semi-public setting the ECE centre introduces.

Additionally, while teacher support was perceived as high, it was apparent that ECE care is lacking the structural support many women need in order to preserve their breastfeeding practice. The women in this study possessed power through their education and social position, which allowed them to navigate tensions with relative ease. It cannot be forgotten that many women do not hold this power and would have been disadvantaged by many of the barriers the participants were able to overcome due to their privilege. Ultimately, ECE centres that fail to support breastfeeding mothers constrain these women's choices and their ability to enact 'good' motherhood. This has implications for women's subjectivity and wellbeing as a mother, as much of this is dependent on the performance of 'good' mothering choices (Wolf, 2010)

Negotiating with employers

Attempting to combine concepts of 'good' motherhood with employment often places women in an impossible position where they must balance two distinct identities. In addition to fulfilling their obligations to mother in accordance with total motherhood ideals, women must also present themselves as a competent employee (Hausman, 2014). This often hinges on their ability to hide their identity as a mother within the workplace (Lubold & Roth, 2012). Recent changes in legislation has meant breastfeeding women's rights are theoretically protected within the workplace. Despite this, the participants' varied experiences suggest that the potential of these policies are not realised within many working environments. I will begin this section by providing an overview of the 'ideal worker norm'. The ideal worker norm explores how workplaces are designed around the 'ideal' worker who is male and unburdened by family obligations (Williams, 2001). This notion informs the findings in this section. I will then touch on how breastfeeding disrupts the ideal worker norm. Following this, I will orient these findings in current research and theory, examining participants potential to advocate for themselves, the influence of public stigma, and the opportunity to resist poor management through employing a human rights discourse.

Combining the 'ideal' worker with the 'good' mother

Women may feel discouraged to advocate for their rights as mothers due to the 'ideal worker norm'. The embodiment of the 'ideal' worker is a male unshackled by the demands of running a household and raising a child (Williams, 2001). The 'ideal' worker does not have the interruptions a menstruating, pregnant, or lactating body may introduce, and is continuously available to devote themselves to work. Neoliberal society celebrates citizens that are able to be productive employees, which promotes the desire to strive towards being an 'ideal' worker (Hausman, 2014). Women are encouraged to reach these ideals to compete with their male counterparts, yet the many demands placed on women inevitably lead to their failure. This is exacerbated by motherhood as women are then placed in an impossible intersection of motherhood and employment. This often leads to women over-accounting for the disruptions introduced by their position as a female employee (Lubold & Roth, 2012), as demonstrated in the following excerpt.

> Ellie*: I think once you're in the workforce and a mother you feel about twice as much pressure to perform just as well as you were performing before – if not more. I think I really wanted to prove that you weren't getting a less good employee just because I was breastfeeding.*

The idea that women feel "*pressure to perform*" once becoming a mother has been a consistent finding across time and context (Lubold & Roth, 2012), including research conducted in New Zealand, in which Payne and Nicholls (2010) interviewed 20 employed breastfeeding mothers, concluding that "workers exert considerable efforts and put in place strategies to meet the demands of being both a 'good' mother and a good worker" (p. 1816). It is unlikely men feel this urge to outperform themselves once they become fathers, which reflects the gendered inequalities in child-rearing (Hausman, 2014). In the workforce women are obliged to hide their gender, which includes minimising the impact that motherhood may have on their career performance.

Breastfeeding vs the 'ideal' worker: disruption in the workplace

Breastfeeding causes a disruption in the workplace as it makes employee's mothering identity visible, threatening their position as an 'ideal' employee. Participants who had experiences of positive workplace support often worked in privileged roles which allowed breastfeeding to fit into their workday without inconvenience to their employers. For example, Sophie was able to pump while working so did not need to take breaks. She worked in a management role in a private office, which allowed her to comfortably pump whenever she wished. Ellie, who combined both going in to the centre for feeds and pumping at her desk, worked in a relaxed workplace without a traditional boss. This meant she was able to easily organise her hours around breastfeeding. In both of these cases the participants were able to organise their own time and resources without needing additional support from their employer. These findings are consistent with Turner and Norwood's (2014) study of privileged mothers in the USA. A key predictor of successful breastfeeding within the workplace is the employer's ability to not have to provide extra accommodations. Consistent with the women in Turner and Norwood's (2014) research, Sophie and Ellie's employers had to do little more than give a nod of approval to be perceived as supportive workplaces. Due to working in privileged roles they were able to organise the rest themselves.

The ideal worker norm places the onus on women to manage workplace breastfeeding, ensuring there is minimal disturbance to their employer and fellow employees. This is because breastfeeding is a gendered practice that is firmly opposed to the ideals that shape the 'ideal' worker, reminding the workplace of the women's disruptive female body and household obligations. Additionally, breastfeeding is not something all women do and substitutes (formula) are readily available and culturally accepted. As a result, there is a view of breastfeeding versus formula-feeding as just another

consumer option rather than an issue of reproductive justice, which makes it easier for employers to step back (Lubold & Roth, 2012). If a woman can continue breastfeeding privately and without direct disturbance to the organisation there is less chance of friction. Often this is possible only in positions of privilege, as these roles afford working conditions such as private offices and flexible work hours, which are conducive to minimising the visibility of breastfeeding related practices (Lubold & Roth, 2012). This was certainly the case in Sophie and Ellie's workplaces, allowing them to combine their identities as both an 'ideal' worker with 'good' mother. Employers are indifferent towards breastfeeding workers who can successfully hide the practice and manage it without interference to their role (Turner & Norwood, 2014).

Employers unresponsiveness may be of less importance for those in a privileged position, yet most women require active workplace support in order to continue breastfeeding (Lubold & Roth, 2012). Dedicating time and resources to breastfeeding requires the company go "above and beyond what the organization is obligated to do for an employee" (Turner and Norwood, 2014, p. 862). This is illustrated in the following excerpt where Madison, whose employer was initially on-board with her pumping, discusses her employers lack of support once they realised they had to provide her with a separate room.

> Madison: *Then they did say 'well we do have one'. And I was like 'Oh my gosh that's amazing! That's so wonderful!' and then they were like 'Oh well actually it's a handicap toilet'…*

Her employer was willing to do the bare minimum, allow her to pump in the toilets. Suggesting the toilets as a place for pumping is an inadequate provision. Such a recommendation is deemed unacceptable in New Zealand's Code of Employment Practice on Infant Feeding (Department of Labour, 2010), and in the event of Madison needing to use the toilet she found the cubicle had no power outlet which rendered the proposal useless. Madison, opposing this suggestion, changed her initial work schedule of a few full-time days to working a few hours each day so that she would not have to pump at work. Because this did not provide disruption to her employer, she was able to do so with relative ease. Here we see how employer's support may withdraw once breastfeeding becomes an inconvenience. In these cases, the responsibility falls on the breastfeeding women. They face either causing disruption to their workplace by demanding better working conditions, putting themselves at odds with an 'ideal' worker identity, or they could cease breastfeeding and risk losing their position as a 'good' mother.

Rather than jeopardise their subjectivity as a 'good' mother and 'ideal' worker, some women will invest vast quantities of labour into ensuring they met each criterion. This can be seen through primary school teacher Emma's account.

> Emma: *Yeah so I said 'when we're doing the duty roaster my breastfeeding will need to be taken into consideration'. Right, okay, you'd think I'm just making everyone aware of the situation. Well, I get an email back saying, 'maybe you need to reconsider if this position is suitable for you'. No joke.*

Emma's employers positioned her as having made a special request and then retracted their support once realising they may have to actively help her. Emma, who was determined to combine breastfeeding with employment, engaged in an exhausting cycle of forgoing lunch breaks, trading duties, managing resistance from co-workers, and dealing with inadequate facilities for pumping. Her commitment to being a 'good' mother and providing breast milk to her son despite these conditions came at great cost to her mental and physical health. Emma describes the experience as follows: "*It was so draining. I lost heaps of weight and I think it's because of the pumping, and the stress, and the not stopping, and also not eating because I wasn't getting time to eat when I was pumping"*.

Low employer support of this type is a consistent finding across research in this field (Lubold & Roth, 2012; Lucas & McCarter-Spaulding, 2012; Payne & Nicholls, 2010). In a New Zealand context, Payne and Nicholls (2010, p. 1810) concluded women in their sample "disciplined themselves to minimize their disruptive potential". This relates to Foucault's theory of disciplinary technologies which posits that once a behaviour or subjectivity becomes normalised people are coerced to adhere to it if they wish to fit in to society (Foucault, 1977). In this instance, both the 'ideal' worker and the 'good' mother are normalised, and women face judgement if they fall short of these subjectivities (Payne & Nicholls, 2010). Consequently, women engage in 'self-surveillance', monitoring their behaviour to fit dominant practices. This operates as a form of control as it places sole responsibility to meet the 'ideal' worker and 'good' mother subjectivities on women. Disciplining oneself to meet these standards is often arduous work, as evident in Emma's account ("*draining")*. Constraints introduced by the ideal worker norm greatly impact many women's breastfeeding choices and their ability to identify as a 'good' mother. By extension, this has implications for women's mental and physical health. Success in this arena is largely dependent on women's ability to fit breastfeeding around their employer's needs, and a certain level of privilege is required to do so seamlessly.

Privilege as a prerequisite for advocacy

Breastfeeding legislation has meant women have legal ground to refuse poor breastfeeding accommodations, however the ability to truly advocate for these rights is often dependent on privilege. Requesting employers fulfil their obligation to meet national breastfeeding standards may position women as difficult, compromising their position within the workplace. Research suggests this issue is highly classed. Educated women in highly-paid, managerial positions have a greater ability to self-advocate as they are more valuable to employers than their low-skill, low-wage counterparts (Lubold & Roth, 2012). Even if low-skill women successfully gain employer support there is often the challenge of finding time and space to do so as these positions regularly lack privacy and flexibility (Lubold & Roth, 2012). Furthermore, race must invariably be considered, as white women have greater opportunity to fill higher roles. The interplay between privilege and advocacy can be seen in the contrast between Madison and Emma's accounts in the following excepts.

> Madison: *Where are you going to meet me? Because actually, well it's not that I don't need this job, but I can go find somewhere else supportive…*
> *I never had any kick back, no one said anything about it to me because I was just like this is what's happening, so how are going to support me? Are you going to feed my child? No, you're not! So you need to create a space for me and her, or I will come in when I can. And that was just like yep, that's fine.*
>
> Emma: *When you're on a temporary contract you don't have legs to stand on anyway, because they don't have to… It was too hard, I don't want to have this guy hate me for the year because he could make my life miserable. So I just sucked it up*

Madison was able to advocate for herself without fear due to her long-standing position and extensive experience. Emma, however, had no "*legs to stand on"* due to her part-time temporary contract, and had less ability to advocate for herself. Despite her knowledge of breastfeeding legislation she said she was aware of the negative implications such demands could have (*"make my life miserable").* This finding has been a reoccurring theme across much of the research in this field (Lowe, 2016). Indeed, New Zealand's legislation requiring workplaces to provide breaks and spaces for breastfeeding mothers is positive. However, with many workplaces disregarding such policy, the usefulness of these laws is diminished for women who are in positions where advocating for their rights could lead to retribution. This is particularly true for working class women in low-skill industries, although they were not represented in this study. Emma, despite being a middle-class, university-educated woman working in an in-demand profession, still experienced this effect due to her temporary contract.

Moreover, the process and result of advocating for oneself remains an individual battle. Resistance to a lack of employer support was often constructed as an individual act. Following Emma and Madison's accounts, Emma had organised her own facilities and time to pump milk without her employer's knowledge. This put all of the responsibility and stress onto Emma and allowed her employer to continue being ignorant to the needs of breastfeeding employees. Madison suffered an unplanned financial loss by changing her work schedule, which many women would not be in the financial position to accept. When breastfeeding women have to individually fight for their rights to be recognised employers may be less likely to create structural change. In both of these scenarios the participants were in charge of working around non-regulation facilities and their employers successfully avoided responsibility. Payne and Nicholls (2010, p. 1080) argue that "such strategies serve to maintain the marginalization of breastfeeding in the workplace and keep women's efforts to continue breastfeeding invisible". In this manner, women may become complicit in the invisibilisation of breastfeeding within the workplace, and the opportunity to create change for future breastfeeding employees is diminished. However, their complicity is clearly a result of constrained options due to a lack of workplace support.

Stigma and the 'leaky' female body

Breastfeeding may face greater stigmatisation than other workplace disruptions, such as smoking, because of its private nature. Women's bodies have long been seen as a threat to public order (Woodhead, 2015). The 'leaky' female body that menstruates and lactates is viewed as polluted and may elicit disgust. This stigma is particularly strong when these processes are brought into the public realm, such as breastfeeding is (Cripe, 2009). Stigma has the ability to disrupt a person's social identity, meaning people engaging in stigmatised acts have a reason to hide their practices (Cooklin et al., 2018). In the workforce stigma associated with breastfeeding can arise from various places. The perception that mothers cannot fulfil their neoliberal duty of being an ideal worker can be enhanced by the practice of continued breastfeeding, constructed as further evidence that they are too distracted or unavailable to be a worthwhile employee.

As alluded to before, pumping breast milk involves bringing a bodily substance into the visibility of the public realm which can evoke disgust (Cripe, 2009). This echoes back to Sophie's previously explored description; "*sitting with the pump going is just the most… It's the hardest part of breastfeeding. It's quite a degrading process, you feel like a cow in milk shed".* In this case the stigma associated with breastfeeding led to Sophie feeling humiliated while pumping, despite her coworkers being outwardly

supportive. Another example of this is Emma's coworkers, who made "*gagging noises*" and said "*ew*" if they saw her milk in the staff fridge. Furthermore, she also explained her attempts to minimise her gender and breastfeeding status to her employer; "*I didn't use the word breast so I didn't freak him out".* Stigma, whether explicit or internalised, appeared to play a role in how self-assured women are with their decision to continue breastfeeding. Real or imagined negative responses from employers or colleagues compels women to hide their continued breastfeeding to protect their social position within the workplace, which further invisibilises and segregates breastfeeding women. Again, this reinforces the notion that breastfeeding women must find pockets of resistance in isolation, and the responsibility to ensure they continue breastfeeding is based on their ability to organise it themselves.

Human rights discourse: A platform for resistance?

Whilst many women were isolated in their attempt to combine employment with breastfeeding, a human rights discourse provided a powerful source of resistance. This included tales of politician's breastfeeding in the UN, new breastfeeding legislation, and recent public health campaigns which had positively influenced the participants. Employing this discourse provided participants a platform on which they could situate the issue outside of the individualisation of breastfeeding. For instance, Ellie discussed how "*it's amazing how post-Jacinda, it's made a big difference to a lot of people's perceptions over that being a possibility. Obviously, it's coming off the back of a long period of change".* Describing the current political climate as *"post-Jacinda"* suggests the gravity of change women perceive due to public examples of women's advocacy, such as in the case of New Zealand prime minister Jacinda Ardern, whose breastfeeding daughter accompanied her to the United Nations general assembly.

Madison, who has both a 13-year-old child and a toddler, emphasised this political shift through her experiences of feeding each child in different pockets of time. Here, she discusses the ease of which she could advocate for herself with her current infant;

> Madison: *This time it's been much different because I'm like 'I'm not coming in. If you don't have somewhere for me to breastfeed or pump, I'm not coming in. It's a human's right violation!'. You know, babies are in the UN now. So yeah I'm just very motivated I suppose.*

Madison drew on a human rights discourse to support her desire to breastfeed. The above excerpt demonstrates how she was able to speak with conviction to her employer, using a discourse of human rights as support. As a whole, society treats breastfeeding as an individual choice, which the participants generally reinforced. However, employing a human rights discourse provided a counter argument. It

gave the participant's an opportunity to shift their focus from an individual level to a consideration of structural barriers. Many employers still hold the power to dictate how successfully women are able to combine employment and breastfeeding. Despite this, many women have a sense of progress towards breastfeeding's acceptance, and a human rights discourse provided motivation for participants, as described by Ellie: "*I think just given where I sit politically I wanted to make a point of working and breastfeeding, and that that was doable".* It is a great positive that participants were able to position breastfeeding in a structural context, as the crux of breastfeeding inequalities and difficulties stems from wider forces than individual choices.

Chapter 5: Conclusion

This research investigated the accounts of women who were combining employment, childcare, and breastfeeding. I was interested in how societal expectations of motherhood, alongside the structural barriers introduced by workplace and ECE settings, impact women's ability to freely choose an infant feeding method. To do so, I have explored the participants constructions of breastfeeding, situating these within wider discourses of motherhood. In doing so, I have shown how these discursive constructions mapped on to the subjectivity of the 'good' mother, shaping the choices available to participants as they navigated the intersections of being both an employee and a breastfeeding mother. Foucauldian discourse analysis, the method applied to this research, allowed me to highlight how participants positioned themselves within these discourses, and how these positions limited or enabled the decisions they were able to make. This chapter begins with a summary of findings, locating these within the specific research aims of this study. The relevance of this project is considered, situating it within the existing body of research and the real-world implications of these findings. This is followed by an exploration of potential limitations and concludes with suggestions for future research in this field.

Summary of findings

This research centred around three primary goals. Firstly, I am aimed to explore the different breastfeeding constructions employed by women. Three primary discourses were identified; breastfeeding as best for the child, a natural part of motherhood, and a difficult journey. Recognising these discourses answered my second research goal; to examine the subjectivities such discourses provide. The subject position of the 'good' mother was evident across all interviews, and each discourse worked to support participant's constructions of themselves as 'good' mothers. I then considered how this subjectivity was relevant in relation to workplace and ECE settings. This allowed me to address my final aim by highlighting how women's subjectivity as a mother enabled or constrained their decisions as they participated in an ECE setting, which also incorporated workplace experiences. In this section I will attend to each of these aims in turn.

Breastfeeding was firmly constructed as the best choice for the child. Participants employed a biomedical discourse to demonstrate breastfeeding's benefits. This was achieved through emphasising the health of their own children, who were often juxtaposed with formula fed children. In this manner,

formula fed children were constructed as sickly and lacking maternal devotion. Consequently, breast milk was considered the superior choice for infant feeding, not only nutritionally but to ensure optimal psychological development. In relation to 'good' motherhood this construction worked twofold: as a show of education and morality. Women's talk of breastfeeding as the educated choice echoed neoliberal ideas of the personal responsibility for health, which allowed breastfeeding to be conflated with morality. Such constructions further located breastfeeding within the neoliberal, individualistic framework that ignores structural influences.

Evolutionary and attachment parenting paradigms informed a construction of breastfeeding as a natural, and therefore expected, part of motherhood. Both biological and psychological benefits of breastfeeding were explored within this construction. Biological benefits were emphasised by drawing on an evolutionary paradigm. This bolstered the argument of breastfeeding as natural, which had the effect of positioning formula as unnatural. The use of artificial formula was resisted through a risk conscious framework, where the 'unnatural' is synonymous with danger and uncertainty. Subsequently, women must choose breastfeeding to avoid undue risk. Participants stressed the psychological benefits of breastfeeding by drawing on attachment parenting ideals, which posits that breastfeeding is essential to the mother-infant dyad and future psychological wellbeing of the child. In this regard, breastfeeding was constructed as greater than the physical health benefits of breast milk. This discourse created a two-pronged approach, wherein breastfeeding can be advocated for both mental and physical health. This is increasingly relevant in Western society where an emphasis on healthy psychological development is becoming increasingly mainstream. Ultimately, constructing breastfeeding as a natural practice makes resistance difficult as an appeal to nature is highly persuasive (Faircloth, 2017).

Despite participants' promotion of breastfeeding as natural and instinctual, its difficulty was emphasised across all interviews. This construction focused on the emotional and physical strain that often accompanies breastfeeding. Breastfeeding was described as a draining practice, often associated with a level of physical discomfort, which women were expected to persevere through. In this sense, breastfeeding required great sacrifice and introduced many restrictions to women's behaviour and embodied experience. As a result, continuation of breastfeeding became presented as a show of maternal devotion, demonstrating the level of commitment participants had to raising their children the 'correct' way. It also revealed how the individualisation of breastfeeding is exhausting, as participants were consumed by their responsibility to continue breastfeeding despite receiving little structural support. Accordingly, breastfeeding was treated as a practice requiring grit and personal strength.

The second aim of this research project was to examine the subjectivities participant's constructed and negotiated. Western society has privileged the total motherhood discourse, which has allowed the subjectivity of the 'good' mother to become a central pursuit of women raising children (Wolf, 2010). The participants continually positioned themselves in relation to the ideal of the 'good' mother, drawing on aspects of the breastfeeding discourses explored above to demonstrate their worth as a mother. The 'good' mother identity was pervasive and meant that participants constructed their parenting as always choosing what is best for their child, using natural, attachment parenting ideals, and willingness to persevere through difficulty. Participants attempts to align with the total motherhood discourse informed their infant feeding decisions. Being the 'good' mother often meant engaging in high quantities of labour to uphold parenting ideals, despite the cost to the mother. This saw the mother's 'wants' as less paramount to the child's perceived 'needs'. Accordingly, it became difficult for women to make decisions based on their own desires as these were constructed as indicators of 'bad' mothering. The implications of such limiting beliefs had great effects for participants' experiences upon returning to work.

Finally, I aimed to investigate how the constructions and subjectivities employed by participants influenced power relations and possibilities for action. The ECE environment and workplace were chosen to examine how these constraints play out in practical settings. The pervasiveness of the 'good' mother subjectivity meant participants took part in considerable measures that allowed them to continue providing breast milk to their children. This was often done in spite of poor management, resources, and facilities. Consequently, the onus was on participants to ensure they balanced 'good' motherhood with employment, which in most cases led to stress and exhaustion. Participants engaged in a delicate dance, simultaneously managing pressure between private and public spheres, ideal worker norms, and principles of 'good' mothering. This constant tension left their status as 'good' mother vulnerable, forcing them to persist daily to maintain this position, despite the strain on their mental and physical health. In some cases, it is possible that these complications may have outweighed the benefits of breastfeeding. Yet, participants' available options, such as ceasing breastfeeding, were restricted due to expectations of 'good' motherhood. Giving up breastfeeding meant risking their position as a 'good' mother. The inescapabilty of total motherhood places pressure on mothers to conform, and the internalised and social persecution women face for failing to meet the standards it imposes thus worked to police participant's infant feeding decisions.

Research relevance

This research fits into an emerging field which challenges the taken for granted notion of 'breast is best'. Most academic literature takes a staunch pro-breastfeeding stance, with most research working to propel this narrative (Wolf, 2010). However, a small body of recent research has proposed a radical idea: breastfeeding may not necessarily be the best choice for many women (Dombrowski et al., 2018; Wilson & Wilson, 2018). This proposal is in violation to many of the parenting ideals Western society endorses and has therefore faced backlash from various communities. Despite this, there is good reason this proposition must be considered, as the exhaustive labour women feel they must invest in breastfeeding may outweigh breastfeeding's benefits. The current project contributes to this field by providing a critical investigation of breastfeeding's multifaceted nature. The accounts provided by participants are consistent with similar research which regularly finds women subscribing to the 'good' mother subjectivity regardless of the strain it introduces (de Souza, 2013; Faircloth, 2009; Marshall et al., 2007; Wolf, 2010)

In addition, recent research in this area has looked at how employment and workplace settings impact women's breastfeeding experiences, providing a critical lens on how structural barriers shape women's subjectivity as they attempt to maintain their status as 'good' mother (Dombrowski et al., 2018; Payne & Nicholls, 2010). The current project advances this field by examining how the ECE settings further influences women's experiences of infant feeding. A significant portion of New Zealand women are engaged in ECE services, yet little is known about the influence this setting presents. This is true on both a local and international scale (Dombrowski et al., 2018). There has been an increasing need to address the often forgotten ECE sector which is routinely ignored in research of this nature.

This research is unique as it worked to acknowledge the ECE setting, illuminating a new set of constraints that breastfeeding women experience. The project revealed a setting in which the public and private spheres clash, causing tensions for both parents and teachers. It showed how outsourced childcare affects participants' position as the 'good' mother, and finally, pointed to the lack of structural support available to both teachers and mothers. It is necessary to begin researching such constraints as they complement the already well-established limitations that workplace settings introduce. Understanding the relationship between these restrictions acknowledges the various ways mothers are unjustifiably held personally responsible for maintaining 'correct' child-rearing practices. Breastfeeding, and the manner in which workplaces and ECE settings influence it, is one platform that demonstrates how 'choice' in our context is merely an illusion.

Implications

The current project demonstrates how mothers cannot be held solely responsible for 'incorrect' parenting practices. This is an important step if we are to shift the narrative of mothering away from the current individualistic approach, which often leads to shame and stress. Normative parenting ideals mean women are expected to put maximum effort into child rearing, yet the level of effort needed to raise children 'correctly' is ever-increasing. Total motherhood stipulates that women need to be constantly available for their children; emotionally, physically, and financially (Wolf, 2010). The increasing popularity of attachment parenting continues to raise these standards, expecting greater investment from mothers than ever expected in the past (Wolf, 2010). Regrettably, this is combined with New Zealand's current economic climate, in which being a stay-at-home mother is a financial luxury few can afford. Therefore, many women have little chance to reach society's imposed ideas of 'good' motherhood. There is also little reason why women should strive to meet these standards, as there is a lack of evidence for most of the practices women are guilted into feeling they should perform (Wilson & Wilson, 2018). A cultural shift is needed to move away from mothers being solely responsibility for the health of their children. Without doing so, women will not be alleviated from the shame and guilt that often plagues motherhood.

Regardless of outside influence, women who decide to breastfeed should be structurally supported. Breastfeeding is culturally meaningful, is beneficial for health, is cost-effective, and, put simply, is a practice many women look forward to and wish to experience. Breastfeeding should be treated as a human right. Women should be able to make a judgement-free decision on which infant feeding method is right for them and to choose breastfeeding, if they wish to do so based on their personal circumstances and family dynamics. These decisions need to be supported, yet workplace and ECE settings in their current form constrain women's ability to choose breastfeeding. Therefore, workplace and ECE barriers need to be addressed.

There are many alternatives arrangements that could change this outlook. Certainly, flexible work hours, on-site childcare, or the ability to easily leave work for feeds are viable alternatives to pumping, yet, introducing these schemes inconveniences employers rather than employees. Women need better workplace facilities, employers should be educated on how to support breastfeeding employees, and preconceptions due to ideal worker norms need to be tackled. In the ECE setting teachers need to receive training on how to support breastfeeding mothers, which will work to ease tension between private and public spheres. ECE environments need better structural support with the introduction of

breastfeeding policies and spaces. In both settings the impact must be considered for all women, irrespective of privilege and power. Ultimately, women should no longer have to advocate for the right to breastfeed. When mothers return to employment there should be enough support that they can seamlessly integrate breastfeeding into their daily life.

A matter of reproductive justice

One of the core tenets of reproductive justice is the right to parent under optimal conditions (United Nations, 2014). This means supporting women's infant feeding practices and creating conditions that are supportive of both formula feeding and breastfeeding. Failure to support women who wish to breastfeed violates their human rights, as well as their right to parent within supportive conditions. Adopting a rights-based approach for policy could address the conditions within which mothering occurs in order to create optimal conditions for women to raise their children how they wish. Not only does failing to support breastfeeding mothers violate human rights, it also compounds social inequalities. When we consider that socially marginalised women are less likely to have conditions that support breastfeeding, we see this is an issue of social justice too (Hardison-Moody et al., 2018). Guidelines and policies should also, therefore, take a justice-oriented view on this issue.

Viewing infant feeding as a matter of reproductive justice highlights the importance of challenging current discourses and practices relating to infant feeding. Firstly, the stigma associated with visible breastfeeding should be resisted. Continuing to treat breastfeeding as a 'private' practice is not only archaic in current society, where women participate in the public sphere more than ever, but further perpetuates shame and disgust associated with breastfeeding (Chrisler, 2011). Managing stigma includes calling out the inherent sexism within breastfeeding which places considerable stress on mothers to both manage all aspects of infant feeding, and to do so privately.

Additionally, the limitations of the 'breast is best' rhetoric need to be addressed. In part, this includes demystifying breastfeeding practices, as in some cases the 'breast is best' sentiment may overstate breastfeeding's importance (Wilson & Wilson, 2018). Moreover, Western constructions of motherhood should be challenged. Viewing oneself as a competent mother should not be reserved for a privileged minority. Alternative constructions of 'good' mothering that are grounded in local realties are a necessary start to improving the wellbeing and subjectivities of mothers. Mothers often work against structural barriers when attempting to align themselves with total motherhood ideals. Rather than

being an accepted challenge, institutions should rise to provide structural support to mothers, and the government should be promoting this systemic change. These need to be inclusive of a range of infant feeding practices, and include promoting socio-cultural, systemic, and structural changes that provide women with support for caregiving. Adopting a rights-based approach highlights the significance of ensuring women are able to feed their infants how they wish.

Methodological considerations

No research project is exempt from considering methodological limitations. Initially, I attempted to recruit a diverse sample by contacting ECE centres in a variety of socio-economic areas. Due to a lack of response the advert was then placed on 'The Big Latch On', the Facebook page of a breastfeeding promotion event, which is where a majority of participants were sourced. The nature of the Facebook page likely skewed the population I was sampling from, as it is probable that women following the page have a higher engagement with breastfeeding. Indeed, it is suggested that public health promotion messages tend to be taken up by certain groups of people who have the time, resources, and education to engage with them (Garcia, 2006). A lack of diversity in women who emailed me meant all participants were white, middle-class, and predominantly tertiary educated. Women fitting such descriptions are likely to have more agency in workplace and ECE settings, which would have greatly impacted their possibilities for action (Johnson et al. (2009). Dombrowski et al. (2018), who conducted a comparable study, sampled from an area of economic deprivation. Their participants appear to have experienced more challenges than these in the present study. Future research in this field should consider prioritising a diverse sample and seeking out voices of marginalised women.

It is important to reflect on my own role in the interview and analysis process. I am not a mother and many of the participants were aware of my position as an ECE teacher. My subject positions as both childless and a teacher may have influenced the way participants related to me. Not being a mother meant I had not experienced struggles relating to breastfeeding, therefore we had less shared culture to discuss. Being a younger woman with no children meant at times participants explained aspects breastfeeding and motherhood to me that they likely would not have explained to fellow mothers, however I feel as though participants understanding of my role as an infant teacher and my topic of research mediated this. Being an ECE teacher while interviewing participants about ECE care may have positioned me as an outsider to participants knowledge base and participants could have potentially

been concerned about saying the “right” things to me about the ECE industry. Coming from seemingly opposite sides of the issue could have weakened whanaungatanga between myself and participants.

Conclusion

Breastfeeding is much more than an infant feeding decision. It operates as a performance of ‘good’ mothering, born out of the total motherhood discourse. Pressure to conform to ‘good’ mothering places a great burden on many women as they must work against structural barriers to individually uphold this subjectivity. The decision to breastfeed should be a matter of reproductive justice, and women should be free to make an infant feeding decision regardless of societal pressure or structural constraints. This research demonstrates how dominant ideologies of motherhood compel women into feeling as though they need to breastfeed to be a ‘good’ mother. In spite of this, workplace and ECE settings regularly fail women in this regard and require further consideration to provide active support. Total motherhood postulates that mothers are wholly responsible for their child’s mental and physical wellbeing. Yet, if mothers spend their time looking after their children’s needs, who are watching out for theirs? Indeed, recent regulations are a positive step, yet participants accounts reveal how policy is often not upheld. Without structural support women are left to fend for themselves, working against the realities Western neoliberalism introduces. Consequently, when this is combined with intersections of race, class, and status, most women will never achieve the Western ideal of ‘good’ motherhood. Unpacking Western societies limited scope of who is allowed to be a ‘good’ mother allows for the redefinition of mothering subjectivities. Change is needed as the normative ideals current motherhood stipulates are largely unachievable. Such dominant discourses work to serve only an elite few, while a majority of women are left to contend with shame and guilt.

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Appendix I: Letter to ECE Centres

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

To whom it may concern,

REQUESTING PERMISSION TO ACESS YOUR CLIENT BASE FOR RESEARCH PURPOSES

Kia ora, my name is Kaitlin Henderson and I am a master's student of the School of Psychology at Massey University. I would like to ask for permission to advertise my research study by placing an advert on Centre notice boards and websites. This would occur over the months of November/December/January 2018.

About the Study

The research focuses on the experiences of breastfeeding women who have children in early childhood (ECE) care, whether they discontinued or continued breastfeeding upon their child's enrolment. I would like to interview a few women from your centre who would like to participate in a one-on-one interview about their breastfeeding experiences.

Research Procedures

I would like to ask for permission to advertise my research study by placing an advert on Centre notice boards and websites

Eligible participants will be required to read an information sheet and agree to a consent form before the study commences.

Participants will take part in a one-on-one interview, approximately 1 hour in duration. These may take place at your centre if you have an appropriate, private room for interviewing. Alternatively, they can take place in participants homes.

The content of the research will focus on their breastfeeding decisions in the context of accessing ECE services.

Privacy

Any information that the participant provides will only be used for the purpose of the study and will be kept in confidence.

The participants' names will be replaced by an agreed pseudonym and all identifying information will be changed (e.g. organisation names, places etc.). Your centre will not be identifiable in the research findings.

If you wish you may request a copy of the final research project.

All research material will be stored securely. In accordance with Massey University policy, after the completion of the research the participants' information will be held for five years and then destroyed.

Yours sincerely,

Kaitlin Henderson
Email: [redacted]

Appendix II: Flyer

Research participants required for interviews investigating women's experiences of breastfeeding while accessing early childhood education services.

Interviews are one-on-one, take approximately 60 minutes, and you will be awarded a $20 voucher to thank you for your time.

You are eligible to participate if:

- You either discontinued OR continued breastfeeding upon ECE enrolment
- You currently (or within the past 3 years) have had an infant/child in ECE care

Women from all different walks of life and experiences are encouraged to apply.

For further queries contact me, or my supervisor

Kaitlin Henderson
[redacted]
Tracy Morison (Supervisor)
t.morison@massey.ac.nz

The information you provide will be used for a Massey University Master's thesis examining the experiences and choices of women who either continue or discontinue breastfeeding, upon ECE enrolment. You identity and information will remain anonymous.

MASSEY UNIVERSITY

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application SOB 18/56. If you have any concerns about the conduct of this research, please contact Dr Gerald Harrison, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83657, email humanethicsouthb@massey.ac.nz .

Appendix III: Participant Information Sheet

MASSEY UNIVERSITY
COLLEGE OF HUMANITIES
AND SOCIAL SCIENCES
TE KURA PŪKENGA TANGATA

What are the experiences of breastfeeding women who access early childhood education?

INFORMATION SHEET

Researcher(s) Introduction
My name is Kaitlin Henderson and I am a master's student at Massey University. For my master's thesis, I am exploring the experiences of breastfeeding women who access early childhood education (ECE) services. This project will look at the varied experiences of women who make decisions around breastfeeding, when their infant is in early childhood education, with the aim of exploring the choices available to women and how they discuss these. If you are interested in this topic, and fit the criteria, I would like to invite you to participate in my research.

Participant Identification and Recruitment
Women currently accessing ECE services are invited to participate, whether they continued or discontinued breastfeeding in this setting. Participants will be rewarded with a $20 voucher as compensation for their time. There is minimal risk for participating, however breastfeeding may be a sensitive topic of discussion for some.

Project Procedures
Participation in this project will mean taking part in an hour-long interview, where you will be asked about your breastfeeding history, your experience of breastfeeding while your child was in ECE care, and any other relevant experiences or stories you wish to share. Interviews can take place at a time and/or location that is suitable to us both.

Data Management
All collected data will be used solely for this project, and will be stored securely on a password protected computer and deleted after five years. Your identity will be known only to the researcher, and interview recordings will be transcribed by the researcher to uphold your confidentiality of identity and deleted once transcribed.

Participant's Rights
You are under no obligation to accept this invitation. If you decide to participate, you have the right to decline to answer any particular question, and can withdraw from the study at any point during the interview, or withdraw your data up to one month post-interview. You may ask any questions about the study at any time during

participation, and can ask for the voice recorder to be turned off at any time during the interview. Your name will not be used unless you give permission to the researcher, and you have the right to a summary of findings when the project is concluded.

Risks/discomfort

I expect there to be minimal risk associated with participation in the study, but you will be required to talk about issues that you might find to be personal and sensitive in nature. If a question makes you feel upset, you do not have to answer it.

All identifying information will be removed from the final project and your data will be kept anonymous. However, there is a risk you may be identified by those who could recognize aspects of your story.

You may contact me at any time following the interview if there are any issues they would like to discuss.

This research will involve discussing your experiences of breastfeeding. We recognize this may be a sensitive topic due to its intimate nature, therefore if you decide to participate we welcome you to contact a support service should the need arise.
La Leche League
Text: 020 4116 9994

Benefits
You may find it beneficial to talk about your experiences with someone who is nonjudgmental and there to listen; to read the findings, and learn of others' experiences; and to engage in reflective thinking about your breastfeeding practices.

Project Contacts
Please let me know if you are interested in taking part in this research. Feel free to contact me and/or my supervisor if you have any queries about the project.

Researcher contact:
Kaitlin Henderson
Email: [redacted]

Supervisor Contact
Tracy Morison
Email: T.Morison@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application SOB 18/56. If you have any concerns about the conduct of this research, please contact Dr Gerald Harrison, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83657, email humanethicsouthb@massey.ac.nz .

Appendix IV: Interview Guide

Background

Woman's age:

Woman's ethnicity:

Child's ethnicity:

If older siblings, were they breastfed?

Age of infant when started in ECE:

Child's age now:

Questions

1. Breastfeeding history
2. Any difficulties?
3. Full or partial? Reason for change to partial? Have you continued or discontinued since starting ECE?
4. Demand or time scheduled feeding? How does this fit in with infant and staff at centre? Difficulties for you?
5. If you express milk and leave it in bottles or containers, how has this worked for you? Issues?
6. What are (or were) your reasons for breastfeeding? How valuable is breastfeeding to you?
7. How does breastfeeding relate to your culture, spirituality, or philosophy?
8. If discontinued – why and when? How did you make this decision? (Partner involvement? Joint decision with ECE staff?). Did you feel happy with this choice?
9. How have you found or managed combining breastfeeding and employment or other commitments? Or, what were the challenges for you and your infant in maintaining breastfeeding when you started in ECE?
10. If you breastfeed at the centre, what are your thoughts and feelings as you feed (on: baby, centre, staff, environment, others opinions of your feeding?)
11. How has the centre and the staff supported you and your infant to continue with breastfeeding? Staff support? Support of other parents? Facilities? Policies?
12. What do you think the centres views of breastfeeding are?
13. What would make the continuation of breastfeeding easier for you at the centre?
14. In what ways might the support provided by the centre differ from your own cultural or family values, spirituality or philosophies?
15. What do you think might shape other's women's decisions to (or not) breastfeed or provide expressed milk?
16. Anything else I've missed?