# 'DOING WHAT'S BEST AT THE TIME':

# FIRST-TIME MOTHERS LEARNING TO BREASTFEED AWAY FROM HOME.

## A GROUNDED THEORY STUDY

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# ABSTRACT

In order to explore what was happening for nine first-time mothers, as they breastfed away from home, the study was carried out when the mothers were still breastfeeding at between six and twelve weeks following the birth of their infants. Grounded theory methodology underpinned the way in which the data were collected, analysed and presented. Semi-structured interviews were used to provide the participants with an opportunity to talk about the reality, for them, of breastfeeding away from their own home environment.

Emerging from the data was a picture of mothers learning to breastfeed, acknowledging that they needed to feel confident with their breastfeeding. As a result they remained in the privacy of their home in the early days and weeks after birth, limiting their social interaction while they gained confidence with breastfeeding. When the mothers felt more confident they moved out of the home into many different social situations, while integrating breastfeeding into their daily lives. The mothers gained a sense of achievement by learning to meet challenges of social interaction, giving them increased confidence as new mothers and encouragement to continue breastfeeding.

If the mothers did not feel confident or comfortable breastfeeding in certain social situations, they planned to avoid them by working around breastfeeding at home. When situations arose away from home in which they did not feel comfortable breastfeeding, they chose to postpone breastfeeding or to withdraw to privacy to enable breastfeeding to continue. The mothers read each situation as it unfolded and chose actions which were indicative of protecting themselves and others from discomfort or embarrassment.

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# CHAPTER ONE

# BREASTFEEDING: A GLOBAL HEALTH ISSUE

**In the beginning was the breast. For all but a fraction of human history there was no substitute for mother's milk. Indeed until the end of the nineteenth century, when pasteurization made animal milk safe, a maternal breast meant life or death for every newborn babe (Yalom, 1997, p.9).**

## Introduction

This study explores the reality of breastfeeding away from home for nine first-time mothers. The mothers were interviewed at six weeks and approximately twelve weeks following the birth of their infant. Breastmilk was the source of nutrition for all the infants up until, during and beyond the period of the study. The milk secreted by the breast following birth is a natural source of nutrition for the newborn infant and can be accessible for as long as the mother chooses to continue to breastfeed. The decision to breastfeed an infant is not necessarily a guarantee of successful breastfeeding. It is merely an acknowledgement that breastfeeding is a biological possibility, especially for a woman who has just given birth.

Breastfeeding has been recognised as an ideal way of promoting the health and development of the infant while also contributing to the health and well-being of the mother. It is therefore an important global health issue endorsed by the World Health Organisation (WHO) as the preferred method of infant feeding(WHO/UNICEF, 1989,1990). Some of the health benefits of breastfeeding which have been identified for mothers are: perceived better physical health with fewer allergies (Reamer & Sugarman, 1987); and development of psychological closeness in the special infant - mother nursing relationship (Lawrence, 1989). Some health benefits for the infant are: a decreased incidence of gastro-intestinal tract infections and respiratory infections (Howie, Forsyth,

Ogston, Clark & Florey, 1990; Fergusson, Horwood, Shannon, & Taylor, 1981); protection against ear infections (Duncan, Ey, Holberg, Wright, Martinez & Taussig, 1993; Cunningham, Jeliffe and Jeliffe, 1991); optimal mental development (Uauy & De Andraca, 1995); and lowered risk of cot death (Mitchell, Taylor, Ford, Stewart, Becroft, Thompson, Scragg, Hassall, Barry, Allen, & Roberts, 1992).

This chapter begins by providing an overview of the prevalence of breastfeeding globally and nationally, while placing breastfeeding in its historical, social-political and health promotion contexts. As breastfeeding is integrated into a mother's daily life, it inevitably takes place within a context of diverse societal values, attitudes and beliefs about breastfeeding. The role of health professionals in supporting breastfeeding mothers and the newness of motherhood will be discussed. The chapter concludes by outlining the research methodology, the aims of the study and providing the chapter divisions of the thesis.

## Breastfeeding trends

Figures from the Global Data Bank on Breastfeeding based on "58% of the world's total infant population" suggest that "35% per cent of the world's infants under the age of four months of age are exclusively breastfed" with an " estimated global median duration of eighteen months" (Saadeh, 1997, p. 122, 123). The assumption is that if so many infants are not being breastfed, then the alternative is infant feeding using formula. The manufacture of formula is an attempt at replicating the nutritional value of breastmilk. Formula costs money, which is of particular concern in developing countries where many mothers cannot afford to buy sufficient formula to adequately prepare it to its required nutritional content. Add to this situation, the use of contaminated water in the preparation of the formula and cleaning of feeding utensils, and the result is deaths from malnutrition and infectious diseases.

In 1974, the Twenty-seventh World Health Organisation Assembly drew attention to the decline in breastfeeding throughout the world, attributing the decline to the marketing of breastmilk substitutes and other socio-cultural factors. In 1981, the Thirty-fourth World Health Organisation Assembly, recognising the need to address the growth in the

marketing of infant formula, adopted the International Code of Marketing of Breastmilk Substitutes. In an introductory statement to the Assembly, Dr Torbjorn Mork, representative of the Executive Board, said:

> We are not today dealing with an economic issue of particular importance only to one or a few Member States. We are dealing with a health issue of essential importance to all Member States, and particularly to developing countries, and of importance to the children of the world and thus to all future generations (WHO, 1981, p.36).

In New Zealand, as with international trends, breastfeeding went into a decline in the 1950s and 1960s. Apple (1994) credits Roberton (1963) with making links between childbirth moving from small maternity hospitals to large hospitals and the increased popularity of bottle-feeding. The Royal New Zealand Plunket Society Inc.(originally known as The Society for Promoting the Health of Women and Children), was founded in 1907 in Dunedin by Frederick Truby King "and a committee of wives and mothers of the affluent and influential citizens of Dunedin" (Ryan, 1998, p.55). Plunket Society nurses visit over 90 per cent of the infants born in New Zealand during the first weeks following birth. The Society has been collecting data on breastfeeding since 1924 so are able to give a comprehensive picture of the incidence and duration of breastfeeding in New Zealand (Infant and Nutrition Advisory Group, 2000, p. 5). Recognising that the term 'breastfeeding' was too general when used to determine breastfeeding prevalence and duration, the Plunket Society adopted Labbok & Krasovec's definitions of 'exclusive', 'full', 'high', 'medium', 'low' breastfeeding and 'artificial feeding' (Labbok & Krasovec, 1989, as cited in Infant Nutrition Advisory Group, March, 2000, p.5).

In 1994, when specified health outcome targets were set to enable the strategic direction for public health to be monitored, targets for breastfeeding were:

> To increase full breastfeeding at three months from 60 per cent (1991) to 70 per cent by 1997 and 75 per cent by the year 2000.

> To increase breastfeeding (full or partial) at six months from 55 per cent (1991) to 70 per cent by 1997, and, 75 per cent by the year 2000 (Public Health Commission, 1994b)

The Ministry of Health (1997), in assessing the progress of these targets and finding "little change in prevalence of full breastfeeding at three months" and "no significant change in full or partial breastfeeding at six months" (p.53) suggested that the target for three months may have been set at too high a level because of using erroneous baseline data. Targets were to be completely reviewed in 1997. The Ministry of Health pointed out that,

> An increased awareness of the importance of exclusive and predominant breastfeeding on the part of both health professionals and the general public should have a positive effect on increasing the rates of breastfeeding. Although programmes targeted at new mothers are critical, a breastfeeding culture and supportive partner, family and workplace are also important" (p. 55).

The Plunket Society report that "today 80% of infants are being breastfed at six weeks, 70% at eleven to fifteen weeks and 60% at four to six months" (Infant Nutrition Advisory Group, 2000, p.5). Angela Baldwin, Plunket's National Nursing Advisor pointed out that " there is little room for complacency as social forces still strongly influence the prevalence and duration of breastfeeding" (as cited in Infant Nutrition Advisory Group, 2000, p. 5).

## The promotion of breastfeeding

In 1989, the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF) issued a joint statement entitled, "Protecting, Promoting and Supporting Breastfeeding" (WHO/UNICEF,1989). This statement was aimed at raising awareness of the important role of the health services in supporting breastfeeding mothers. In 1990, by means of the Innocenti Declaration, the WHO/UNICEF called upon governments to enact the "Ten Steps to Successful Breastfeeding". This declaration

supported the idea that women should be enabled to practice exclusive breastfeeding for the first four to six months of the infant's life.

In 1991, the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF) further promoted breastfeeding by launching the Baby-Friendly Hospital Initiative. This initiative is intended to encourage health professionals associated with maternity wards and hospitals worldwide to practice the 'Ten Steps To Successful Breastfeeding' (WHO,1990). The principles underpinning these ten steps are that:

> Mothers should be counselled correctly, and enabled to make and carry through informed choices.
>
> Mother-infant contact should be unrestricted.
>
> Infants should be fed whenever they indicate a desire to feed.
>
> Newborns usually require no food or fluid other than breastmilk, not even water.
>
> Mothers should be supported during the postnatal period. (Saadeh and Akre, 1996, p.154).

In New Zealand, progress is being made toward establishment of the Baby-Friendly Hospitals Initiative (BFHI) by way of a funding contract held by the New Zealand Breastfeeding Authority (NZBA). Initial workshops will be run to train assessors to enable BFHI to be in place in all of the maternity facilities around the country (New Zealand Breastfeeding Authority Newsletter, March, 2000).

## The role of health professionals

Since breastfeeding is likely to be initiated in a maternity hospital where the majority of mothers, in New Zealand, deliver their infants, health professionals would be

influential in the breastfeeding experience. Antenatally and postnatally, opportunities exist to support the mother in making decisions about breastfeeding. Mothers can be supported in the initiation and establishment phases of breastfeeding. They may also be advised about factors or situations which may influence early management and long-term maintenance of breastfeeding. Numerous studies show that continuance of breastfeeding is influenced by many factors, for example, physical, psychosocial, economic and cultural (West, 1980; Houston, Howie, Smart, McArdle & McNeilly, 1983; Walker & Walker, 1983; Ekwo, Dusdieker, Booth & Seals, 1984; Hally et al, 1984; Loughlin, Clapp-Channing, Gehlbach,, Pollard & McCutchen, 1985; Kearney, 1988; Davies, 1989; Rentschler, 1991; McNatt and Freston, 1992; Bergh, 1993; Salt, Law, Bull & Osmond, 1994; Janke, 1994; Hills- Bonczyk et al., 1994; Quarles, Williams, Hoyle, Brimeyer & Williams, 1994; Essex, Smale & Geddis, 1995; Lothian, 1995; Humenick, Hill & Wilhelm, 1997).

Birkbeck (1996) proposes that a range of health professionals who advise mothers,

> need to be very well-informed about the nature and promotion of breast-feeding, and [have] a commitment to assist women in making it work. We must then provide a social and economic environment in which women feel that the provision of breast-milk is valued by all around them, not just the infant (p.34).

If "making it work", as Birbeck (1996) points out, depends on a range of health professionals being "committed to assist" the mother, then commitment extending beyond the first few days and weeks following birth is essential (p.34). The practice of mothers leaving hospital within twenty-four to forty-eight hours of giving birth has taken place since the 1970s in New Zealand, but was not officially acknowledged as a choice for women until 1982 (Kilgour, 1990). Early discharge is seen by Donley (1990) as a positive practice which "contributes to the establishment of long term breastfeeding" (p.iii). Follow-up and support from an appropriate health professional is, nevertheless, essential at this critical time if ongoing breastfeeding is to be achieved by the mother and infant. The time following the birth of a first baby may be a time of great

vulnerability for the new mother. The newness of the life experiences of birth and breastfeeding can be overwhelming, not only for the mother, but also for other members of her family. The process of breastfeeding is situated alongside that of adapting to motherhood and needing to recuperate physically and emotionally from the birth.

## The new mother

Becoming a mother and breastfeeding are new social positions or roles for first-time mothers. 'Role' is defined by Banton (1996, p.749) as "the expected behaviour associated with a social position". Horton and Hunt (1980) state that,

> The concept of role implies a set of expectations, both of one's own behaviour and of the reciprocal behaviour by other people in the situation. Whether a new role is taken on a pretend basis or as a genuine result of acquiring a new status, the person is forced to analyze the attitudes and behaviour of himself and those about him (p.106)... Successful role performance often requires competence in a number of related behaviours (p.108).

The mother and her infant are in a dyadic relationship during breastfeeding. It is in this relationship that the new mother moves out of her own home and into the public arena to carry on with activities of daily living. She begins to blend her 'old world' with her 'new world' of motherhood in a context of social interaction. Oakley (1979) in her book, 'Becoming a Mother', describes this life event:

> Motherhood is like a new recipe - or like a new job; it takes some time to get used to it. Having a baby turns a woman into a biological mother, but she only becomes a mother in the social sense when she begins to care for the child, when she is seen by other people to be a mother - and when she thinks of herself as a mother. Taking on this occupational identity does have parallels with other jobs...But it is crucially different in one way, for mothers are what women are supposed to be (p.249).

Being a mother implies a caring relationship between two or more people. For a new mother, the caring relationship is between herself and the new infant, who is dependent on others for nutritional, health, safety and emotional needs. Either prior to or soon after the birth of her infant, the mother needs to decide how she will nourish her infant. The decision that the mother makes at this time, to either breastfeed or not, will become a topic of interest for those people with whom she comes in contact in the ensuing weeks and months. Nutrition is an essential requirement for growth and development of the infant and as such becomes a concern of the mother, her family and the health professionals.

## The breast, breastfeeding and society

By choosing to breastfeed, the first-time mother subjects herself to the diversity of societal and personal beliefs, values and attitudes about motherhood, breasts and breastfeeding. Yalom (1997) in her book, 'A History of the Breast' points out that throughout history, the breast has been conceptualised in many different ways and that this has changed the way in which the breast has been viewed and symbolised by Western society. She states that, " Underlying this progression is a basic question: Who owns the breast?" (p.3).

In today's society the breast is subject to cultural, moral, religious and economic forces which have the potential to influence the way in which breastfeeding is viewed. Yalom (1997) proposes that,

> These sacred and sexual aspects represent two different tugs at the breast. The mandate to nurse and the mandate to titillate are competing claims that continue to shape women's fate. Since the beginning of the Judeo-Christian era, churchmen and secular males, not to mention babies, have considered the breast their property, to be disposed of with or without women's consent (p.5).

Signifying various perspectives on the breast, Yalom uses chapter heading descriptors such as 'sacred', 'erotic', 'domestic', 'political', 'psychological', 'commercialized',

'medical' and 'liberated' (Yalom, 1997). With this range of perspectives on the breast, a mother who chooses to breastfeed within a context of social interaction, sets out on a journey that is potentially a complex one. McConville (1994) suggests that, "... perhaps, more than in any other arena, it is in breastfeeding that women experience their breasts as a battleground" (p.9).

## Research focus and methodology used

For this research study, while recognising the many perspectives on the breast, historically and in the present day, I make the assumption that the breast belongs in the context of a mother nurturing her infant. This is the natural function of the mammary glands known as the breasts. In this context, the breastfeeding mother very quickly becomes aware of the infant's dependence on her physically for nutrition. Yet, in modern society, an infant would not be deprived of nutrition if breastfeeding was not possible. For many mothers, breastfeeding may be a time of pleasure and satisfaction. It may be a time of validation that breastfeeding is the right thing to do. For other mothers it may be a time of frustration and dissatisfaction if they feel that they have had to wean their infant too early or have 'failed' in the process of breastfeeding (Fahy & Holschier, 1988; Lowe, 1994).

Breastfeeding is usually initiated shortly after birth and becomes established within the context of health professional support either at home or in a maternity ward. In this study, I was interested in finding out what was happening for new mothers in the weeks after they left maternity wards, as they went about their daily lives while breastfeeding a new infant. First-time mothers were chosen for the study so that the newness of motherhood and breastfeeding could be acknowledged as significant events in their lives.

## The aims of the study were:

(1) to explore with first-time mothers what happens when they have to breastfeed their infants away from their own home environment

(2) to find out how this situation impacts on their breastfeeding experience

Grounded theory was chosen as an appropriate methodology to explore qualitatively what was happening for mothers as they breastfed away from home.

## The structure of the thesis

The thesis is presented in **nine** chapters.

**Chapters One to Four** present the context and methodological issues relevant to the study:

**Chapter One** presents the historical and social-political context of the study with particular reference to breastfeeding as a global health issue, specifies grounded theory as the chosen methodology and sets out the aims of the study.

**Chapter Two** presents an overview of the methodology of grounded theory. Its usefulness and relevance in researching nursing and midwifery situations is described.

**Chapter Three** presents an outline and critique of literature which was reviewed prior to commencement of the study, in keeping with the methodological perspective on the use of literature.

**Chapter Four** addresses ethical issues of research by describing: Protection of privacy and maintenance of confidentiality for the mothers as participants in the study; the methods used to access the participants and to obtain informed consent. The methods used to analyse the data are described.

**Chapters Five to Eight** present the findings in detail.

**Chapter Nine** presents and explains the basic social process (BSP) which was taking place for the first-time mothers as they breastfed away from home. The study concludes with a discussion of the limitations and implications of the study for practice, research and education.

# CHAPTER TWO

# METHODOLOGY

## Introduction

In this chapter, grounded theory methodology, which was chosen as an appropriate research approach for this study, will be explained. The theoretical roots of the methodology, its original and later uses, together with its specific processes of data collection and analysis, will be outlined. The methods used in this study to access the mothers as participants, collect and analyse the data will be described in Chapter Four.

## Background to the methodology

The qualitative nature of the methodology and its relationship to the context of social interaction, underpinned my decision to use this research approach to answer the question of what was happening for first-time mothers as they breastfed their infants away from home. The development of this methodology and its processes of collecting and analysing qualitative data, are attributed to two sociologists, Barney Glaser and Anselm Strauss, who worked at the Chicago School of Sociology. In the 1960s, they explored the phenomenon of dying, publishing their book, 'Awareness of Dying' in 1965. They published their methodology in a book, entitled, 'The Discovery of Grounded Theory' in 1967, followed by the publication of 'Time for Dying' in 1968 (Glaser and Strauss, 1967; Glaser, 1992).

After developing their methodology, Glaser and Strauss joined the nursing programme at the University of California, San Francisco. They introduced their methodology to students of nursing, for example, Jeanne Quint Benoliel, who was the first nurse researcher to work collaboratively and individually using grounded theory methodology. She published her book , 'The Nurse and the Dying Patient' in 1967. Other students who have studied with Glaser and Strauss have explored phenomena such as 'the politics

of pain management' (Fagerhaugh & Strauss,1977); and 'affiliation in stepfathers' (Stern, 1978).

In 1992, Barney Glaser published a book, entitled 'Emergence versus Forcing: Basics of Grounded Theory Analysis'. In this book, he included letters which he had written to Anselm Strauss, the co-originator of grounded theory methodology, asking him to withdraw a book he had co-published with Juliet Corbin in 1990. Glaser (1992) wrote to Strauss that the book, 'Basic Qualitative Research,' "misconceives our conceptions on grounded theory ... and ... you implied ... my complete endorsement of these misconceptions" (p.1). Glaser believed that categories should be allowed to emerge rather than be forced from the data. He believed that if the researcher could be patient and trust that emergence would occur, then it would happen. This was an area where Glaser could see contradictions to the original methodology in the way Strauss and Corbin (1990) described the methodology in their book.

Stern (1994), who acknowledges that she is "a strict Glaserian", points out that while Strauss and Glaser offer "fundamentally different methods", it is hoped that "readers of *Basics of Grounded Theory Analysis* (Glaser, 1992) can see ... the clear exposition of the original grounded theory method of allowing theory to emerge" (p.221). While taking account of the groundwork carried out on development of this methodology by both Glaser and Strauss and other researchers who have used it since, I have tended to follow Glaser's ideas on 'emergence' while working through the research process.

Glaser and Strauss (1967) propose that grounded theory methodology is appropriate to the study of situations where little is known about a phenomenon and seeks to answer the question, 'what is happening here?' It derives its name from its emphasis on generating theory which is grounded in the data (Glaser, 1978). The methodology has its roots in the sociological theory of symbolic interactionism attributed to a philosopher and social psychologist, George Herbert Mead (1861-1931).

In his work, Mead (1934) elaborated on the ideas of Charles Horton Cooley (1864-1929), who asserted that the self is basically a 'social product'. The central concept of

Cooley's (1902) theory is the 'looking glass self' with society being 'the looking glass', a mirror which reflects others attitudes toward us, enabling us to evaluate ourselves and our actions and subsequently repeat or change our behaviour. This idea rests on the premise that in order to have 'self' there needs to be society to provide a self-image, that is, where there is 'I' then, correspondingly, there needs to be a 'they' (Cooley, 1909, as cited in Robertson, 1987, p. 122). It is through interpretation of what we see in the image that we come to learn our identity. There is possibility for misinterpretation of what we see in the image leading to "unrealistically high or low self concepts as a result" (Cooley, 1909, as cited in Robertson, 1987, p. 122).

Following on from Cooley's (1902) work, Mead (1934) introduced the concept of symbolic interaction, the interaction that takes place between people through the use of symbols such as spoken language, gestures or facial expressions. Mead maintained that:

> The self can only arise where there is a social process within which this self has had its initiation ... the individual is in a social process in which he is a part where he does influence himself as he does others. There the self arises. And there he turns back upon hims[e]lf, directs himself. He takes over those experiences which belong to his own organism. He identifies them with himself. What constitutes the particular structure of his experience is what we call his "thought". It is the conversation which goes on within self ... is what constitutes his mind ... it is through this so-called "thought" that he interprets his experiences ... that thought is only the importation of outer conversation, conversation of gestures with others, into the self in which the individual takes the role of others as well as his own role. He talks to himself. This talking is significant. He is indicating what is important in the situation. He is indicating those elements that call out the necessary responses (Mead, 1934/1972, p. 42).

Herbert Blumer (1969), a scholar of George Herbert Mead (1861-1931) at the University of Chicago, describes three premises on which symbolic interactionism rests. These are:

> [1] ... that human beings act toward things on the basis of the meanings that the things have for them ...
>
> [2] the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows...
>
> [3] these meanings are handled in, and modified through an interpretive process used by the person in dealing with the things he [or she] encounters (p.2).

Mothers breastfeed away from home in social settings within a context of social interaction. The theoretical underpinning of symbolic interactionism in the methodology of grounded theory therefore also underpins this study. It is the mothers' interpretation of the meaning of their social interactions and subsequent actions that provide the information for analysis in this study.

## Grounded theory and nursing research

When a topic of research is being considered, the appropriateness of the methodology used may be influenced by personal philosophy about research methodology in general. However, choice of methodology needs to focus on an appropriate way to find out about the phenomenon of interest. Munhall (1993), in seeking to address "epistemological interests", the ways in which nurses seek to increase their knowledge about the concerns of their clients, asks the question, "What is it we want to know about?" (p.49). The professions of nursing and midwifery seek to expand knowledge for their wide-ranging practice in order to improve situations and practices and promote optimum health care for their patients or clients. The use of any one of a variety of research methodologies may be appropriate to answer the questions of practice.

Professional caring with its underpinning philosophy of health promotion takes place within a context of social interaction. Grounded theory, with its roots in the theory of symbolic interactionism, is one methodology which nurses and midwives have used to obtain a greater understanding of events which have significance in the human-to-human

interaction of caring practice (Stern, 1985; Chenitz & Swanson, 1986; Hutchinson, 1986; Christensen, 1990; Euswas, 1991; Lawler, 1991; Gamble and Morse, 1993). Chenitz & Swanson (1986) link the theory of symbolic interactionism to the research method by stating that,

> Symbolic interaction focuses on the meaning of events to people in natural or everyday settings and is therefore akin to the school of *phenomenology*. Both phenomenology and symbolic interaction are concerned with the study of the inner or "experiential" aspects of human behaviour, that is, how people define events or reality and how they act in relation to their beliefs (p.4).

Baker, Wuest & Stern (1992) caution against 'method slurring' when using these two distinct methodologies in the context of qualitative research methodologies. While each has different intellectual roots, that is, phenomenology is rooted in philosophy and grounded theory in the theory of symbolic interactionism, each also has distinct differences in the way information from participants is collected and analysed. Stern (1994) asserts that:

> Grounded theory is but one of the interpretive methods that share the common philosophy of phenomenology - that is, methods that are used to describe the world of the person or persons under study. The desired end product determines the method used (p.213).

The language to describe the grounded theory methodology is reflective of its time of writing when Glaser and Strauss (1967) sought to challenge the work of quantitative sociologists. Keddy, Sims & Stern (1996) believe that in order to distinguish this methodology from other qualitative methods the language of grounded theory, which they propose "sounds static and linear", should be used as originally written and remain "stable and separate", even though it may seem confusing to the researcher who is new to the methodology (p.450). Keddy et al. advocate for the process of 'constant comparative analysis' saying that this term "needs to be emphasized, because it captures

the essence of the method" (p.450)

## Grounded theory as a qualitative research approach

Grounded theory methodology is considered to be an inductive qualitative research approach. The processes used to gather and analyse the data attempt to keep the emerging theory 'grounded' in what the participants are telling the researcher. The inductive nature of the research approach allows the theory to emerge from the information given by the participants without forcing it to fit other theories (Glaser,1992). It is this attempt to tell 'their story' faithfully which underpins the qualitative nature of the methodology.

### Sources of data

Data may be collected from a combination of sources such as interviews, participant observation, literature sources, diaries, newspapers or historial documents. The information gathered during interviews or observations is written down, analysed, and presented in non-numerical form in a research report. Interviews enable the researcher to understand the meaning of the situation or phenomenon from the participants' perspective through use of their own words. Lofland (1971) describes this process as "a flexible strategy of *discovery*" giving the "unstructured interview" as an example, saying:

> Its object is not to elicit choices between alternative answers to pre-formed questions, but, rather, to elicit from the interviewee what he [or she] considers to be important questions relative to a given topic, his descriptions of some situation being explored. Its object is to carry on a guided conversation and to elicit rich, detailed materials that can be used in qualitative analysis. Its object is to find out what kinds of things are happening, rather than to determine the frequency of predetermined kinds of things that the researcher already believes can happen (p.76).

The spoken language has the potential to give meaning to the reality of the participants. Keddy et al. (1996) propose that, "In league with feminist research approach, grounded

theory allows for the voices of the participants to be heard as they tell their story" (p.450). When interviews are audiotaped, quotes from the transcripts can be integrated into the grounded theory report, providing support to the emerging theory. Wuest (1995) says that by doing this, "the power of this knowledge is attributed directly to the participants" (p.133).

## Specific features of the grounded theory methodology:-

The aim of the methodology is to generate theory, the basis of which is the discovery of a core category or basic social process (BSP). Basic social processes (BSPs) provide a picture of the social processes that occur over time irrespective of varying conditions. Bigus, Hadden and Glaser (1979/1994) point out that the idea of a basic social process "was conceived *in the process of doing* grounded theory research" (p.38). Glaser (1978) emphasises that in order for a core category to be also characterised as a basic social process, it needs to have "at least two stages...Process is a way of grouping together two sequencing parts to a phenomenon. Processing refers to getting something done which takes time or something happening over time" (pp. 74-75). Benoliel (1983) suggests that theory which is generated using this methodology provides a way of "conceptualizing the interacting influences of personal characteristics, social processes, and cultural circumstances as they bear on the adaptation of individuals and groups to crisis and change" (p.184). In order to to achieve the aim of grounded theory methodology of discovering a basic social process (BSP), the following features or processes, which are recognised as being specific to this methodology, are used.

### (1) Open coding

Open coding is the first type of coding or initial coding in the analysis process. Each transcript of an interview is read and analysed, line by line. "What category or property of a category does this incident indicate?" is the question that should be constantly asked of the data (Glaser, 1992, p.39). Open coding should take place without imposing pre-conceived theoretical codes too early in the analysis. Glaser (1978) uses the term, "running the data open" to describe the way in which the data are coded "in everyway possible" (p.56). Glaser (1992) says that "the mandate of open coding is the analyst starts with conceptual nothing - no concepts. Open coding comes to an end when it

yields a core category" (p.39).

**(2) Memoing**

Writing memos is a critical part of this research process - just as one would write a memo when an idea came into one's head, the process is similar and can take any form of writing - it does not have to be formal in the same way as the report writing is formal. Memos are for the use of the analyst and are not evaluated in the overall theory. Memo-writing should begin when the first interview is being coded - this is when ideas begin to occur and need to be written down for future sorting and integration into the writing up of the theory. Ideally, memos should be dated, referenced to the page of the relevant transcript and filed in a safe place for future reference. Glaser (1978) suggests that it is useful to carry around a notebook in which to jot down ideas as they occur. These can be developed into memos if necessary at a later more convenient time.

**(3) Constant comparative analysis**

The grounded theory methodology uses a method of 'constant comparative analysis' to further develop categories emerging from the open coding. This means that the information obtained from one mother is compared with information obtained from each other mother in the study as it proceeds. This procedure is ongoing throughout the data collection and analysis hence the name given to it. Constant comparative analysis prompts the collection of further data through a process of 'theoretical sampling' (Glaser, 1978).

**(4) Theoretical sampling**

Further data collection is guided by the categories emerging from the first or open coding - "They tell you what to focus on in your next interview and where you might go to find instances of the phenomenon to which the category refers" (Strauss and Corbin, 1990, p.73). The process of 'theoretical sampling' is used to select participants who are representative of the data, that is, in this study, the participants' experience of breastfeeding away from home, rather than for age, geographical location or race (Glaser, 1978; Sandelowski, 1986). Glaser (1978) cautions against confusing theoretical sampling with Schatzman's (1973) idea of 'selective sampling', a method used in

qualitative research analysis. Glaser (1978) states that:

> Selective sampling refers to the calculated decision to sample a specific locale according to a preconceived but "reasonable" initial set of dimensions, (such as time, space, identity or power) which are worked out in advance of the study. The analyst who uses theoretical sampling cannot know in advance precisely what to sample for and where it will lead him ... It is never clear cut for what and to where discovery will lead. It is ongoing (p.37).

It is in describing the process of theoretical sampling that Glaser (1978) stresses the inductive nature of the grounded theory methodology, yet concedes that deductive logic is also used but that it:

> is in the service of further induction and the *source* of derivations are the codes generated from comparing data, *not* deductions from pre-existing theories in the extant literature ... the focus of deduction is on more comparisons for discovery, not on deriving an hypothesis for verification (though this may occur as a byproduct) (p.38).

**(5) Saturation of the data**

When there is no new information coming from the data, this is termed 'saturation' of the data and is usually the point when data collection can be drawn to a close. By this time, one or two core categories may have emerged which indicate the basic social process (BSP). Glaser (1992) advocates for achievement of "a theory that fully accounts for variations in the data" and cautions against "premature cessation of coding and analyzing all the data" because of the speed with which grounded theory can emerge (p.20).

**(6) Evaluation of the theory**

Stern (1983) states that, "If you grasp the *truth* in your analysis of the data, your participants reward you with a physical response to your findings: they react with a start or a gasp" (p.151). The mothers participating in this study should recognise in the theory what was happening for them as they breastfed away from home as first-time mothers. This is what Glaser refers to as 'grab' in relation to the theory.

The criteria by which Glaser (1992) evaluates "a well constructed grounded theory" are "fit, work, relevance and modifiability" (p.15). He states that:

> If a grounded theory is carefully induced from the substantive area its categories and their properties will fit the realities under study in the eyes of subjects, practitioners and researchers in the area. If a grounded theory works it will explain the major variations in behaviour in the area with respect to the processing of the main concerns of the subjects. If it fits and works, relevance has been achieved. The theory itself ... should be readily modifiable when new data present variations in emergent properties and categories (p.15).

Glaser (1992) also asserts that grounded theory "meets the two prime criteria of good scientific inducted theory: parsimony and scope. It accounts for as much variation in behaviour in the action scene with as few categories and properties as possible" (p.18). Evaluation of a grounded theory can also be achieved through careful description of the processes used to arrive at the core category or basic social process. Description should include an indication of how the participants were accessed, continuing through the processes used in analysing the data to the identification of a basic social process. These processes will be outlined and explained in Chapter Four.

## The use of literature in grounded theory

Glaser (1992) claims that, since grounded theory is an inductive research methodology, a traditional review of the literature in "the substantive area of study as carried out, for example, in hypothesis testing or verificational studies, is not necessary" (p.31). Rather than advocating for non-use of literature, Glaser (1992) cautions that literature reviewed

at the beginning of a study runs the risk of influencing the emergence of concepts and categories in the early phases of data collection. However, it is necessary to identify gaps in the literature since grounded theory methodology is suited to exploration of situations about which little is known. When there is some indication and confidence that a core category, which is well grounded in the data, is emerging, then this may be the time when the literature can be related to the emerging theory (Glaser, 1997). May (1986) suggests that the "literature should be treated with a healthy scepticism" (p.152). The researcher should enter the field unbiased by the literature and with a focus on "discovering naturally occurring patterns in the social setting under study" (May, p.152).

According to Glaser (1992) there are three types of literature used in this methodology: "(1) non-professional, popular, and pure ethnographic descriptions, (2) professional literature related to the substantive area under research, and (3) professional literature that is unrelated to the substantive area" (p.31). Each of these types of literature has its place in the overall use of literature. Glaser (1992) emphasises the need for reading throughout the study, the ideas from which increase theoretical sensitivity. This in turn helps to provide direction for theoretical sampling. Literature can be drawn into discussion of emerging categories or a basic social process.

## Summary

In this chapter, the distinctive nature of grounded theory methodology was described and explained as one qualitative methodology that has been used in researching situations of social interaction in disciplines such as nursing, midwifery, education and sociology. Glaser and Strauss (1967) were credited with the origins and development of this methodology. While many scholars have used this methodology in their own way since its 'discovery', the language of the original methodology continues to distinguish it from other qualitative research methodologies. The inductive nature of the methodology is supported by the attention given to allowing theory to emerge from the data, and the way in which literature is used. The literature reviewed prior to commencement of the study will be presented and critiqued in Chapter Three.

# CHAPTER THREE

# REVIEW OF THE LITERATURE

## Introduction

A review of the literature is traditionally carried out early in a study. This chapter will include a review, which is congruent with the methodology in relation to when to review the literature and which literature to review. In carrying out a review of literature, I was influenced by ideas of Glaser and Strauss (1967) and Glaser (1978; 1992) on how literature is used in grounded theory methodology. These ideas have been previously described in Chapter Two. I carried out an initial review of breastfeeding literature, primarily to gain an overview of and to identify gaps in breastfeeding research. Since the intention of this study focused on the behavioural and social aspects of breastfeeding, the review included, but was not limited to, studies which specifically related to what was happening when first-time mothers breastfed their infants in the context of their daily lives. The data for this study were collected during 1996 and 1997 therefore the literature, which is included in this review, pre-dates commencement of data collection, in keeping with the inductive nature of grounded theory methodology. Literature which was published after commencement of data collection will be integrated, where relevant, into the presentation of the findings of the study.

## Background to breastfeeding research

As a topic of interest, breastfeeding has been widely researched from many perspectives and much has been written about its value as the preferred method of infant feeding (World Health Organisation, 1981, 1989, 1990). A review of breastfeeding literature reveals that research studies cover a wide range of foci, for example, nutritional, immunological, physical, cognitive and psychosocial benefits for mother or infant. The methodologies used to research breastfeeding have been both quantitative and qualitative

depending on the research questions posed. However, amidst the wealth of knowledge gained about breastfeeding, there is a concern, from a global health perspective, that some mothers do not initiate breastfeeding or maintain it, once initiated, for up to four to six months of age as the World Health Organisation recommends (WHO, 1990). This health promoting strategy underpins much of the research which relates to 'prevalence and duration' of breastfeeding.

With a focus on breastfeeding as a health promotion strategy, the question being asked with regard to infant feeding is not only ' does the mother breastfeed?' but also 'for how long?' Breastfeeding research studies which focus on 'prevalence and duration', aim to identify reasons why mothers did or did not initiate breastfeeding or choose not to continue breastfeeding, once initiated, for longer than a few days or weeks (West, 1980; Houston, Howie, Smart, McArdle & McNeilly, 1983; Wright & Walker, 1983; Ekwo, Dusdieker, Booth & Seals, 1984; Loughlin, Clapp-Channing, Gehlbach, Pollard & McCutchen, 1985; Morse & Harrison, 1987; Fahy & Holschier, 1988; Davies, 1989; Bernard-Bonnin, Stachtchenko, Girard & Rousseau, 1989; Renschler, 1991; Bergh, 1993; Janke, 1993; Ford, Mitchell, Scragg, Stewart, Taylor & Allen, 1994; Salt, Law, Bull & Osmond, 1994; Quarles, Williams, Hoyle, Brimeyer & Williams, 1994; Essex, Smale & Geddis, 1995).

## Breastfeeding in New Zealand

Issues of prevalence and duration of breastfeeding require a database from which to identify national or global breastfeeding trends. In New Zealand, national data sources used by the Ministry of Health (1997) and other researchers have included: The Plunket Management System, 1993-96; The Plunket National Child Health Study, a five year "longitudinal study of a birth cohort of 4286 children born in New Zealand between 2 July 1990 and 30 July 1991" (Essex et al, 1995, p.355); the New Zealand Cot Death Study, 1987-1990, a three year case-control study (Ford et al., 1994); and the Sudden Infant Death Risk Factor Survey, 1995-1996.

Not breastfeeding, along with prone sleeping, maternal smoking and sharing the parents' bed were identified by the New Zealand Cot Death Study (Mitchell et al., 1991, 1992)

as "four major modifiable risk factors for sudden infant death syndrome (SIDS or cot death) in New Zealand" (Ford et al., 1994, p. 484). In a study which aimed at finding out factors which might influence "successful establishment and continuation of breast feeding" (p.483), Ford et al. (1994), used control data from 1529 infants who were studied in the New Zealand Cot Death Study (1991,1992), 88 per cent of whom were exclusively breastfed on discharge from hospital, with figures dropping to 61 per cent by 4 weeks. The definition of 'exclusive breastfeeding' used in the study is that the infant had been fed only with breastmilk (Labbok & Krasovec, 1991, as cited in Ford et al., 1994, p. 484).

Factors identified in the Ford study which were significantly associated with 'not breastfeeding' when the infant was discharged from hospital were: "twin pregnancy, being a Pacific Islander, mother not bedsharing, subsequent dummy use, birthweight less than 2500g, heavy smoking and mother less than 20 years old at first pregnancy" (p.483). The mothers in the study represented a range of 'parity', that is, first-time mothers and those who had had more than four pregnancies. Of note in this study is that first-time mothers have the highest incidence, at 88.9 per cent, of exclusive breastfeeding when discharged from hospital. But by 4 weeks, the incidence of first - time mothers still breastfeeding has dropped to 69 percent, the lowest of all the five groups of mothers arranged by number of previous pregnancies. The incidence of mothers with more than four previous pregnancies and who were breastfeeding exclusively at both discharge from hospital and at 4 weeks, remains consistent at 77 and 77.2 per cent respectively.

Some consistency can be seen here, in relation to first-time mothers, in a study carried out by Da Vanzo et al. (1990). who found that " first-borns ... were more likely to be breastfed than later-borns" (p.231). They also suggest that the decision made about breastfeeding with the first infant is "the best predictor of later breastfeeding behaviour" (p. 231) They found that 80 percent of first-time mothers who breastfed their infant also breastfed later infants. Conversely, 82 per cent of mothers who did not breastfeed their first infant also decided not to breastfeed their later infant.

Ford et al. (1994) also recorded information about "maternal smoking, dummy [or pacifier] use and the mother sharing the bed with her infant" (p. 483). The study found that these three modifiable factors were associated with "a reduced amount of breastfeeding" (p. 488). In the case of maternal smoking, breastfeeding was found less likely to be initiated and if so, to be of shorter duration, with " the heaviest smokers breast feeding for the shortest time" (p. 488). This study concluded that while the habit of smoking "can be modified" (p.489), further study is needed to investigate whether the use of dummies and bedsharing influence the duration of breastfeeding.

Using feeding data which was available on 3929 infants, who were enrolled in the Plunket National Child Health Study, Essex et al. (1995) aimed at finding out the prevalence of breastfeeding in the six months following birth and why mothers stopped breastfeeding. Breastfeeding rates at 6 weeks following birth were found to be 79.5 per cent. At 3 months, there was a drop in figures to 71 percent and a further drop at 6 months to 56 per cent.

Findings of the study indicated that in overall groups, at all three intervals of birth to 6 weeks, 6 weeks to 3 months and 3 months to 6 months, the most common reason for stopping was a perception of the mother that she had an insufficient supply of milk. At 6 weeks to 3 months, 38 per cent of mothers from the Pacific Islands' community, however, gave 'returning to work or study' as the main reason for stopping breastfeeding, the highest percentage of any ethnic group in the study for this reason (p.356). While the category of 'work or study' was presented as combined figures in this study, it would have been interesting to see each of 'work' and 'study' percentages, particularly when cited by such a high percentage of women from the Pacific Islands' community. Galtry (1998) suggests that the high rate of cessation of breastfeeding earlier than six months, in this group of women, may be attributed to a number of "employment-related factors specific to this group" (p.154). The economic need to return to paid employment which may involve shiftwork and longer working hours, and conditions which may limit their access to breastfeeding support in the workplace. Galtry (1998) points out that, "the labour market characteristics of Pacific Islands women match the profile, established by international research, of those least likely to

be able to combine labour market involvement with breastfeeding" (p.154).

Essex et al.(1995) conceded that figures of 93 per cent of infants being breastfed at birth, are high. However, they proposed that these figures may be maintained beyond six months following birth, with increased education and support for parents and mothers returning to work or study. The education of health professionals, partners and mothers regarding the physiological process of milk production is also proposed as a means of increasing the breastfeeding figures (Essex et al.,1995). The authors suggest that the perception of so many mothers that there is insufficient milk to provide adequate nutrition or to deal with the unsettledness of the infant "is a cause for concern" (p.357). Similar cause for concern was expressed at a meeting of the Forum on Maternity and the Newborn in the United Kingdom (1986) when it was predicted that,

> ... there would be 650,000 women giving birth in 1986 of which 36,000 who started breastfeeding would give up in the first two weeks because of an 'inadequate milk supply'. A further 120,000 would give up 2-16 weeks post partum as a result of what they perceived to be inadequate milk supply ... this was a startling number of women to be seemingly unable to carry out a biologically imperative function, and implied that something was preventing them from doing what they are naturally able to do. That something might be the system of rules that has been operating for the last few decades (reported by Inch, Meeting report, 1987, p.57).

## Historical trends

Ideas on breastfeeding set in the social context of the 1990s may differ from ideas on breastfeeding in the 1950s and 1960s when a decline in breastfeeding was becoming evident and the words 'success' and 'failure' were being attributed to the ability or inability of the mother to continue breastfeeding (Roberton,1963; Deem and McGeorge, 1958). In Roberton's (1963) survey study of 450 mothers carried out by the Canterbury Faculty of the College of General Practitioners, 36 per cent of mothers were breastfeeding at 3 months compared to 71 per cent in 1990-1991 (Essex et al., 1995).

The most likely cause of weaning given by Roberton (1963) for 23 per cent of mothers who weaned their infants at 2 weeks following birth was "poor supply or no milk" (p.327), a reason also highly rated in other studies ( McDeem and McGeorge, 1958; Hood et al., 1978; West, 1980; Gunn, 1984; Rentschler, 1991; Essex et al., 1995).

Noting the decline in breastfeeding during and after World War II, Roberton (1963) attributes its likely cause to the move from small maternity homes to larger hospitals. He believed that this move brought about a tendency to "excessive dependence on scales, tables, and techniques, to apply the principles of bottle-feeding to breastfeeding and to neglect the feelings of the mother" (p.326).

Roberton's (1963) study portrays a picture of maternity culture in hospitals and in society in the 1960s. Roberton says that "the prevalence of breastfeeding depends more on fashion than anything else. Appeals to reason or virtue have very poor results" (p.328). He urged staff in hospitals to use the successes of some mothers to advantage in order to encourage others to try breastfeeding, thus lending an air of fashionableness to it and to avoid pressuring the mothers to breastfeed for fear of making them anxious. Roberton advises that, " Mothers in the first few days after their confinements are, of course, unstable, and are more suggestible than they are normally" (p.327). The choice of the word, 'unstable' here, which can be defined as "changeable" or "showing a tendency to sudden mental or emotional changes" (Kuper & Kuper, 1995, p.1538) highlights the vulnerability of the new mother particularly in the first three or four days postpartum.

Rubin (1984) suggests that the third day postpartum "is not conducive to the goodness of fit in the feeding relationship" (p.138). She attributes this situation to physiological changes taking place in the body of the mother and body of the infant. Referring to these changes, Mercer (1995), says that " Mothers experience bewilderment and confusion as they begin to work on their new reality and new identity as a mother" (Carlson, 1976, as cited in Mercer, 1995, p. 98). Roberton (1963) sees the doctors and nurses as being people in authority during this critical postnatal period and suggests that, "Perhaps they could allow themselves to show some enthusiasm for breast feeding and

encouragement for those who are prepared to try, as otherwise they appear to support the principles that breast feeding is not worth bothering about" (p.328).

While this study is set in the context of its time, with its contemporary language and 'absence' of midwives, the messages are similar thirty years later. Breastfeeding is identified as a global health issue and a New Zealand public health target, with a focus on increasing the incidence and duration of breastfeeding (WHO/UNICEF,1990; Ministry of Health, 1996, 1997).

Between the 1950s and the 1980s, breastfeeding increased in prevalence. Hood et al. (1978) noted that there was a rise in breastfeeding rates in Dunedin in 1971 which coincided with the formation in the city of the New Zealand La Leche, an organisation formed in America to promote and support women who choose to breastfeed. While an increase in duration was also noted since the formation of La Leche, duration of breastfeeding continues to be a focus for many research studies.

## Prevalence and duration

One such study, carried out by Wright and Walker (1983), of 617 primiparas (first-time mothers) whose births had been notified to the local health authority of Leeds, England. was aimed at predicting the duration of breastfeeding. The data were gathered from interviews with mothers at around four weeks following the births. Mothers still breastfeeding at the first interview were followed up with a "brief postal questionnaire" at four months and six and a half months following birth. Wright and Walker (1983) suggest that attitudes expressed by the mother "towards convenience, uncertainty [of milk supply], embarrassment, and enjoyment of breast feeding clearly relate to its subsequent duration;" (p.94). They also suggest that it is important to identify mothers who are at risk of terminating breastfeeding earlier than four months and to support them. Mothers identified in this study as especially 'at risk' were young mothers who had left school early.

Walker and Wright (1983) use the word 'premature termination' while Janke (1993) uses the terms, 'attrition' or 'premature weaning' in relation to cessation of

breastfeeding. An assumption can only be made that 'premature termination' or 'attrition' is assessed by the recommended criterion of four to six months duration (WHO, 1990). Janke (1993) refers to the work of 107 authors who have contributed to breastfeeding research and literature to identify the "Variables Associated with Breastfeeding Initiation and Success" (p.28). By using the words 'success' and 'attrition', the assumption could be made that if a mother stops breastfeeding there is an element of 'failure' or 'wastage' about her action (Thompson, 1995, p.80). Morse and Harrison (1987) note that the use of the word 'success' is "usually defined by the medical profession as *time*..." (p.206). The 'medical' profession may include a wider group of professionals in this context, but what is significant is that there are limits and recommendations being imposed on mothers, which for some, may or may not be realistic. Mothers themselves may think differently about the meaning of the word 'success' in relation to their own experience of breastfeeding irrespective of its length.

In classifying the variables, which may be associated with the initiation of and success in breastfeeding, Janke (1993) includes: those that cannot be modified, for example, race, class, age, marital status, breastfeeding history, for example being breastfed herself or having previously breastfed an infant; those that can be modified, for example, commitment to breastfeeding, intent to breastfeed for a long time, good support, positive attitude, time of feeding; and those variables which have shown inconclusively to be associated with initiation and success, for example, "parity, sex of infant, prenatal class attendance, type of birth" and lifestyle planning such as returning to work (p.28).

Janke (1993) suggests that health practitioners need to develop a 'pro-lactation protocol' at the first prenatal visit to assess the mother's plan for feeding her infant. The questions which the mother would be asked would reflect the modifiable variables previously identified by Janke (1993), for example, plans for feeding her infant, ability to identify the advantages and disadvantages of breastfeeding, perception of own feelings of comfort about breastfeeding, support of significant other or others and plans to return to work if any, such as, how soon and how the mother will feed once she returns to work.

With 'attrition' of breastfeeding as a focus, Janke (1994) further developed her work and describes the "Development of the Breast-feeding Attrition Prediction Tool" which could be used in practice to classify women "as high risk for attrition" (p.104). Results from the use of this tool suggested that, "women who weaned prematurely tended to agree with negative attitudinal statements, to express less control over their ability to breastfeed, and were more susceptible to negative breast-feeding influence from social and professional referents" (p.104). The latter aspect of Janke's study, relating to societal influences on breastfeeding is also noted by Smith (1976); Hally, Bond, Crawley, Gregson, Philips and Russell (1984); and Bergh (1993).

A study by Salt, Law, Bull and Osmond (1994) which aimed " to determine attitudes to breastfeeding practice" (p.291) was designed to test an assumption that breastfeeding rates vary within a country. They chose the geographical regions of Durham in the north of England and Salisbury in the south, since "socio-demographic characteristics of mothers differ from one area of the country to another" (p.291). Data were gained from a questionnaire administered during an interview with the mothers in their homes at six weeks following birth. Approximately 50 per cent of the mothers in Salisbury were first-time mothers and 51 per cent in Durham. A greater percentage of mothers breastfed immediately after birth (79 per cent) and at six weeks (50 per cent) in Salisbury in the south than in Durham in the north (54 per cent and 26 per cent respectively).

The authors found that "willingness to breastfeed away from home had an independent influence on the continuation of breastfeeding to six weeks" (p.295). They suggest that there are other influences which may account for the differences in the two districts and these may be attributed to "behavioural or cultural characteristics" (p.295). Salt et al. (1994) recommended a need to break down cultural barriers through early education about breastfeeding in schools.

In New Zealand, studies which have explored trends in breastfeeding prevalence and duration in different geographical areas from south to north of New Zealand include: a Dunedin study (Hood, Faed, Silva and Buckfield, 1978); a Wellington study (Briggs

and Allen, 1983); a Manawatu study on four cohorts of infants born during 1933-1939, 1940-1944, 1945 -1949 and 1950-1954 (Trlin and Perry, 1982); a Tauranga study (Dawson, Richardson, Carpenter, Blair, McKean, 1979); and an Auckland study (Gunn, 1984).

The fact that mothers in New Zealand do breastfeed at all whatever the length of time is surely positive in terms of health promotion. To perpetuate the 'labelling 'of mothers who do not continue to breastfeed for the proscribed length of time as 'failures' is punishing and not conducive to encouraging mothers who may not be able to or may not choose to breastfeed for four to six months. On the contrary, a more positive message needs to be given to mothers who breastfeed at all, even though it is not as long as the recommended global health policies state.

In 1963, Roberton said that mothers "instead of being congratulated on giving the baby a good start, and being advised to make up the deficit with a bottle and wean gradually, the mother is told that she has failed" (p.327). Although this advice on supplementary bottle feeding would today be contrary to demand feeding practices and in relation to the WHO Code for Marketing of Breastmilk Substitutes (1981), the idea of not labelling mothers as 'failures' is valid.

## Challenges for new directions in breastfeeding research

Ewing and Morse (1989) in sending out a challenge for new directions for research into breastfeeding, propose that there are two models of infant feeding research: (1) " the medical science model" and (2) " the behavioural science model " (p.25). Each model has a different perspective whose underlying philosophies influence the research methodology. Infant feeding research from a "medical science model" may focus on the physiological aspects of milk production and on the "caloric content and biochemical composition" of the milk (p. 25).

Infant feeding research from a behavioural science perspective has the potential to focus on factors which influence the act or the process of breastfeeding and hence includes the infant and mother within the context of family. Ewing and Morse (1989) call for an

increase in research studies which give voice to the mother's views about the act of breastfeeding. They propose that this may be a way of enhancing the prevalence and duration of breastfeeding.

Reiterating what Ewing and Morse (1989) are saying in relation to giving voice to the views of the mothers, studies using qualitative approaches have been carried out with this intention in mind (Bottorff, 1990; Vares, 1993; Beasley, 1993). Using a phenomenological approach to capture the essence of the breastfeeding experience of three women through a process of exploration and reflection, Bottorff (1990) suggests that:

> A breastfeeding mother's way of being in the world is reflected in her everyday experiences. By paying attention to mothers as they breastfeed in the context of their families and of our present society, we may come to understand the lived meaning or the significance of the experience of breastfeeding (p.52)

Vares (1992) carried out a study of six New Zealand women who identified as feminists, and had breastfed their infants for periods of between nine and eighteen months. The women's experiences of breastfeeding which were being explored spanned a period between 1984 and 1991 when three of the women were still breastfeeding at the time of the study. Vares used two group interviews with three mothers in each group as well as herself. Although Vares does not make it explicit, the reader is left with the impression that the women were not necessarily first-time mothers.

Starting from a premise that breastfeeding is socially constructed and is "a site of competing and often conflicting discourses" (p.26), Vares wanted to ask the questions:

> how do feminist women experience breastfeeding?
> What understandings do they bring to this practice? How do these understandings draw on their feminism? What, if any, contradictions, ambivalences and inconsistencies do they experience? How do these

reflect the tensions between women's experience of breastfeeding and the social construction of breastfeeding?" (p.26)

While wanting to place the issues within a "feminist framework", Vares also admits that she wanted to take part "in penetrating what I perceived was a barrier of silence surrounding women's actual breastfeeding experiences" (p.27) Vares' own breastfeeding experience influenced her choice of topic and she is very honest about her journey within feminism, finding herself "being drawn to a cultural feminism which embraced and celebrated the embodied aspects of womanhood, particularly breastfeeding" (p.25). She does not claim to be using any particular methodology but writes from a feminist perspective and uses a qualitative approach to her research. She acknowledges her dilemma of how best to be true to the realities of the women's experiences as she writes up her study and says, "I have attempted an ongoing analysis interwoven with their voices" (p.26). As part of the overall experience, mothers talked about breastfeeding in public and found that it was generally not acceptable practice in public places. Vares pointed to the conflict between acceptance of breastfeeding as the 'best' method of feeding and the social acceptance of breastfeeding.

In reviewing the literature published between 1980 and 1996 there were no studies found which set out specifically to examine first-time mothers experiences of breastfeeding away from home at six to twelve weeks following birth. However, Beasley (1993) carried out a study for a master's degree in which she explored from a critical interpretive perspective, the experience of four first-time mothers in the first three months following birth. She included some of the mothers' experiences of breastfeeding in public. Beasley proposed that, "each mother's ideas regarding breastfeeding in a public situation reflected habitus generated ideas and values concerning both socially acceptable practice and a mother's personal assessment of priorities relating to a baby's need" (p.12).

Some issues for the mothers in Beasley's study, stemmed from their inexperience in breastfeeding as first-time mothers. Anxieties about breastfeeding in public were interpreted as arising from their lack of confidence in breastfeeding as a first-time

mother and the fear of others being "critical of her techniques" (p. 120). There was tentativeness expressed by one woman about breastfeeding in certain social situations because of conflicting ideas of what was acceptable public practice in relation to nudity as a woman as opposed to nudity as a mother while breastfeeding. One younger mother who did not express hesitation about breastfeeding in front of other people, was described by Beasley as being "stationed outside the dominant discourse and had little to lose by failing to conform socially" (p.123).

The study by Salt, Law, Bull and Osmond (1994), which suggested unwillingness to breastfeed away from home as a possible reason for mothers not continuing to breastfeed for the WHO recommended period of four to six months, provided the direction for the present study. It became clear that the present study should focus on finding out what was happening for first-time mothers when they breastfed away from home earlier than four months. With research pointing to many mothers often not continuing to breastfeed beyond three to six months, I wanted to hear about their reality of breastfeeding within a context of social interaction, preferably while they were living that reality. I assumed that by focusing on this time period, the mothers would have had to extend their context of breastfeeding beyond their own home to many and varied social settings.

Having gained an overview of the breastfeeding research, I felt that to search any further might influence the research by contradicting the inductive nature of the grounded theory methodology. A search of the literature in the substantive area was discontinued until the data collection commenced and literature would be drawn into the emerging theory (Glaser, 1992). At an early stage in the study, I wrote the following memo:

> I am running into a problem with the literature review. This is a conflict between how much of a review to carry out without pre-empting the outcomes of the research and remaining true to the grounded theory methodology. The theory is grounded in the data collected and is generated from the data. I am getting into a situation whereby I have been searching the literature ... and in doing so, I am beginning to make assumptions about outcomes and what I will find when I speak with the

> woman participants. This has been an easy trap to fall into ... I would like to proceed to data gathering as soon as possible (personal memo, March, 1996).

## Summary

This chapter has situated breastfeeding within the research literature which helped to provide focus and direction for this study. Given the wealth of knowledge about breastfeeding which can be gained from a broad spectrum of breastfeeding research, this review further focused my thinking on finding out what was happening for first-time mothers when they breastfed away from home. I did not find any literature which intentionally focused on and addressed mothers' reality of breastfeeding away from home in the early days and weeks of motherhood. In Chapter Four, the methods used to access the mothers, as participants in this study, will be described.

# CHAPTER FOUR

# THE METHODS

## Introduction

In this chapter, the data collection and data analysis methods of grounded theory methodology, as used in this study, will be described. Ethical considerations in research will be addressed by explaining the processes that were used to access the mothers, inform them about the study, and obtain their consent to participate in the study within a context of protection of human rights. Interviews, carried out individually with each mother, were a source of data for the study. During the process of analysis, literature sources, informal conversations, personal and professional experience and observation were also used to increase theoretical sensitivity (Glaser, 1978) and as data sources. For this study I interviewed nine mothers who had recently given birth to their first infant. Seven mothers were interviewed twice and two mothers were interviewed once each.

## Ethical considerations

Prior to commencement of the study, approval was sought from and granted by the Massey University Human Ethics Committee and a Regional Health Authority Ethics Committee. This process was to ensure that the study would be carried out in accordance with international ethical standards and guidelines for the conduct of research involving human beings (Health Research Council of New Zealand, 1993). Ethical issues of informed consent, prevention of harm and protection of the privacy of the participants and their families are explained in detail in the following sections.

## Confidentiality and anonymity

At the beginning of the study, each interested woman was given an information sheet (Appendix 2). At each interview, I reassured the mother that her participation in this study would be kept confidential. Codes were used instead of real names throughout the

transcripts to protect the privacy of the participants and their families. I transcribed all the interviews and was the only person who had access to the links between the codes and the names of the participants. Transcripts were kept separately from the tapes in secure places. The mothers were offered the choice of either having the tapes returned to them or having them destroyed at the end of the study. Some mothers expressed a wish to have the tapes returned and others did not. At the end of this study, I shall contact each mother and confirm their wishes regarding the tapes.

## Accessing the participants

To participate in the study, the mothers needed to have breastfed their infants and, if possible, still be breastfeeding when the study was in progress. The experience of breastfeeding away from the mother's own home environment was essential to the context of the research. All the mothers were still breastfeeding by the time of the first and second interviews. The process of accessing the participants was initially intended to commence prior to the mother giving birth. This happened, as intended, with four of the mothers but the other five mothers were accessed after they had given birth as required by theoretical sampling. The first group of mothers had given birth in autumn and winter and the second group in spring and summer. This provided seasonal variation to the context of the mothers' experiences of breastfeeding away from home.

The process of accessing the first four participants was lengthy. I had to wait until the infants were born before I would know whether the mother still wished or was able to participate in the study. I then waited until the infants were six weeks old before interviewing. I felt that it was important to keep in touch with the mothers at various times throughout the accessing process particularly to acknowledge the birth of the infant when the mothers first told me of it. Prior to any pre-arranged visit, I needed to make contact, in case the mother needed to change her plans in relation to how she and the infant were progressing during the postnatal period.

## Initial contact with antenatal agencies

At the beginning of the study, I wrote to antenatal agencies to arrange a suitable time to meet with potential participants (Appendix 1). During antenatal classes, I met with

women who were at various stages of their pregnancy. The proposed study was outlined and an information package was left with the women. The information package included: An outline of the requirements of the study and the process of giving consent to participate in the study (Appendix 2); a form entitled 'Consent to be contacted after your baby is born' (Appendix 3); and the consent form (Appendix 4). Some women, having heard about the study from other women, contacted me at home by telephone. I posted the information package to these women and arranged to meet with them to enable them to make an informed decision about participating in the study.

I gave the women the opportunity to express their interest in participation by returning to me the completed form entitled 'Consent to be contacted after your baby is born' (Appendix 3). Receipt of this form gave me permission to telephone the mother at an appropriate time after her infant was born. Mothers who had already given birth were also asked to complete this form which included the date of birth of the infant, and which let me know when to arrange a meeting to discuss the study and gain their written consent.

## The process of obtaining informed consent

On receiving the completed contact forms (Appendix 3), I made contact by telephone, at a suitable time stated by the mother, to arrange a meeting to discuss the proposed study and to enable the mother to ask any further questions before signing a consent form to participate in the study (Appendix 4). I met with each mother at a place convenient for her, usually in her own home. The mother was given a further opportunity to discuss the study and ask any questions about the study. When the mother was satisfied that she had sufficient information about the study and was fully aware of her right to withdraw at any time, she was asked to complete the consent form (Appendix 4). I also completed a section on this form confirming that I had explained the study. This emphasised my responsibility as a researcher to ensure that consent was given within a context of protection of human rights.

I asked the mothers if they would be willing to have the interviews audio-taped and all mothers consented to this process. Unwillingness to have the interview audio-taped did

not preclude participation in the study. I assured the mothers that an interview would be terminated or temporarily discontinued if either the mother or the infant needed to attend to other pressing situations, for example, to attend to the infant or to breastfeed. On some occasions, the mothers chose to breastfeed their infant during the interview.

## The mothers as participants in the study

During the informed consent process and the subsequent interviews, the mothers talked about themselves, their background and their birthing experience. They ranged in age from early twenties to early forties. At least two of the mothers were born outside of New Zealand and had spent a great part of their life overseas. All of the mothers had partners and had been in employment outside of the home prior to giving birth. By the time of the first interview at six weeks, three mothers had returned to work either on a full-time or part-time basis. By the time of the second interview between ten and thirteen weeks, five of the mothers had returned to either full or part-time employment.

All of the mothers had attended antenatal and postnatal education classes. These classes were attended either in hospital or with an independent midwife. Some mothers had also attended Parents Centre classes. All of the classes had included information and advice on breastfeeding. The mothers had been supported during the initiation and establishment of breastfeeding by either hospital midwives, community midwives, independent midwives and the Plunket nurses or a combination of midwife and Plunket nurse at different times in their progression through the postnatal period. All of the mothers had given birth in a hospital setting and had returned to their own homes with their infants at varying times after birth. The mothers stayed in hospital for varying lengths of time depending on their birthing and postnatal experiences, which included premature birth; normal birth; forceps delivery; and caesarean section.

## The timing of the interviews

The timing of the interviews was important. I wanted to interview mothers preferably while they were still breastfeeding, in order to explore with them the reality of breastfeeding as they were experiencing it. Interviews were planned to take place when the infant was at least six weeks of age and again when at least ten weeks of age. The

timing of the second interview ranged from ten to thirteen weeks depending on each mother's individual circumstances and commitments and my own commitments.

I was mindful of two aspects of a new mother's life which influenced the timing of the first interview in particular. One aspect was the necessary period which the mother and her family might require to adapt to caring for a new infant. While the mother was recuperating emotionally and physically from the experience of birth, I did not wish to add any unnecessary stress to this process. The second aspect for consideration was integration of breastfeeding into the mother's daily life. I assumed that, by six weeks, the mother may have had experiences of taking her infant out of her own home to proceed with her usual activities of daily living. I also assumed that the mother would take her infant with her and have to feed the infant away from home.

## The interviews

The well-being of the mother and her infant were my first consideration and took priority over my necessity to proceed with any interview. For this study, the main source of data was semi-structured interviews with the mothers. Partners were present with two of the mothers intermittently throughout the interview. After the first interview, I confirmed with each mother the possibility of a second interview approximately four to six weeks later. Seven of the nine mothers were interviewed a second time. Two mothers, who were not able to be interviewed at six weeks due to their infants being born close to holiday times and the difficulty of making contact during this time, were each interviewed once, at ten weeks and at twelve weeks respectively.

Each interview was audiotaped and I transcribed the interviews verbatim. At the end of each interview I offered each mother the opportunity to read the transcripts. I took the transcript of the first interview along to the second interview. After the second interview I followed up with a telephone call when the second transcript was completed. Some mothers chose not to read either transcript. Minor changes were made to two transcripts at the request of two mothers.

In the first interview at approximately six weeks following birth, I explored with each mother the different contexts of breastfeeding away from home. I asked the mother to think about and recall any situations where she had breastfed away from her usual environment and to describe what had happened in those situations. I wanted to find out where the breastfeeding took place, who were the other people involved in the situation and how the mother managed in certain situations. For example, if the breastfeeding had taken place within a family setting, I explored with the mother her interpretation of 'family' and which family members were present on each occasion. 'Family' can be defined variously, and can include not only members tied by blood lines or marriage but also friends or occupants in a same dwelling who are not necessarily related (Friedman, 1992).

Mothers described a range of situations specific to social, economic and spiritual life. Examples of social interaction included visits: to family members; to the shops or supermarket; to the bank; to church; to sports or entertainment functions; to parties, picnics and to restaurants. Some situations were described by the mothers as 'formal' and others as 'informal'.

As all of the mothers described situations specific to friendship, I sought more information about breastfeeding with friends and acquaintances. If the mother described a social situation with friends, I explored with her how she perceived the friendship, for example, in relation to closeness or acquaintance, whether her friends were recently acquired or of long-standing.

All of the mothers had been in employment prior to giving birth, so I explored with each mother this aspect of her life as she combined it with motherhood. Many of the mothers had wanted to take their infants back to their place of employment to let friends and colleagues see their new infants. Some mothers had done so by the time of the first or second interview.

## Analysing the data

Data were analysed using the method of 'constant comparative analysis', described by Glaser and Strauss (1967). The interviews were mostly one hour long which generated lengthy transcripts. All the mothers had agreed to have the interviews audiotaped, enabling verbatim transcription of the interview. This also enabled the emotional responses to be heard and noted, such as joy, frustration, humour and disbelief, giving a sense of reality to the situations described by the mothers. The transcript of the first interview was read and coded line by line. The codes were either single words or phrases which were reflective of what was happening in the situation as the mothers described it and were written in a wide left-hand margin of the transcript. The code names were often the actual words used by the mother. This was to enable the meaning of the actions, interactions or situation as interpreted and described by the mother, to remain grounded in her own words.

As the participants became available for interview, open coding of the other interviews took place. This was an exciting stage of the process as codes from the first interview began to emerge from the second and subsequent interviews. These could be constantly compared as the process continued. Codes began to be grouped together into categories by reason of their similarities and differences. The categories which were emerging were sought in subsequent interviews and compared one with the other as each interview took place. In order to further develop the findings and to look for further similarities and differences in the emerging categories, a process of theoretical sampling took place.

Other first-time mothers, who had given birth in spring and summer, were accessed as the research progressed to see if the codes or categories showed a range of behaviour which indicated a basic social process or a core category. As more codes emerged, these were analysed and grouped together into categories which signified an overall conceptualisation of what was happening for the mothers in various social situations. Each of these categories was named and the sub-categories or concepts, which emerged to articulate their properties, were named often from the actual words used by the mothers.

A stage was reached in the research when a number of categories had emerged but there did not appear to be a clear core category or basic social process emerging. In order to remain congruent with this methodology, it was essential that the emerging categories stayed grounded in the mothers' stories. This process involves dealing with a huge amount of qualitative data. A very long process of re-examining and re-conceptualising of the categories took place and as Glaser (1992) had encouraged, a basic social process emerged.

As the process of 'constant comparative analysis' was taking place, memos were being written as the ideas from each interview emerged and were compared with other data. Other data were being accessed from sources such as literature from the substantive area of breastfeeding as well as other relevant literature not related to breastfeeding, but which related to either the research methodology or other studies, for example, in sociology and health. Observations were made during the course of the study, of any situations where mothers were breastfeeding either in public places or in their own homes on an ad hoc basis. All of these together with conversations and media reports were drawn into conceptualisation of the emerging theory as appropriate, to increase theoretical sensitivity.

## Summary

It is a privilege and not a right to be able to enter into a person's life to obtain information for the purposes of research. Research, involving human beings, has the potential to cause harm to the participants and to invade their privacy. Therefore, the reasons for carrying out the research and the way in which it is conducted must remain within ethical guidelines. The processes used to enable the mothers to give informed consent to participate in this study have been presented. The methods used to analyse the data have been described. The words used in naming categories and their conceptual properties emphasised the grounding of the emerging theory in the mothers' reality of breastfeeding away from home. In the following chapters, the nature of 'what is happening here?' which is the question that grounded theory methodology proposes to answer, will be described and discussed.

# CHAPTER FIVE

# PREFACE TO THE FINDINGS

## Introduction

This is the first of five chapters, in which the findings of the study will be presented. In the previous chapter, an explanation was presented of how grounded theory methodology guided data collection and data analysis in this study. In this chapter, the context of the study will be presented, situating it in breastfeeding and first-time motherhood. A process of unfolding will take place in presenting the findings of this study, beginning with an explanation and discussion of three categories and their conceptual properties in Chapters Six, Seven and Eight, concluding with the overall basic social process (BSP) in Chapter Nine.

The theory which emerged from the data indicated that mothers used a basic social process (BSP) of **Learning** within the context of breastfeeding and which guided their subsequent actions and interactions with their infant, family, friends and others in society. Since breastfeeding was part of the daily lives of the mothers over a period of time, three categories have emerged which acknowledged growth taking place in their ability to breastfeed and to better deal with situations of social interaction as their confidence with breastfeeding grew. The categories of: **Limiting Social Interaction while Learning to Breastfeed**; **Meeting Uncertainty in Social Situations** and **Reading the Situation**, will be presented through description and discussion of their conceptual properties to reflect what was happening for the nine mothers in this study, as they breastfed at home and away from home.

As conceptualisation of the data took place and the initial codes were raised to a higher level of abstraction, some actual words used by the mothers were retained in naming the concepts. Other concepts have been described which could be compared with concepts

inherent in studies from the disciplines of sociology, psychology or health, for example. Literature from studies of breastfeeding, social interactions and other sources of data, for example, personal observations, conversations and the media, have been integrated where relevant to increase theoretical sensitivity. The actual words of the mothers have been used, where appropriate, to support the theory and to ground the study in the reality of breastfeeding as presented by the mothers in this study. These words are distinguishable in the text by their placement *in italics* and referenced at the end of each quotation with the use of the codes which identify the mothers to me, for example 'E1:6' indicates the mother's code (E), the interview number, either first or second (E1) or (E2), and the page number of the transcript (E1:6). The letter 'R' is used where questions are asked or comments are made by me, as the researcher. When a word is underlined in the mothers' transcript, it indicates that the mother emphasised the word(s). These emphases are an attempt at providing some of the nuances which I heard in the audio-taped interview.

## Situating the study

There is a sense of urgency about the cry of a young infant who needs to be fed and is dependent on another person for nutrition. One of the principles underpinning the 'Ten Steps to Successful Breastfeeding' (WHO,1990) is that "Infants should be fed whenever they indicate a desire to feed" (Saadeh and Akre, 1996, p.154). When the person on whom the infant depends is a mother who breastfeeds, then the infant needs to be close by and have easy access to the mother. The closeness of infant and mother is essential for the continuance of breastfeeding. In this chapter, the newness of the infant and mother to breastfeeding is acknowledged. A newly born infant is **learning** to suckle at the breast while the woman with her newly acquired name of 'mother', by virtue of giving birth, is **learning** to breastfeed and to be a mother. Together infant and mother travel the breastfeeding journey. For them it is a new and an uncertain journey, each situation of social interaction has the potential to be different, requiring the mother and infant to respond to each situation differently. Bottorff (1990) suggests that when a mother chooses to breastfeed she embarks on a " journey into the unknown" (p.201).

The contexts of social interaction, within which the first-time mothers in this study

breastfed, were influenced, to some extent, by their recent pregnancy and birth experience. Contact with family members was evident with either the mothers spending time with them in their homes or family members visiting the new mothers either in hospital or at home. The mothers sometimes met with other new parents for educational aspects of postnatal classes. These other parents had previously been their peer group at antenatal classes and continued to be so after the infant was born. These groups also met socially and sometimes became a new social network, mutual support group or a new network of friends. Glaser and Strauss (1971) refer to this new network in relation to 'status passage' where groups of people, particularly those who find themselves moving through new and similar experiences in situations of, for example, illness, may make new friends within this new group (Davis, 1970, as cited in Glaser and Strauss, 1971, p.145).

The differing birth experiences of premature birth, normal birth, forceps delivery and caesarean section reflected the individuality of each mother's experience of learning to breastfeed. For example, limited accessibility to an infant who was born prematurely meant that the mother was not able to initiate breastfeeding in the same way as a mother who could have her infant close to her from the birth. One mother, whose infant was born prematurely, described the beginning of breastfeeding for her saying:

> *I wasn't given a chance initially to feed [infant] ... it was ... [five days] before [infant] had the first breastfeed at all. And you're sitting there not knowing what to do and ... you're in there because you're by the incubator. [Infant] still had a drip in ... arm, so [infant] couldn't go anywhere - you couldn't go in private ... first feed at all was Day Five and then it was - maybe another couple of days and then maybe another day and then I would do one and then maybe two and then maybe three out of six feeds ... until Day Eleven I was only doing three out of the six feeds a day anyway (E1:7).*

Other differences in the beginning of the breastfeeding process, such as physical pain caused by perineal sutures or the wound of a caesarean section, could inhibit the early

breastfeeding process. One mother said, *"Initially, I had trouble with latching [infant] on ... for the first week when I was in hospital and having a caesarean made it a little bit uncomfortable [with infant] sitting across my tummy ... (A1:6).*

The process of giving birth and breastfeeding her infant are new life situations, a process, described by Gibson (1986) as 'a rite of passage' suggesting that, "Having a baby and becoming a mother is one of the most significant milestones in a woman's life" (p.10). Raphael (1973), referring to the work of van Gennep (1909) who "coined a phrase *rites de passage*, to mark the ceremonies and rituals ... that mark special changes in people's lives", says that "a woman's most critical *rite to passage* occurs when she becomes a mother" p.19). Mercer (1995) refers to the transition a woman makes "from nonmother ... to mother" (p.13), stating that:

> Concepts from transition theory that are applicable include pregnancy as a marker upsetting the woman's status quo, requiring that the woman move from one reality to another, leading to vulnerability and uncertainty in defining the new role, and requiring a new role identity. In response, the woman has to recognize the permanency of the required change, seek out information, seek out models in the role and test herself for competency and mastery (p.14).

As the mothers reflected on and interpreted the meaning of events surrounding the birth and breastfeeding they did so with the newness of motherhood and breastfeeding as their reality. In their day-to-day actions and interaction they now needed to consider the needs of their new infant. Lazarus (1966), in his exploration of the process of 'coping', cites the work of Murphy (1962) who analysed how children cope with new situations in their lives. Murphy (1962, p. 1-2, as cited in Lazarus, 1966, p. 151) states that:

> It is possible that by watching them [children], we may learn something about how all of us deal with new demands and stressful experiences, newness that cannot be met by well-established habits of ready-made answers (pp.1-2) ... Newness of course does not present itself in pure

> form. It comes with aspects of challenge of new gratifications, difficulty or threat of failure, loss or danger of it, pain or some threat to comfort and security. When newness brings fresh and interesting possibilities in its trail, there is motivation to master it for the sake of the obvious rewards (p.2).

## Summary

The mothers in this study were dealing with a new aspect of their lives, and what was happening for them in relation to breastfeeding during this time of adjustment to motherhood will be presented in the first of three categories which emerged from the data. The first category of **Limiting Social Interaction while Learning to Breastfeed** is explained in Chapter Six.

# CHAPTER SIX
# THE JOURNEY BEGINS:

# LIMITING SOCIAL INTERACTION
# WHILE
# LEARNING TO BREASTFEED

## Introduction

The previous chapter situated the context of this study in the newness of breastfeeding and first-time motherhood. In this chapter, the category of **Limiting Social Interaction while Learning to Breastfeed** will be described and discussed. This category relates to a phase early in the mothers' breastfeeding experience when there was a need to learn the skill of breastfeeding. The category is explained through its properties which include three interrelated concepts. These concepts reflect what was happening for the first-time mothers in this study during the early days and weeks of breastfeeding. Located in this category are the mothers' interpretations of events, and their feelings about breastfeeding as they spoke about them during interviews, the first of which took place at six weeks following birth. The concepts which will be explained and discussed in this chapter, are as follows:

**Acknowledging Learning** - knowing and realising that learning a new skill is taking place as a result of being in new circumstances

**Needing Props** - support required to assist in the process of learning to breastfeed, as identified by the mother

**Planning to Avoid** - intentionally avoiding difficult situations to enable breastfeeding to happen comfortably.

## Limiting Social Interaction while Learning to Breastfeed:-

## Acknowledging Learning

At the first interview at approximately six weeks after each had given birth, the mothers reflected on their birth and postnatal experiences and acknowledged the early struggles that they had had with breastfeeding. As a consequence, the early phase of breastfeeding was a period of time when the mothers were often not prepared to breastfeed away from their own home saying, *" We tended to stay at home a little bit to start with" (D:1) or " ... in the first few weeks ... I hardly left home at all" (F1:1).*

When these mothers described how they had limited their social interaction to their own home at this time, their reasons for acting in this way were underpinned by what was happening for them early in their experience of breastfeeding. The supporting concepts of **Needing Props** and **Planning to Avoid** are interrelated with the concept of **Acknowledging Learning** and further help to explain her actions. It was often easier and more comfortable for the mothers to stay at home while learning to breastfeed. A mother, interviewed when her infant was eight weeks old, described the early weeks in this way:

> *I didn't feel confident with it ... It's only in these past two weeks that [infant has] been able to just lie here and suck like this. Mostly it's been a bit of a battle ... in the hospital there was a bit of variance in the information they gave me there, but I just took the advice I wanted to hear and ignored the rest. That's the only way I could cope with different advice (C1:2).*

In the critical early days of learning to be a mother and to breastfeed, mothers found conflicting advice given by health professionals unhelpful. This is an ongoing problem for new mothers, whether first or subsequent-time and has been well documented in literature (Inch, 1987; Davies, 1989; Vares, 1992; Bergh, 1993; Stokoe, McClarey & Dakin, 1994; Bradfield, 1996; Beasley, 1996; Basire, Pullon & McLeod, 1997; Vogel & Mitchell, 1998; Turner, Hounsell, Robinson, Tai & Whittle, 1999). A recent Health

Dakin, 1994; Bradfield, 1996; Beasley, 1996; Basire, Pullon & McLeod, 1997; Vogel & Mitchell, 1998; Turner, Hounsell, Robinson, Tai & Whittle, 1999). A recent Health Funding Authority survey indicated that "30% of women said that they had received conflicting advice about breastfeeding from different health professionals" during the postnatal period (Review of Maternity Services in New Zealand, Health Services Committee, 1999, p.26).

Step One of the 'Ten Steps to Successful Breastfeeding' urges maternity facilities to "Have a written breastfeeding policy that is routinely communicated to all health care staff" followed by Step Two which states, "Train all health care staff in skills necessary to implement this policy" (WHO, 1990, as cited in Saadeh, 1997, p.8). These first two steps, if followed, would be critical to promotion of breastfeeding and have the potential to reduce the previously mentioned prevalence of 'conflicting advice' given to mothers at the crucial early stage of learning to breastfeeding. The steps are proposed to ensure that all health professionals caring for mothers in the postnatal period: are educated in the processes of breastfeeding and lactation; can assess whether a mother is breastfeeding effectively or not; and have the appropriate knowledge required to assist and support mothers during initiation and establishment of breastfeeding. Saadeh and Akre (1996) suggest that practices such as these can "contribute to increased duration [of breastfeeding], just as inappropriate practices and failure to support and encourage mothers have the opposite effect" (p.155). Leach (1989), offering advice on breastfeeding, suggests that:

> A busy ward is not the best place to combine learning yourself with teaching your baby ... You will probably work things out better when you and the baby can be alone together in your home surroundings, with everything under your control and the privacy you need to experiment without feeling a fool (p.59).

In this study, the desire of the mothers to establish breastfeeding influenced their decisions on how long to stay in hospital. As a result, some mothers identified a need to get home to their own environment rather than prolonging their stay in hospital.

Other mothers stayed in hospital until they felt that they were breastfeeding sufficiently well to cope with it at home. This situation required the mother to have some autonomy to select the option which best met her needs at the time. Ultimately the mother made a decision on her stay in hospital taking into consideration how she felt about her breastfeeding at the time. This resulted in her going home either before or after breastfeeding was established. Acknowledging the newness of her experience and her initial 'struggles' one mother said:

> *Just after the birth - [the infant] was delivered by forceps - so [infant] didn't feed in the first couple of days and then just learning to feed ... [infant] wouldn't latch on properly and I was finding it hard. I was getting stressed out and ... I ended up spending five days in hospital and I only decided to come home then because we'd finally got our feeding right ... I wasn't going to leave hospital until I had it sorted ... But even now, I mean, [infant is] nine weeks old and we still have bad feeds when neither of us are right ... it's a bit of a struggle (D1:6).*

Another mother acknowledged, on reflection, that she may have been better to have gone home sooner to her own environment, saying:

> *I hadn't been feeding [infant] very well at all ... we had [some] problems with the positioning, but I will admit I felt more relaxed when I got out of hospital. Probably, I stayed a bit long ...I stayed the full time ... maybe six full days. And I think if I had have stayed a day or two less, I think I would have been better off because I felt much more comfortable and more relaxed in my own home (G1:16).*

While learning to breastfeed, mothers identified and described areas of difficulty where they needed and received assistance from staff. These included: positioning of the infant correctly for breastfeeding; managing effective attachment of the infant at the breast; preventing and coping with sore nipples; coping with visitors while trying to breastfeed. Breastfeeding in front of visitors was perceived by one mother to be her first experience

of breastfeeding away from home because of the 'public' nature of it. The hospital practice of encouraging visiting, while socially accepted, was not viewed as conducive to demand feeding. This new mother, who was learning to breastfeed, did not wish to appear incapable in front of family or friends and described her situation saying:

> *... in hospital I had quite a few visitors and I found that really hard to handle because that was a real learning time and generally each time I fed I did call one of the midwives to help me get going and sometimes if I had visitors over that time, I would get some of the expressed milk so I didn't have to breastfeed... I felt a bit frustrated and I wanted the visitors to go - which sounds... really mean - but... I didn't want them there... it would have been nice to catch up with them when I was feeling a bit more on top of things... you'd feel really pressured... you had these people, like cousins and aunties and other people like that there that you didn't want to feed in front of (F1:14).*

This is the first example of how a mother, very early in her breastfeeding experience, read into the situation a feeling of inadequacy and chose to avoid breastfeeding in the presence of others. Feelings of inadequacy in the early days in hospital were commonly described by mothers. One mother had felt that she had been successful in all other aspects of her life but became very disillusioned and frustrated at her inability to breastfeed in the early days after the birth, saying:

> *... I had endless trouble ... in the hospital, I was just a nervous wreck ... The midwives were really , really good, but I just couldn't get it [breastfeeding] ... I'd been working ... so many years - older mother... professional type of person... Thinking it would be a breeze having a baby - it's not ... I just couldn't do it [breastfeeding]. I'd see all these young fifteen-year-olds. Wow! They could do it and I was just so annoyed with myself. The midwives were really good. They were really patient, but I just felt really useless ... (G1:3,4).*

From this feeling of 'uselessness', this mother was able to move forward and, with early support from the midwives, managed to breastfeed for at least thirteen weeks. In a study of 400 women carried out in Auckland in 1999, it was found that 62% of mothers were breastfeeding at six weeks, a drop of 13% from figures of 75% quoted in 1994. The authors drew attention to the finding that 15% of mothers in this study had failed to establish lactation or experienced failure of the child to 'latch on' in the first place. Indirect links were made between the changes in postnatal funding, introduced in July 1996 and the decline in breastfeeding during this period. The study recommended that "Urgent further work needs to be done in the area of postnatal health services" (Turner et al. 1999, p.398).

The feelings of a new mother when she goes home with a new infant, particularly if breastfeeding has not been established, may not be understood by many people. A mother expressed those feelings in this way:

> *You do feel like it is a massive learning curve. And you do feel really unconfident when you first get home. Like you don't know what you're doing at all. In regards to everything - in regards to the feeding and the whole bit of looking after a baby. But as time goes on, you feel that you do know what you're doing and you know what you're doing more than what other people try and tell you. You know that you're doing it okay yourself. And even if people try and tell you something different, now you know things are working now and ... you feel really confident and really good that you've virtually figured it all out by yourself (F1:21-24).*

With this increasing confidence and sense of achievement, the mothers gradually moved out of the home to breastfeed. They were, nevertheless, circumspect about when they would go out and where they would go. One mother described this way of working around her own level of confidence in breastfeeding as follows:

> *Probably the first two weeks, I probably lived a pretty sheltered life - stayed at home, just getting my confidence with [infant] - just seeing how*

> *[infant] was going. It would ... probably be about three weeks old when I was taking [infant] out with me. And ... [infant] comes to most places with us now [at twelve weeks] ... but I just pick and choose where I go ... to breastfeed ... certain places I wouldn't... I've got certain stop-offs that people won't mind me doing it [breastfeeding] and I have no problem with (G1:8).*

Limiting social interaction was a way of enabling breastfeeding to take place at this critical early time of gaining confidence. The mothers decided, by reading each situation, what was best for them at the time. What seemed to be important for the mothers was to be able to breastfeed in an environment that was conducive to their comfort and was not threatening to their confidence. Learning to breastfeed was critical to feeling comfortable with their own ability.

Growth in confidence, as a mother and with breastfeeding, was more evident at the second interview at around twelve weeks. The mothers felt they had recuperated from the birth process and were starting to get more rest and sleep and hence have more energy. They were feeling more confident about their breastfeeding and confident about going out of the home to breastfeed in some situations. In order that breastfeeding could continue and become integrated into the mothers' daily lives, breastfeeding away from home became necessary or as one mother said, *"I'm out [breastfeeding], has got to happen" (E2:8)*. The learning appeared to pass through stages of development relating to:

> (1) the time when the mothers stayed close to home to gain confidence in breastfeeding
>
> (2) the time when the mothers were ready to attempt breastfeeding away from home
>
> (3) the time when the mothers felt that they were sufficiently confident to breastfeed almost anywhere and that they felt confident about their

But even with this development in breastfeeding confidence, what would happen for the mothers when they moved out of the home to breastfeed depended on the social context of their breastfeeding. Whether the mother would breastfeed away from home or not could not be predicted because of the uncertain nature of each social situation.

While progress in breastfeeding was taking place for the mother, in the meantime the infant was growing and developing. The mothers were noticing that their infants were not so urgent about needing a feed and therefore could wait a little longer to be fed if the mother was busy. They also indicated that they knew their infants better, could interpret their crying and were better able to cope with a crying infant. Mercer (1995) describes the stage of "informal/role making" in relation to the process of achieving maternal role identity wherein:

> the mother structures the maternal role to fit herself according to her past experiences and future goals. Much cognitive restructuring occurs as she learns her infant's cues and begins to develop her unique style of dealing with the role during this creative role making (p.14).

The mothers acknowledged that they were gaining confidence over a number of weeks in many ways and as a result of many experiences. Some of these experiences involved moving beyond the home with the infant and hence having to face breastfeeding in a new situation. Trying new things, such as going out of the home to breastfeed, was contingent on having the confidence to do it but also being willing to 'give it a go'. In challenging the idea that maternal behaviour is 'instinctive', Rubin (1984) says that:

> There is nothing preprogrammed or prepackaged in maternal behaviours ... All behaviour, manifest or latent, originates in the mind, in the cognitive processing of subjective experience. The most striking characteristic of maternal behaviour is the openness to new and additional learnings, the silent organisation in thought, and the high value placed on knowing (pp.2-3)

Knowing oneself as a mother who could confidently and competently care for a new infant was linked to feeling competent to breastfeed. Caring for an infant included being able to hold the infant securely and comfortably, dress and bath the infant and change the napkin. If a mother was also confident in breastfeeding then this would boost her confidence as a mother and as a woman, "*... if I had not been able to breastfeed, I would have been ... a failure ... less of a woman ... because that's me, a woman, that's me, a mother ... (A1:11).*

The mothers reminded themselves of how they had persevered to continue breastfeeding. Mothers were philosophical about the possibility of failure to breastfeed. It was their success at the time of interview that led them to reflect on just how far they had come in the process of learning to breastfeed. They remembered the people who had encouraged them and supported them both in hospital and when at home. They felt that they could easily have given up, had they not had support from others, for example, the midwife, the La Leche support person and their partners, or their own mothers. A mother spoke of this support in the context of how she would have been very disappointed if she had not been able to breastfeed, saying:

> *I was very lucky in that I had a very, very, good midwife ... she came every day, for a stage there ... She used to come and say, "and how's [infant] feeding?" and, "yes, that's good"... And she'd be here for ten minutes ... And that's all I needed <u>just</u> to keep going ... and I knew that I could ring her ... and so having that support made all the difference - it really did - otherwise I would have chucked it in - I really would because _ (partner) didn't know what to do either ... The only thing he could do was to be there and that's exactly what he did do (A2:27).*

While support from partners was very important in the process of learning and gaining confidence, the mothers always had to consider carefully what the act of moving away from home meant in terms of their ability to breastfeed in any situation in which they would find themselves. This was when the concept of **Needing Props** was significant in the process of learning to breastfeeding.

## Needing Props

The mothers spoke of the time when they began to feel ready to go beyond the bounds of their usual existence - the comfort of their own environment. Home was the private place where they could 'be themselves' as learners of a new skill. This was the place where they decided what would be best for them and for their infant and chose to avoid situations perceived by them as being potentially difficult for breastfeeding. When they breastfed at home they were able to have their 'props' around them to give them confidence in positioning the infant for correct attachment at the breast and to make breastfeeding more comfortable.

A 'prop' is described as a noun and a verb and defined as 'a rigid support, especially one that is not an integral part of the thing supported' (Thompson, 1995, p. 1097). With reference to breastfeeding, the props could be pillows, cushions, tri-pillows or anything firm and cloth-like, which could provide physical support for the infant at the breast to enable effective breastfeeding. The mothers used the props to position the infant close enough to their body for correct attachment at the breast ('latching-on') which is essential for effective suckling and prevention of sore nipples (Minchin, 1985). Rubin (1984) suggests that a pillow placed under the arm which supports the infant's head could reduce fatigue in the mother as she continues to feed. The mothers in this study had learned to use props while being assisted with breastfeeding in hospital and continued to use them when they returned home. In the early days of learning to breastfeed, the mothers became used to their props and therefore found it disconcerting when faced with breastfeeding without them.

While props may appear to be 'physical' in nature, they also contributed to the mothers' overall well-being during the breastfeeding act and appeared to influence positively or negatively the success of breastfeeding in specific situations. For example, a mother described how she breastfed at a friend's house:

> *... I just asked if there was anywhere quiet and I just sat on her bed and fed [infant] on there. But that was a bit awkward because [of] not having any support ... I needed to be sitting on a chair or something and I just*

*bounced on the bed. So that was a bit awkward ... because I haven't quite mastered feeding [infant] in my arms ... I still need help from a pillow or something like that (D1:3).*

The effectiveness of props was demonstrated in a study by Humenick, Hill & Hart (1998). They evaluated the effectiveness of a special pillow designed to promote breastfeeding, by giving it to half of a group of 130 first or second time mothers. They found that in the group of mothers who had been given the pillow, the levels of continuance of breastfeeding between two and eight weeks were significantly higher. For the mothers in the present study, the presence or absence of props were significant when breastfeeding away from home. One mother, who was suddenly thrust into the prospect of having to go out with the possibility of having to breastfeed said:

*Panic! I'd had my mother there the whole time that I'd been feeding _ (infant) and I'd been using my chair and my tri-pillow - hadn't dared to try another position ... Another time we went out on a picnic ... I didn't have my tri-pillow or anything and I couldn't quite work out a position... That was still only four weeks. Yes, I still prefer to feed [infant] using my tri-pillow (Y1:5).*

The 'physical' nature of props is easily seen, but as pointed out previously, the mothers were supported by many people during their breastfeeding experience. People can also be seen as social and emotional 'props' giving support which became very necessary for continuance of breastfeeding either at home or away from home. The mother in this situation had been supported by her own mother as she was learning to breastfeed. Raphael (1973) uses the term 'doula' for the person, either female or male, who is there for the mother and who will "surround, interact with, and aid the mother at any time within the perinatal period, which includes pregnancy, birth, and lactation (p.24).

Breastfeeding in public places proved to be difficult when the mothers found themselves without their props. One mother described what happened when she tried to breastfeed in a room in a public toilet block, which was designated for mothers and children. As

in so many places, for example, supermarkets, office blocks, public buildings, public toilets seem to equate with places to breastfeed often with no alternative provided (personal experience). The mother said:

> *I have had to feed [infant] once in town. I went into the public toilets ... that was a bit of a mission. I found it quite hard to get into breastfeeding at first as far as positions and things go ... I prefer to use a pillow ... it's easy because I can support [infant] on a pillow... But ... at the toilets I found that a bit awkward - it wasn't very - sort of user-friendly. ... sitting on a couch, I tend to prop myself up with a pillow and I make myself comfortable, whereas you've got the stiff brick wall and you've sort of got to try and juggle things around (D1:2).*

This mother was able to access a place to breastfeed albeit not a breastfeeding-friendly one, unlike another young mother whom I observed. This mother was sitting outside a toilet block trying to feed a very young crying infant. At the time of ten o'clock in the morning, the mother and infant room was locked so she had no place to go but to sit in public view and 'struggle' with her breastfeeding on a hard bench against a brick wall (personal observation, 1997). It was the potential for unsatisfactory situations like this to occur that prompted the mothers to stay at home, initially planning to avoid them, until they felt more confident in their breastfeeding.

## Planning to Avoid

The concept of **Planning to Avoid** assumes that some prior contemplation of a situation takes place before the decision to avoid it is made. The mothers in this study, while reflecting on the new experience of being a mother and breastfeeding, had a perception that other people with whom they came in contact would expect them to be competent in breastfeeding. Sometimes the mothers were simply not ready to go out and face other people while feeling a lack of confidence and competence either as a mother or with breastfeeding. The mothers often did not feel strong enough either emotionally or physically to cope with exposing themselves in a physical way or exposing their perceived level of competence in breastfeeding outside of their own home. A mother

described this feeling in relation to being a first-time mother:

> *D. If it was a second child I don't think I would be as... anxious being out in public... I am anxious about going out and having to feed [infant] in some situations but then other times, it's got to be done...*
>
> *R. Does it depend on how you feel or not on that day?*
>
> *D. I think so... Because... if you're having a bad day and ...you're not feeling happy with yourself on a particular day, you may not want to...be out exposing your all to the world... some days it's got to be done (D1:9).*

Rather than face an uncertain breastfeeding experience, mothers often planned their day around feeds, by breastfeeding before going out to avoid doing it away from home. If they were not ready or willing to interact with others as they breastfed they were not ready to take the risk of placing themselves in potentially stressful or threatening situations where they could not immediately attend to the needs of their infants. They planned to avoid breastfeeding in front of certain people and in certain places and chose places which were akin to their own home, such as their parent's home, or to the home of a very close woman friend. For example, one mother explained:

> *... once I did start getting out, I'd always plan going out after [infant had] had a feed so I wouldn't have to feed [infant] out of home because [infant] was really quite hard to latch on. It really hurt when [infant] was on there [the breast]... The main places that I did actually go were out to Mum's and to [partner's parents]. And that wasn't too different from actually being at home because you could just sit down ... and relax ... But as far as going anywhere else too far in the first few weeks - I just didn't (F1:1).*

One woman described how she managed her breastfeeding at the time by saying,

> *... if there [are] tricky situations, I try and avoid them just at the moment - till I get [infant] more comfortable with feeding in my arm rather than having all the bother with pillows and stuff ... I do find in some ways that I tend to work around [infant's] feed time so that I don't get myself in that sort of situation ... it just seems easier not to have to do it ...I feel more comfortable just doing it at home - getting it out of the way and then going out (D1:5).*

Mothers felt that they were learning to be mothers through gaining confidence and competence in the parenting skills of breastfeeding, handling their infants safely and changing napkins. They felt that other people would 'naturally' expect them to be confident and competent in these skills. The idea of others watching them as they cared for their infants, was a contributing factor in the mothers planning to avoid breastfeeding away from home. The idea that breastfeeding is a natural thing to do, in terms of the 'natural' way that the breast produces milk when stimulated by suckling of an infant, does not necessarily mean that breastfeeding is 'instinctive' for all mothers. Balsamo, De Mari, Maher & Serini (1992) discuss this idea in relation to women's choice to breastfeed in their research amongst mothers in Turin, Italy. They point out that while the medical profession and the feminist movement focused on childbirth in the 1970s, breastfeeding was not given the same level of attention:

> While delivery was seen as a social event to be piloted by institutional forms of socialisation such as antenatal classes, breast-feeding was long bound up with the concept of 'nature'. As a 'natural' phenomenon it belonged to the area still regarded as the mother's concern, a matter of maternal instinct ... On the other hand, while, in theory, breast-feeding was left to the mother and traditional folklore, in practice it was illogically bound up with feeding schedules and quantities laid down by the doctor (p.59).

These conflicting messages about breastfeeding and its 'naturalness' which appeared to equate with 'being naturally able to do it' were reflected in the need to avoid attitudes

and beliefs about breastfeeding which might be imposed on the new mother. Today the heritage of the days of 'rules and regimes' of infant feeding remains. Some of the mothers in this study were experiencing the application of these rules to breastfeeding 'on demand' when questioned by other older women about their breastfeeding. The mothers were bemused and sometimes upset when their breastfeeding 'on demand' was being judged by the standards and practices of breastfeeding in the 1960s or 1970s. One mother could not understand why such questions were being asked:

> *A ... she wants to know how much, how often ... how long is it taking ... how much weight does he gain each feed? ... I mean how am I supposed to know how much milk [baby] is getting - I don't know ... it strikes me as being very odd to be that specific.*
>
> *R. ... maybe [she is] someone who has been used to that timing ... there was a period when [mothers] went through test-weighing before and after feeds to see how much the babies were getting ... and they would say that the baby has to be fed every four hours ... at the beginning they might say three minutes on each breast, then five minutes the next day and work up to ten minutes to stop your nipples getting sore.*
>
> *A. ... It sounds dreadful. I'm not a machine (A2:22-23).*

For mothers who have breastfed in the 1990s and possibly only know about or understand 'demand feeding', these ideas of regimentation and regulation seem unusual. With a gradual location of the majority of pregnancy, birth and postnatal management within the control of small and large hospital organisational systems by the 1950s, regulation of breastfeeding practices became 'normal' practice. The prescriptive practices of weighing infants on specific days following birth, usually the third and every alternate day till discharge from hospital were often a source of stress for mothers. Test weighing before and after feeds was instituted particularly when there was a suspicion of excessive weight loss after the fifth day (Ryan, 1998; Kennedy, personal experience). Ryan (1998) points out that:

> In 1935 two pamphlets first published in 1926, in response to maternal deaths from puerperal sepsis, *The General Principles of Maternity Nursing* and *The Management and Aseptic Technique of Labour and the Puerperium* were combined to form the booklet known as H.Mt.20, the handbook of maternity nursing, which was unofficially but extremely effectively, policed by the powerful Nurses and Midwives Registration Board (p.75).

Reporting on the eleventh meeting of the Forum on Maternity and the Newborn (1985), in the United Kingdom, Inch (1987), pointed to "the lack of unrealistic antenatal information" which may leave mothers unaware of the frequency with which infants may breastfeed in the early weeks following birth. This was seen as one "obstacle to maternal confidence" (p.57).

Breastfeeding is a complex process by its very nature, demanding action and interaction which requires the mother to expose part of her body in public to feed her infant in view of other people. Learning to be comfortable with breastfeeding includes doing it in front of others. There needs to be a period of learning for the mother first to feel comfortable with breastfeeding and then to be able to breastfeed in front of others. The idea of 'social facilitation' was demonstrated in 1898 by Triplett (as cited in Peterson, Beck & Rowell, 1992, p.226) who found that the presence of others enhanced the speed at which children could wind fishing reels. More recent research showing that performance can be seriously inhibited by others watching is explained by Callan, Gallois and Noller (1986):

> The presence of other people always increases physiological arousal and thus increases drive. This higher drive increases the probability of making a *dominant response*... If the dominant response is appropriate, then the performance is facilitated ... The studies which found decrements in performance, on the other hand, generally involved complex tasks, which had to be learned. Therefore the response which was facilitated - the dominant response - was incorrect, so that speed and

accuracy declined (p.252).

With reference to breastfeeding, the skill also needs to be effectively performed for its intended purpose, as one mother explained when she was being watched by another woman:

> *...very early on, a lady that I work with came in and saw me and I was feeding and I was footballing. And she went, "aahh! Gosh! That's really awkward - what on earth are you doing?" And I just went 'yeow' - this big (downward gesture meaning made to feel 'small') ... But then I started being a bit more assertive. "It's working for me - what are you talking about?" sort of thing (A1:15).*

In situations, where new mothers were not comfortable with being watched, they felt that other people expected them to be able to breastfeed competently. Being watched made them feel nervous because they felt that they had to be seen to be 'doing it right'. This was particularly relevant when they first went out to breastfeed away from their own home. This type of watching was perceived as 'scrutinizing watching'. Mothers were not often ready for this perceived scrutiny before they were confident in their ability to breastfeed. This led them to avoid situations where there was the possibility of being watched in a scrutinizing sense. The people, whom they perceived as most threatening, were: Women with previous experience of breastfeeding; older women, including mothers-in-law, with some mothers assuming that older women were 'experts', whether they had previously breastfed or not; and professional colleagues. One mother said:

> *The worst thing about feeding outside the home ... is my own anxiety and apprehension. And being looked at ... I think its this judgemental thing. Another woman looking on and judging me. Whereas, [with] this guy, I felt quite comfortable with it - "what would he know about breastfeeding?" (laughter) (Y1:6).*

But younger women who had not had children could also make a mother anxious when they watched her:

> *... I took [infant] out to a friend's house. [The infant] was a little bit younger [less than eight weeks old] than [infant] is now. It was the first time I'd been to see her with the baby ... she's a very clucky kind of person so she was watching everything I did. And I found I was a little bit nervous because she was watching me ... and being in a strange house ... it took a little time for [infant] to settle properly ...I didn't mind her watching but I felt just that little bit of pressure to get it right ... not to bungle things up ... we got there eventually. But that was one of the worst experiences I'd had with people watching me ... it wasn't uncomfortable. I ... felt that I wanted to get it right straight away so she could think, "oh, yes, she's grasped this breastfeeding bit well" (D2:3)*

In contrast this mother did not worry about 'getting it wrong' when breastfeeding with her postnatal peer group, and said,

> *I was fully breastfeeding and one other lady was fully breastfeeding. And we had a good feed that day so that was really nice. ... it was a ... relaxed atmosphere. I didn't ... worry about getting it wrong too much because I thought all these mothers would have had their troubles as well and I think that's possibly why I was more relaxed (D2:4).*

Another mother expressed it in this way:

> *... its really good with mums because there's no judgement there ... we've all got very similar histories (A2:20).*

A different experience of scrutinizing in a breastfeeding peer group was explained by another mother, saying, *"I didn't want to feed [infant] right in the group then, mainly*

*because, having learnt about breastfeeding, you felt like you were under scrutiny ... that you're under inspection ... because of who they were (E1:4).*

Breastfeeding in front of professional peers or colleagues was something the mothers planned to avoid if at all possible. The mothers were not comfortable with the prospect of breastfeeding in the presence of colleagues with whom they had *" this professional relationship" (B1:12).* One mother did not want to be seen by her colleagues in 'conflicting' roles of mother and professional person. She felt that her position might be undermined if her colleagues saw her in a 'mother role' as opposed to a 'professional role'. In contrast, she said, *"I would be perfectly fine in front of strangers to do it, which is interesting ... (B1:12).*

The 'professional relationship' was also seen as a limitation to breastfeeding either at home or away from home by the mothers whether they were back in employment or not. The idea of breastfeeding in front of a person with whom the mother had had a previous 'professional or workplace relationship' was seen as potentially challenging or not even possible. The mere presence of another person watching when the mother was previously known to that person within a context of a professional or work relationship was not acceptable to the mother. Breastfeeding in front of peers in the work environment was definitely something that a mother, who was not one of the participants in this study, would not do. She had previously heard her work colleagues say, when a mother breastfed at work, "I don't think she should be doing that here" or other negative comments such as, "I don't want to eat my lunch and see - big breasts" (personal communication, 1998). There was a feeling on the part of this mother that there is a need to command respect from work colleagues. If the mother was then placed in a position where the possibility of negative comments were made about her activities, in this case breastfeeding, then that had the potential to undermine the quality of the 'professional relationship' she had with her peers.

The 'professional relationship' was a context within which another mother found it impossible to breastfeed. She saw the 'friendship relationship' change to one of 'professional' when she began to breastfeed. A person who saw herself as a friend to

the mother, but whom had also been known to the mother in her role as a 'professional person,' became a person, in front of whom the mother could not breastfeed. This mother, like the previously mentioned mother felt that the relationship with this person needed to stay intact at the professional level. The mother explained it by saying:

> *... I just don't want to give that much of myself to her or expose that much of myself. It's not a physical thing, it's an emotional and mental thing that I just cannot do ... she would see me as a friend ... but I still see myself in that [professional] role (Y1:14,15).*

Another mother who was planning to return to work was forced to plan her infant care around not being able to breastfeed at work:

> *... he will ... need a bottle if I'm going to work.*
>
> *R. And you wouldn't consider taking him to work and breastfeeding?C.It's not viable ...it wouldn't be possible at work ... they said, " well, you know of course, that you can't have the baby here. It's okay just for a few minutes now and then. But you can't have the baby on site" ... they ... I suppose warned me that if I had any intention of feeding the baby at work that wasn't going to be possible.*
>
> *R. There would be no facilities available?*
>
> *C. ... definitely <u>not</u> and they wouldn't encourage it anyway but that would be fairly typical - it wouldn't be unusual. It's bad enough getting a job anyway, I feel if you've got children because they think your child is going to get in the way of your concentration but to ask for things like feeding facilities would be pushing it a bit.*
>
> *R. How did you feel when they said that?*
>
> *C. I felt a bit put off ... because I wasn't even going to ask for that sort of thing but ... they got in first ... they sort of implied that I wasn't very professional. In fact ... that's what professional means is that you don't do that sort of thing. It would be <u>nice</u> if we could ask for those things, but I don't think it would help women's case doing that.*

*R. So being professional is not breastfeeding your baby at work?*

*C. That's right ... to get ahead in my job ... you have to ... come across with that professionalism. And children don't mix with that ... it would be nice if there was a law that said that there must be facilities in every working premises for women to be able to breastfeed their baby and that would be the end of it ... The only thing that will change things is that if more men are involved with the whole baby process. They have children of their own - they see their wives struggling with the same problems and they voluntarily say, "well, why don't we have facilities here at work for our women?" ... that's the way it's best to change.*

*R. Change from the inside?*

*C. Yes, not through demands made of employers. It's just education of men ... and then they'd be a bit more understanding about it. It would be nice to have a room at work where I could just have [partner] bring [baby] to work and I could feed him ... but it's probably a long way down the track (C2:6,7).*

Soon after this mother expressed these feelings, it was reported that

> A group promoting family-friendly workplaces is advising employers to encourage women with babies to feed them at work ... The idea is being welcomed by the Employers Federation and the Minister of Women's Affairs, Christine Fletcher, who says it will get women into responsible positions in the workforce ... ideally working mothers would pop into the creche to feed their babies... Where it was not possible to provide day care, employers could help women by encouraging nannies to bring babies to the workplace to be fed and by providing a clean, comfortable and private place for them to be fed (Adelia Ferguson, New Zealand Herald, 14 April, 1997).

The economic and health promotion benefits of this initiative were explained by pointing out that breastfed infants were usually healthier thus reducing the number of work days

that parents may spend caring for their children if they are sick. These ideas are potentially supportive of mothers who breastfeed and are in paid employment, but not all women are able to work during hours when daycare facilities are available.

The perceived opposing ideals of motherhood and professionalism were reasons for these mothers to alter the way in which they approached breastfeeding. They expressed milk and left it for another person to give to the infant. While this action placed a value on the breastmilk, it did not attempt to value the process of breastfeeding. Expressing milk was not the preferred option for the mothers, but was a necessary one in the absence of support for breastfeeding from employers. This placed constraints on the mothers' freedom to act in the way they wanted and in a way that they judged best for their infant and necessitated them planning to avoid such situations.

The perception of being scrutinized, judged or seen as a 'different person' by colleagues, made the mothers more anxious in contrast to 'curious watching' which was accepted for what it was and viewed positively in some situations. A mother, who was so intent on watching a sporting event while breastfeeding, was minimally aware of and not worried by teenage girls looking round at her. She attributed their watching to curiosity. One mother described an interaction with pre-school children, saying, *" they stand and they watch and they think it's cool -they don't come across as horrified or anything - they're just making an observation and they're fascinated by the babies" (A2:2).* This mother thought that this type of watching was a positive factor in teaching young children about breastfeeding, since some of the children had never seen anyone breastfeeding.

In contrast to this view, the mothers of some of these children did not want their children to see a mother breastfeeding and threatened to withdraw them from the situation. This put pressure on the mother to discontinue breastfeeding in that setting to avoid offending other mothers. This was disconcerting for the mother who was breastfeeding and who interpreted this situation as follows: *"These mums are not okay with the kids seeing - I think it's them seeing my breast more than anything ... for me I find it [attitude to breastfeeding] quite unusual" (A2:3).*

Reflecting on this situation, the mother wondered about whether the mothers had breastfed their own infants and if they had, how they had done so, making an assumption that the children had not been allowed to see their mothers breastfeed. When children are able to see breastfeeding happen, as Kitzinger (1989) believes they should, this modelling of breastfeeding behaviour may be a way of promoting breastfeeding. McConville (1994) states that, "... many new mothers have never watched another woman breastfeeding. Yet breastfeeding is not an instinct: it is a process which every new mother has to learn for herself, and learn at a time when she is often mentally and physically exhausted" (p.101). The mother in this situation was planning to avoid future interactions with the mothers and the children while she was breastfeeding, not because she herself wanted to, but because others did not want her to breastfeed publicly.

**Planning to Avoid** was explained in relation to how mothers interpreted the meaning of events in the early days and weeks of breastfeeding and acted in their own best interests. The mothers found breastfeeding away from home initially easier in places like their own homes, such as parents' homes, or amongst supportive friends. They felt that to expand their breastfeeding beyond these situations was a challenge that they needed to avoid, hence they limited their social interaction during this early period of learning to situations which would enable them to breastfeed within a supportive environment.

## Summary

Emerging from the data was a picture of mothers learning to breastfeed in similar, but different ways, depending on their individual situations. The contexts varied with each mother but some were similar in that for all these mothers there was a large element of learning taking place and breastfeeding away from their own home presented a challenge to them. Therefore, within the context of learning, they chose to limit their social interactions often until they felt more confident with breastfeeding. They read each situation, assessing their own abilities and the social contexts and did what they thought was best at the time. Having to go away from one's home occurs in any aspect of human life, and involves the possibility of social interaction. When a person moves away from their own home environment, it is more than simply walking out of the door to move from inside to outside; it is a complex construct of what happens within a

context of newness, particularly following a change in their life. It therefore has significance for any person in their everyday life when the person is facing new and difficult situations, such as: meeting people after the death of a loved one; learning to walk again after a period of disability. For first-time mothers, the prospect of having to go out of their own home to breastfeed presented its own particular challenges. In Chapter Seven, the category of **Meeting Uncertainty in Social Situations** is explained.

# CHAPTER SEVEN

# MEETING UNCERTAINTY IN SOCIAL SITUATIONS

## Introduction

In Chapter Six, the meaning of events, as interpreted by the first-time mothers in this study, was presented through the category of **Limiting Social Interaction while Learning to Breastfeed**. The newness of motherhood and breastfeeding underpinned the mothers' progression through their early breastfeeding experience. In order to retain their choice of continuing to breastfeed, the mothers needed to be able to breastfeed whenever and wherever the infant needed to feed. Therefore, whether they breastfed away from home or not, depended on how they would read each situation and how confident they felt about breastfeeding. In the previous chapter, it was shown that the mothers needed to limit their social interaction away from home while they gained confidence in breastfeeding. In this chapter, the category of **Meeting Uncertainty in Social Situations** will explain what was happening for these first-time mothers when they were away from their own home and needed to breastfeed their infants. Because breastfeeding was always a possibility when they went away from their home with their infants, they could not be certain that the social context would enable breastfeeding. This category which emerged from the data, will be explained through its conceptual properties. The concepts which will be described and discussed are as follows:

**Exposing the Breast** : A necessary action initiated by the mother to enable the infant to attach at the breast for effective feeding. The process of the infant attaching at the breast is popularly referred to as 'latching-on'.

**Identifying Milestones**: Recognising significant points in the process of learning.

## Meeting Uncertainty in Social Situations

There was a period following birth when the mothers felt more comfortable learning to breastfeed amongst health professionals or supportive family or friends. However, there were times when during this early period, the mothers would have go out of their homes with their infants and would have to meet some situations of uncertainty. This category relates to those times of uncertainty. The next statement represents one mother's feelings about meeting the challenge of uncertainty:

> *Each time you do it it's like a challenge...am I going to do it and is it going to go well or am I going to do it and is it going to be a disaster? The thing is if you have any doubts, it generally is a disaster (Y2:21).*

Cohen (1993) in her study of uncertainty in relation to chronic or life-threatening illness in children maintains that uncertainty is universal and multidimensional, varying "from the overarching, existential issues of life and death to the inconsequential contingencies and probabilities that are the substance of everyday life" (p.78). She also points out that uncertainty can be either "overwhelmingly" stressful or "provide a challenge" (Cohen, 1993, p.78). Trying something new in an uncertain situation demanded courage and mothers did this only when they felt competent enough to move forward. The mothers interpreted situations and acted according to their feelings of confidence and comfort. Sometimes they were in a situation where they were challenged to try something different and new because of where they were and the necessity to feed their infants. The concept of **Exposing the Breast** explains what happened when the mothers needed to initiate a breastfeed and it was crucial to the feed that the infant was correctly attached at the breast. This concept interrelates with the concept of **Identifying Milestones** as the mothers were able to see some progress in their learning resulting from experiencing challenges and rising to them.

## Exposing the Breast

A situation of uncertainty for the mothers at this stage was when they had to initiate breastfeeding for the first time in front of other people. As discussed in Chapter Six, the mothers in this study needed to feel confident and comfortable about breastfeeding

in the presence of others, otherwise, they planned to avoid those situations. Unless the mother intends to stay at home for all of the time when she breastfeeds, there must be a first time when she has to breastfeed away from home. To enable the infant to attach at the breast or 'latch-on', the mother moves to open or pull up a garment covering her breast, actions that are symbolic of starting to undress. There is, at this moment, the potential for exposure of the breast. Getting the infant initially attached at the breast requires the mother to be in a good position for feeding. Some of the mothers described how they felt while exposing their breasts to feed:

> *...My first sort of 'outside' feed was a bit awkward because I wasn't sure how people were going to react - and I wasn't a hundred per cent confident about breastfeeding...it was just sort of like flopping yourself out ... and I probably wouldn't have thought about it except for the people's place I was at... I hadn't known them for very long... (A1:1)*

> *...we'd had a couple over for dinner and the husband was there and I felt uncomfortable with that just because I'm a very private type of person and I didn't feel comfortable whipping out my breast... (B1:2).*

> *Friends ...at work invited us over to their place for dinner...I was a bit apprehensive as to what I would do if [infant] wants to be fed while I was there because I wasn't so sure about it...but it wasn't bad...I think it had to do with the whole atmosphere because we felt very relaxed and very comfortable with these people...I was a bit cautious of how - like I wasn't probably as free with exposing myself as I would have been at home or something...I was surprised because I was <u>very</u> apprehensive about it at the beginning (B2:2)*

> *You're not sure how they're going to take it if you suddenly sit there and flop out your boob and attach your baby. Yes, you do wonder [what] <u>they</u> think of the situation. Especially if they are older people - whether they think it's a bit obscene or something like that (F1:7).*

Beasley (1993), in her study, found similarly that one mother was aware that breastfeeding in public sometimes caused problems for young men and elderly people.

In the early days of breastfeeding, the mothers often hoped their infants would not need to be fed when out visiting in order to avoid a challenge which might generate, in themselves, feelings of awkwardness, discomfort and apprehension, such as these mothers described. The feelings of exposing the breast, for example, when the infant was initially attaching to the breast ('latching -on') was something that one mother had not thought about before her infant was born, saying, *"... if somebody had told me six months ago that I'd sit and bare my [breast] in the ... Bank, I'd have said they were ridiculous" (E1:3).* The possibility of needing to expose the breast during breastfeeding may or may not have been discussed in antenatal classes. One mother pointed out that she had got used to breastfeeding in public by nine weeks while people around her were not so familiar with seeing a mother initially exposing her breast and nipple. Once the infant was correctly attached, the mother would arrange her clothes to cover the breast and perceived herself to be breastfeeding discreetly:

> *I find that people tend to look away a little bit when you feed in front of them - probably more males - perhaps people that you don't know...Sometimes you've got to ...wear certain clothes to try...not to expose too much out in public ... (D1:8)*

> *I think people tend to be more embarrassed than we are from feeding in public... because its nine weeks I've been breastfeeding and I've sort of got used to it ... people tend to look away a bit more...they get a bit uncomfortable and ...look away when you're starting to prepare your feed and once [infant is feeding] they talk to you again. But the eye contact's not there, you know. It's a bit embarrassing ... You're probably exposing yourself a bit more and you know you've got to get the right position. You then can ... pull your shirt down a bit more...(D1:9)*

Another mother reinforced this by saying, "*Feeding out in public ... you know, ... it's done discreetly ... (E2:4).*

The clothes that the mothers wore were mostly chosen with discretion in mind. A tee-shirt was felt to be a more useful garment than a button-through garment in reducing the amount of exposure of the breast. Even the colour of the clothes was considered, for example, the contrast between the colour of the milk and the colour of the tee-shirt was minimised to hide the fact that milk was leaking from the breast. One mother and her partner discussed the contrast between skin and clothing colour saying:

> *C: ... Did you notice me breastfeeding?*
>
> *Partner: You were so discreet about it I just wouldn't know ... It's the clothing that you wear that makes it more discreet, though ... Even the pale colour of your clothing makes it more discreet. If it was dark, you'd notice it much more.*
>
> *R: Is that the difference - between the colour of the skin and the colour of the clothing?*
>
> *C: You mean wearing white skivvies?*
>
> *Partner: Yes. That's why I hardly ever notice (C2:4,5).*

The initial movement toward attaching the infant at the breast was a time of vulnerability and uncertainty for mothers, particularly in the early days, when the infant and the mother were learning to breastfeed. The infant would attach and then detach from the breast sometimes several times before eventually 'getting it right' and settling in to suckle. A mother described how she felt in those initial moments when the infant was 'latching-on' in her first experience of breastfeeding away from home with friends:

> *... it was just like flopping yourself out ... and the [friend's] husband, he was a <u>little</u> bit awkward and didn't look directly at me when I did that [latching on] and that's what made me think, " hey, maybe this is not the right thing to do " ... it was just that initial undoing of the shirt... sort of like baring yourself to the world whatever ... (A1:1,2).*

The mother interpreted the man's response by questioning the rightness of her own actions. When she was placed in a similar situation in her own home and friends came to visit she described the reactions of the males at the beginning of the breastfeed:

> *... the guys didn't quite know what to say and didn't quite know where to look ... so the conversation changed about three different times in about two and a half seconds ... everyone sort of tried to fill a gap ... and there wasn't a gap to fill but they tried to fill it anyway ... and that didn't last anytime ... It was really good ... because it wasn't really prominent, but the guys were a bit uncomfortable until [infant] was latched and the <u>breast</u> ... wasn't exposed any more ... (A1:10).*

In these initial moments of uncertainty with 'latching-on', mothers were aware of the presence of others and particularly the reactions of the males at the beginning of the feed. It may be difficult for people other than the mother to set the breast in its context of nurturance at the moment of exposure, which was described by some of the mothers as a feeling of 'flopping out'. Beasley (1993) points to how a mother in her study described "nudity resulting from breast exposure while feeding an infant ... labelling it as 'flaunting' behaviour, a habitus generated 'common sense' notion of propriety" (p.122). Some exposure of the breast and the whole of the nipple is necessary for effective attachment. McConville (1994) admits that she has not had much success in discussing with men how they feel about breasts, pointing out that the way men view breasts varies in different cultures. However, she notes that Western men tend to say that they behave sexually when confronted with breasts while "Men from countries with different cultural traditions are not so fixated by breasts ..." (p.23).

While this sense of **exposing the breast** was initially a new challenge for the mothers, it became added to the variety of learning experiences which gave them confidence for future breastfeeding situations.

## Identifying Milestones

New situations of breastfeeding away from home were seen by the mothers as learning experiences or challenges, and described variously by the mothers as a 'major', a 'milestone', a 'turning point' or a 'danger' feed. When the mothers succeeded in doing something new in relation to breastfeeding, this gave them a sense of achievement. They were able to identify these times of achievement during uncertainty as 'milestones' in the learning process during the six to twelve weeks following birth. One mother described this feeling as:

> *yes, I had struggled - and trying something new was very threatening - like, oh, maybe he won't ... - I'll go back a step if I try something new and every time I have tried something new it has worked so I think I have been lucky (A1:6).*

Whichever way the mothers described this experience, it indicated a step forward in learning to breastfeed. The term 'milestone' has been used to highlight the mothers' interpretation of a significant point in the learning process.

As the mothers began to move out of their own environment to breastfeed they were faced with a variety of social situations. They were interacting often with people who were unknown or not very familiar to them and they did not know for certain whether they would be able to breastfeed in the situation in which they found themselves. Young infants in the first six weeks after birth have an urgent need to feed and are not easily pacified. This urgency to feed sometimes caused the mothers stress. A mother described such a situation as a 'danger feed'. By 'danger' she did not mean that she would be in any physical harm but she was questioning the 'rightness' of breastfeeding in a public place and at a time when she had not tried it before in public. She did not know how she would manage or if she should be attempting to breastfeed in that situation:

*... it was my first sort of 'danger feed'... because not knowing, and it's very public, and it's very - not like that I would be in any danger or that [infant] would, it's just that ... comfortableness - it was like ..." ooh! This is ... almost like a bit naughty ... is it alright to do this?" (A1:6).*

The experience proved to be very positive for this mother and she saw it as a 'milestone' in learning to breastfeed and in being a mother and describes this move forward saying:

*... I knew [infant] was due for a feed and I took longer than expected [shopping] and I thought ... "I can change [infant] in the car, so why can't I feed [infant] in the car?" ... so I just did ... and all these people were wandering by ... ones that noticed sort of looked twice ... everybody smiled, nobody was upset about it or anything... it wasn't like I was really on show ... I felt really proud of myself that I could do that - that I just did that all by myself ... And then I changed [infant] and went shopping, and you know, it was buzzing for me all day - it was really nice, just being able to do that for me - being confident to do that, sort of a real step.*

*R. How old was [infant] when you were able to do that?*

*A. [Infant] would have been about six weeks old ... it was just like, "I can do this, I can do anything!" ... we didn't have a pillow, I didn't have a cushion ... it was just me and [infant] so we did this by ourselves without any extras ... that was a real proud moment, a real milestone for me ... it made me more capable for other things too ... like, "if I can do <u>this</u>, then I know that I'm going to be capable of being a good mum" ... and every first mum has concerns about being a good mum ... and that was a real confirmation that I could do it and I will be okay - it was really good (A1:7).*

This 'milestone' may have been the point when this mother could have identified herself as a 'competent breastfeeding mother'. Referring to their study of how people acquire skills, for example, airline pilots and chess players, Dreyfus & Dreyfus (1996), point out that " ... a novice, if he or she possesses innate ability and has the opportunity to acquire sufficient experience, gradually becomes an expert ..." (p.35) They have chosen to identify five stages of skill acquisition - "novice, advanced beginner, competent, proficient, and expert" (p.37). However, they point out that their choice of five stages was adequate for their purposes and should not be considered "as definitive" (p.35).

The sense of achievement, of satisfaction, and the excitement expressed by the mothers when they identified 'milestones' is similar to how Dreyfus & Dreyfus (1996) describe the emotional involvement associated with their stage of "competence" (p.39):

> There are ... more situations than can be named ... so, no-one can prepare for the learner a list of what to do in each possible situation. Thus competent performers have to decide for themselves what plan to choose without being sure that it will be appropriate in the particular situation. Now coping becomes frightening rather than exhausting, and the learner feels great responsibility for his or her actions ... often at this stage things work out well and a kind of elation unknown to the beginner is experienced, so learners find themselves on an emotional roller coaster.
>
> This combination of necessity and uncertainty introduces an important new type of relationship between the performer and his or her environment ... The competent performer, ... after wrestling with the question of a choice of perspective or goal, feels responsible for, and emotionally involved in the result of [her] choice. An outcome that is clearly successful is deeply satisfying and leaves a vivid memory of the situation encountered as seen from the goal or perspective finally chosen (p. 39, 40).

Another mother, describing her experience at a sports event as a milestone in her experience of learning to breastfeed, is faced with uncertainty about what to do in this new situation, saying:

> *... we went to a [sports event] ... I was very proud of myself that I fed there in front of everybody ...[infant] slept for most [of it] and then... woke up halfway through when [infant] was hungry ... and when [infant] wants to be fed, [infant] wants to be fed - [infant] lets you know pretty straight away ... and so I thought, " ... now what do I do?" ... because that was in the aisle with people everywhere ... and I thought, "well, [infant] has to be fed". So I just fed [infant] and I ... felt very proud of myself when I came home. [I said], "I fed [infant] in front of the [game] and everybody was around and it didn't bother me". ... that was my biggest milestone ... once I did that, I felt pretty confident that I could breastfeed anywhere - it didn't matter what I was doing ... I think being such a big open place with so <u>many</u> people - that's what made it important to me. That I was able to do that there and I felt comfortable with it and _ (infant) was obviously satisfied afterwards (B1:4,8)*

One mother, who was able to breastfeed in front of a male other than her husband, when she had previously perceived this as a possible challenge, identified her experience as a milestone for her and said:

> *The first time [breastfeeding away from home], I went down to [my girlfriend's] and [her partner] was there. I did feel proud of myself that I didn't back out and ... go back home or asked to go back into a room. I told [my husband] that night, "I fed in front of my first male stranger!". And I actually told him that and so that was ... a milestone for me (F1:24).*

Each of these examples of achievement in the face of uncertainty, as Dreyfus & Dreyfus (1996) said they would, left "a vivid memory" with these mothers. But for me, as

researcher, the memory was also there, not because I was with them at the time, but because of the way in which they related these experiences to me. I can still hear their voices, full of emotions of sheer joy and satisfaction at their achievement. These experiences were significant in their process of learning to breastfeed away from home.

With each new situation, the mothers began to feel more comfortable about breastfeeding away from home. There would, however, always be people in front of whom they would not breastfeed. They knew who they were and why they would not breastfeed in their presence. Yet, as the previous mother found out, she was glad that she had persevered to breastfeed in front of a male person. She saw this challenge as a step forward in her breastfeeding experience. One mother wanted to pass on her experience to encourage other mothers, saying:

> *And to all women breastfeeding in public [advice for breastfeeding women] - once you've done it once, each time you do it subsequently it gets so much easier. You just get more comfortable, learn ways to be more discreet because you know more what you're doing, the baby knows more what you're doing. Now at three months, if the baby comes off [they] just put [themselves] back on - you know, at six weeks [infant] couldn't do that (Y2:2).*

**Identifying Milestones** was the mothers interpretation of their progress in the breastfeeding journey. A sense of achievement was obvious from the manner in which they related these experiences of learning to breastfeed away from home.

## Summary

The mothers continued to gain confidence through increased and ongoing social interactions while breastfeeding away from home. However, each time they went away from home to breastfeed they would not know for certain how they would act until they were in the relevant situation and this presented a challenge to them. They tried to meet these challenges of having to expose their breasts while they attempted to attach the infant at the breast. They responded to new situations and were rewarded by a sense of

achievement. While they felt that they had gained confidence to breastfeed in the company of others in most situations, the uncertainty of many situations remained. The mothers read each situation as it presented itself. They attended to their breastfeeding in ways which reflected their feelings about the situation, including the place and people, or their level of confidence at the time. The category of **Reading the Situation** is explained in Chapter Eight.

# CHAPTER EIGHT

# READING THE SITUATION

> **... the human individual confronts a world that [she] must interpret in order to act ... [She] has to cope with the situation in which [she] is called to act, ascertaining the meaning of the actions of others and mapping out [her] line of action in light of such interpretation (Blumer, 1969, p.15).**

## Introduction

The above account of the 'nature of human action' given by Herbert Blumer (1969) in his book, 'Symbolic Interactionism: Perspective and Method' (1969) is compared with the words of a first-time mother talking about breastfeeding away from home:

> *...you've sort of got to pick your situation - and who you're around and just the way you do it... it's just a matter of reading the situation and just doing what's best at the time (D1:10).*

I was constantly drawn back to the way in which this mother described what was happening for her at the time as she continued to breastfeed at approximately six weeks after the birth. There is congruency between Blumer's explanation of a premise of the theory of symbolic interactionism and what this mother is saying about her ways of acting within a context of social interaction.

**Reading the Situation** has emerged from analysis of the data as a category, the properties of which represent what was happening for the mothers as they were faced with the possibility of breastfeeding. While grounding this category in the words of one of the mothers in this study, **Reading the Situation** reflects what was happening for

the other mothers. The mothers interpreted each situation of social interaction. As a consequence they acted according to their best judgement of the situation. The words of this mother, when she says, *"just doing what's best at the time" (D1:10)* captures the reality of what she needed to do to enable breastfeeding to happen within a context of social interaction and learning to breastfeed. She indicated that she mentally interpreted each situation in which she found herself in order to guide her actions. *"Who you're around and just the way you do it" (D1:10)* conjures up a reality which will be described and discussed in this chapter.

"Situation" includes the environment in which breastfeeding takes place, the circumstances or context, that is, the social and cultural as well as the physical aspects. Picking the situation and reading the situation implies that there is an element of contemplation about subsequent action in relation to breastfeeding. There are ultimately decisions to be made and choices to make depending on where the mother is, who she is with and how she feels about breastfeeding and herself at the time. Overall the mothers used their discretion to guide their actions. The use of discretion encompassed the strategies they used to manage their breastfeeding from the early days of lacking confidence to their ongoing interactions in a variety of settings. Discretion is defined as 'self-preservation', 'prudence' 'being discreet', to 'act according to one's own judgement' (Thompson, 1995, p. 386). Each of these words indicate that there is some contemplation about the action to be taken as well as some care in taking that action. The mothers used their discretion in situations where they were uncertain of the outcome for breastfeeding in the beginning, because of their own feelings of inadequacy about the situation. They therefore chose strategies which appeared to be the best way to act in the circumstances to protect themselves and others from potential embarrassment or feelings of emotional discomfort. These were actions which acknowledged the newness of their experience of breastfeeding and the uncertainty which they faced as mothers learning to breastfeed and moving out of their own 'secure' environment to breastfeed. The concepts which explain this category are as follows:

**Asking Permission**: An action identified by the mother as a necessary pre-requisite to breastfeeding in the presence of others.

**Postponing**: Delaying breastfeeding in favour of a situation which is more conducive to breastfeeding.

**Withdrawing**: Moving away from a situation to protect own and others privacy and possible feelings of discomfort.

## Reading the Situation:

### Asking Permission

Assumptions underlying the concept of **Asking Permission** are that:

(1) Breastfeeding is not an ordinary everyday activity to be undertaken anywhere and therefore requires permission to be asked of someone to do so;

(2) freedom to breastfeed does not exist and mothers need to ask permission to breastfeed in public;

(3) people other than the mother or the infant might prevent breastfeeding from happening.

These assumptions may lead the mother to perceive breastfeeding in a context of rightness or wrongness, allowed or disallowed. The idea that breastfeeding can be controlled by other people has the potential to discourage mothers from even trying to breastfeed. Each time the infants needed to be fed, the mothers needed to initiate that feed and therefore they also needed to make a statement to whomever was around at the time that they were intending to breastfeed. This led the mothers to ask permission to breastfeed as a preliminary gesture to feeding. When going out into social situations the mothers were aware that they were in 'different spaces' and not in their own home or 'space'.

The varied contexts, within which the mothers in this study breastfed and their own values and beliefs may have influenced their reasons for asking permission. Reasons

given by the mothers included: *"I'm in someone else's house ... it's their space" (A:4)*; *"because it's polite to ask those things ... [when doing] anything out of the norm ..." (E1:11)*; *"some people might have been offended" (A1:4).*

When supposedly advanced countries such as the United States of America still have laws which forbid women from breastfeeding in public, then permission to breastfeed is not even able to be given let alone requested. As recently as 1993 and 1994, the states of New York and Florida passed laws which permitted women to breastfeed in public or private places, "irrespective of whether or not the nipple of the mother's breast is covered during or incidental to the breastfeeding" (New York law of May 16, 1994, as cited in Yalom, 1997, p.142). The message is very mixed here and is underscored by the idea that breastfeeding in public is verging on indecent exposure. Yet women are being encouraged to breastfeed for health reasons (WHO, 1990).

By asking permission to breastfeed, the mothers chose to be respectful of what they did in other people's homes because 'that was <u>their</u> space'. If there was a potential to cause offence, then they felt that they needed to ask permission from the owners of the home or the premises. On the first outing with her new infant, a mother explained why she felt she had to ask the cafe-owner if she could breastfeed:

> *The first time I had to do it we were going out to get groceries ... and [infant] got really unsettled ... there was a little cafe just outside there ... I ... felt I had to ask permission before I actually breastfed [infant] - I don't know if it was ... me being uncomfortable. The first time I was really unsure of it as well ... or the people there ... I said, " do you mind if I feed my [infant]?" And they were like, "no, no, go ahead, that's okay". But I could tell it was an uncomfortable situation - for them and for me just because I wasn't used to it as well ... and that was like, 'okay, quick, hurry up - let's get this over with' (B1:1).*

This mother was facing an uncertain situation compounded by her lack in confidence to breastfeed at that time and never having had to do it away from her own home before.

She was acknowledging that she was in someone else's place and not her own. Permission was also sought because the mother was uncertain of the reaction she might receive, or how the other person might feel about breastfeeding occurring in public. Another mother explained why she would ask permission to breastfeed and how she would act in an uncertain situation:

> *...with those particular people ... I know that they would be offended, but in general, if I've got any doubt, I would ask and I would just say, especially if I'm in someone else's house - because it's... their space and if they're not comfortable with it, then it's their space ... (A1:4).*

Interpretation of another person's 'space' extended to a variety of places. One mother described her visit to a health professional:

> *... I asked where was the most suitable place to go and they put me in a different sort of area not ... directly in the waiting room - all sorts of people coming - some people might have been offended ... I said, " well, I'm going to have to give [infant] a feed ... are you okay if we do it in here or would you rather I go somewhere else?" And they said, "no, no, we've got a spare room that you can have some privacy in" - and that was <u>great</u> ... I could feed [infant] quite comfortably in whatever position I felt like ... which was really nice (A1:2).*

By asking permission, this mother was offered some privacy which enabled her to breastfeed in the way she felt most comfortable. The mothers also asked permission to breastfeed out of a sense of courtesy because it was the socially accepted thing to do. A mother who had to feed her infant during a lengthy visit to a bank, felt she needed to ask permission to breastfeed out of courtesy for the bank teller's 'space'. The mother felt that breastfeeding was an example of doing something *" out of the 'norm' as it were" (E1:10). "... it's just a straight courtesy - it's not a real ask - not in that situation " (E1:11).* The mother <u>had</u> to feed her infant because of its urgency to feed, so she saw her question *"you don't mind, do you?" (E1:2)* in this situation as rhetorical.

When this mother was asked what she would have done, if the bank teller had refused her permission to breastfeed she said:

> *... I would have said I'd come back later and gone somewhere else. I had to feed [infant]. Because [infant] did need feeding ... [infant is] used to demand feeding and you suddenly say ... "no, wait ten minutes". I mean [infant is] six weeks old - [infant is] like 'w-a-a-h!' [urgent crying] (E1:12).*

This mother's proposed alternative action presents a picture of how a mother's will to breastfeed could potentially be constrained as a result of other people's regulation of her breastfeeding. This constraint on her actions moves the mother to act in other ways depending on the situation. The mother decides to postpone breastfeeding or withdraw from the situation and breastfeed somewhere else.

For the mothers who had returned to work and were intending to continue breastfeeding, permission to breastfeed was asked of the employer in order to work within the rules of the workplace. For the four mothers who had returned to work during the course of this study, combining breastfeeding and employment was central to the organisation of their day.

The idea that breastfeeding and or motherhood are not 'professional' activities was perceived by two of the mothers as barriers to breastfeeding at work. While one mother was able to access facilities for expressing milk, the idea of actually breastfeeding while working in a professional role was perceived as difficult. The difficulty arose firstly from the constraints placed on her by her employer as to where she could and could not feed. While the employer was supportive of having the infant at work for a few hours, limitations were placed on having the infant at work during meeting times. Added to this, the mother placed constraints on herself because of her position in the organisation. This led to the postponement of breastfeeding and to the initiation of intermittent bottle-feeding. Bottle-feeding, an alternative method of infant feeding, is often used when breastfeeding is not possible. The concept of **Postponing** in relation to breastfeeding

will be explained in the following section.

## Postponing

Postponing is usually preceded by an event, situation or 'crisis' which delays action until a later time. Postponing may have positive or negative consequences depending on the circumstances. There are many life situations where postponement is used as a means of protecting the person from an experience for which they are not ready or which may cause them some stress. Postponement of events can take place when the weather is not right and to proceed would have undesirable consequences of discomfort or poor performance.

Examples can be drawn from across the lifespan and from a wide range of life situations. Postponement of childbearing or first pregnancy may have consequences for future fertility in that the women may take longer to conceive (Sundby & Dahl, 1994). Women may postpone health care or health screening for various reasons, yet disease prevention is known to depend on early detection. McKinney and Marconi (1992) suggest that the cost of having a mammogram is rarely the major reason given by women for postponing a mammogram. Postponing death can take place when technological interventions are used to prolong life. Postponement of death can take place, for example, in infants who are 'at risk' from causes associated with premature birth (Piper, 1991). Postponement of death can take place right across the lifespan to older age. Technologies which are used to 'save lives' have raised ethical issues such as the right of the individual to choose or refuse care when faced with what postponing death might mean in terms of quality of life (Baer, 1992). People who wait for surgery sometimes have the added stress of postponement. Bresser, Sexton, & Foell (1993) found that patients who were awaiting coronary artery by-pass surgery and had had it postponed, sometimes more than once, felt angry, powerless and disappointed.

Morse & Gamble (1993) identified 'postponing' as a basic social psychological process which "placed the father in a position of supporting the breastfeeding pair from birth to weaning" (p. 360). Within a context of "making breastfeeding work", the fathers postponed their relationship with their infant, during the period of breastfeeding,

realising that it was "qualitatively different from the relationship the infant had with the mother" (p.360). Morse & Gamble found that the fathers "found ways to catch up" (p.358) once the infants had weaned.

When mothers in this study used postponing, it was an action that they took when they knew that breastfeeding would not be possible in the present situation. They postponed breastfeeding until a more suitable time or place was available to them. They postponed breastfeeding because they were also not willing to expose themselves emotionally or physically to the possibility of failure to breastfeed. They may feel uncomfortable, be embarrassed or feel they may offend others by their actions. Bearing in mind that a young infant often has urgency to feed, a mother needs to take alternative actions to meet the infant's nutritional and emotional needs and to satisfy herself that she is caring for her infant.

Postponing breastfeeding was only a temporary measure and by necessity of short duration. When there was difficulty with attaching the infant at the breast or problems during the breastfeed, the mother temporarily discontinued breastfeeding. Mothers would postpone breastfeeding often through lack of confidence to continue. Mothers then had to decide quickly on a strategy to compensate for not being able to breastfeed at the time.

One strategy which a mother used was to give the baby a bottle and she always carried a bottle when out visiting in the early weeks of breastfeeding 'just in case'. This 'just in case' strategy enabled the mother to continue socialising with friends in the early days of breastfeeding and could be interpreted as self-preservation or proceeding with caution on the part of the mother. It was strongly linked to wanting to feel comfortable and not be drawn attention to by the behaviour of the infant. A mother explained that:

> *... at some friends' place ... he was starting to get scratchy, so I just put him on the breast but he kept on pulling away and screaming and so it just drew attention to me and him, so I gave up very quickly, because I didn't want people actually staring while I was trying to breastfeed or*

*think that I don't know what I'm doing ... I just quietened him down by talking to him and jiggering him and distracting him ... I didn't feel comfortable with it [breastfeeding] ... We had had some successful goes ... before that so I felt that I could ... but as it didn't happen straight away, I just gave up (C1:1).*

Another aspect of this action relates closely to the unwanted consequences of breastfeeding away from home. The mother did not want to give the impression of being incapable of breastfeeding and also being stared at while trying to breastfeed. This reason for postponing was explained also in relation to the concept of **Planning to Avoid** scrutiny in Chapter Five. The potential for scrutiny caused the mother to postpone breastfeeding or withdraw to breastfeed.

Another strategy used by some mothers was to give the infant a 'dummy' or pacifier. This strategy is contraindicated in Step Nine of the 'The Ten Steps to Successful Breastfeeding' (WHO/UNICEF, 1990). Used in this situation, it enabled the infant to be pacified and avoided unwanted attention being drawn to the mother through the infant crying. The mother explained, *" ... [infant] was probably due for a bit of a feed but I just put a dummy in [the infant's] mouth ... and eventually [the infant] settled down a bit ..." (P1:2).* In a study evaluating factors which may be associated with duration of breastfeeding, Vogel and Mitchell (1997) explored attitudes of mothers and health care professionals to the use of dummies (pacifiers) and found concerns such as "weaning the baby off the dummy, keeping it clean and not losing it" (p.395). They concluded that the context of dummy use was important when "analysing the relationships between dummy use and breastfeeding" (1997, p.395). The mother in this study used a dummy because she did not feel that she could breastfeed in the restaurant, where she was having a meal with friends, saying, *"I felt that I couldn't, it's just something I wasn't comfortable with ... it's just over my comfort zone" (P1:2).* This mother was however able to breastfeed in a restaurant setting when she had gained more confidence with her feeding. She described this movement forward, saying:

*And although I've said I would never feed in restaurants ... I was in*

*circumstances where I had to. It wasn't too bad ... it was ... sort of tea-rooms, so I think they probably have so many people coming through, it's just something that would be accepted. And I felt quite comfortable and happy ... that was probably quite a major for me ... I didn't feel like anyone was offended by it all ... I had [my mother] with me so that was probably a comfort thing (P2:1,2).*

The fact that the circumstances were different and that this mother was in the company of a person, whom she perceived as a supporter, enabled breastfeeding to take place. Previously, in a different place and in the company of different people she might have postponed breastfeeding and resorted to alternative delaying strategies.

Another mother, while accepting the need for her infant to be fed, also did not want to be identified as a 'mother with a crying baby'. Common strategies which mothers use to pacify their crying infants have been identified by Hill, Humenick and Tieman (1997) in a study of 120 mothers when their infants were three weeks old. These include walking or rocking, burping, patting and stroking the infant. The underlying issue here is that infants do need to be fed more urgently in the first few weeks of life and mothers were very aware of that need. If the mother decided not to breastfeed in her present situation, the mother postponed breastfeeding but, out of necessity, temporarily found other ways to satisfy the suckling needs of the infant.

Mothers also had to postpone breastfeeding because of the lack of breastfeeding facilities in public places. While some mothers were aware of places where they could breastfeed when out in a town or city, others were not. The Plunket Rooms, which are a feature of most New Zealand towns and cities, appear to be well recognised as places where mothers can go to breastfeed. However these are not always conveniently placed for the mother when the infant urgently needs to be fed. This is an example of where suitable breastfeeding facilities at supermarkets or other public buildings would advantage the breastfeeding mother. The urgency of the hungry infant's cry guides the mother to meet her infant's needs and the infant's right to be fed as this mother explained:

*E: When I was at the supermarket shopping and she got whingey and I suddenly realised the time, I just finished the shopping and went home... (E2:10)*

*R: And that was an easier thing to do then?*

*E: Than trying to do anything else with a baby that's beginning to cry ... when I realised she actually had a right to be crying at this stage rather than sort of pacify her...There's a few things I missed at the end...I couldn't find them and I was getting annoyed...if there was somewhere where I could have left the shopping, fed her, come back to my basket of shopping, I might have done it. But there wasn't - well not that I know of in [the supermarket] (E2:11).*

This example highlights the dilemma for the mother who is out in public places such as supermarkets with a new crying infant. Attention is easily drawn to an infant who persistently cries for food. These infants cannot be easily pacified. The mother, therefore, needed to address two issues. She needed to satisfy a very urgently hungry infant and also make a decision about her own ability to satisfy the infant's needs at that critical time. She doubted her own ability to satisfy the infant in the particular situation in which she found herself. In this situation, her action was determined by the environment in which she found herself, and what she was doing at the time. The expectation that toilets can double up as breastfeeding rooms was highlighted for me when I enquired of the manager of a newly opened supermarket if there were any breastfeeding facilities in the new building. I was told that, "no, but there are toilets that the women could use" (Kennedy, personal experience, 1998).

Being placed in a situation where breastfeeding has to be postponed can be stressful for the mother. While in a bank one day, I watched a woman with a very young infant who was crying urgently. The woman was showing signs of becoming stressed as she tried to pacify her infant while attending to her business at the counter. The bank teller appeared to know the woman as a friend. Consequently she offered the woman a private

room in which she could breastfeed her infant out of view of the rest of the customers. The woman appeared to be very relieved and grateful for the offer. This was a gesture that may not have been possible for every woman. It was, nevertheless, an acknowledgement of the woman's necessity to breastfeed her infant and to provide assistance in a stressful situation (Kennedy, 1998, personal experience).

Breastfeeding facilities are becoming more common in public places, but not always exclusively designated or well designed for the process of breastfeeding. For example, in some large department stores in the United Kingdom, rooms are designated for 'nursing mothers' but often these rooms are combined with toilet facilities and double up as toilets for other women who are not breastfeeding. The 'nursing' seats are usually hard and uncomfortable, placed against walls in a row and limited in size and number. The most suitably designed room for breastfeeding mothers which I have recently seen was in the Jersey Museum in the Channel Islands. This room which is approximately in the middle of the building, was equipped with comfortable 'nursing' chairs, was quiet, airy, tastefully decorated and, while it had napkin-changing facilities, was not placed in the vicinity of the public toilets. This was a room specifically designed for breastfeeding and gave the impression of having been designed with breastfeeding mothers' needs in mind. This was a room which was used when mothers needed to withdraw to privacy to breastfeed (Kennedy, 1998, personal experience).

While **Postponing** was an action that primarily affected the infants because they did not get fed until the mothers were able to do so, it was often followed by trying to find a suitable place to breastfeed. The concept of **Withdrawing** describes a strategy which the mothers also used when they did not feel able to breastfeed in the place they were in at the time.

## Withdrawing

**Withdrawing** is similar but different from **postponing** in that it was an action a mother took to deliberately protect herself from others watching her breastfeed. A mother, reflecting on how she had experienced a friend breastfeeding, even before she had her own child, said,

> *I do remember going to one of my co-worker's home who was breastfeeding. And she had a big blanket covering herself and the baby ... and it was very 'hush-hush' and covered up and ... I can remember looking at her thinking, " oh, why is she hiding it so much? Like it's not like you're open and exposed there, because you're not. You can't really even see anything anyway"* (B2:9,10).

**Withdrawing** was like 'hiding-away' or becoming 'invisible' yet often wanting to stay 'visible' while breastfeeding. It was essentially withdrawing for privacy. The interpretation of 'being private' in public was presented in different forms by the mothers. For example, the need for withdrawal to privacy could mean putting up a physical barrier such as moving to another room, or maintaining a distance, within the same room, which provided protection from the gaze of others. An expectation of a mother's needed privacy could be assumed by another person and would be accompanied by an offer of it. For example, when a mother asked permission to breastfeed in a public waiting room, the receptionist said, *"we've got a room that you can have some privacy in" (A1:2).* Schwartz (1968), in exploring 'The Social Psychology of Privacy', states that,

> Patterns of interaction in any social system are accompanied by counter-patterns of withdrawal, one highly institutionalized (but unexplored) mode of which is privacy. There exists a threshold beyond which social contact becomes irritating for all parties; therefore, some provision for removing oneself from interaction and observation must be built into every establishment (p.360).

One mother described **withdrawing** in this way,

> *I fed her in the back of the car and that was interesting ... we managed quite well ... now that she's getting older, it's ... a lot easier to feed her without a pillow ... And it's one of those things. You're out in public but it's not really 'public' public. No-one can see you feeding (D2:1).*

While mothers gave the impression that they wanted to be able to breastfeed in 'public' they nevertheless withdrew to places where they remained 'private' in public. For example, they often breastfed in the car while out shopping or simply 'out and about'. This was their own 'space', and they did not have to ask permission to breastfeed here. It gave a feeling of privacy, as this mother described it:

> *We've been out with the car. And so I've fed in the car, or outside, where nobody's around ... Some people do come past and it's not a problem. In the car they don't see, probably because of the level - I don't know (E1:1).*

**Withdrawing** was an intentional act which the mothers carried out to enable them to breastfeed in situations where they wished to be or found themselves, but where they found it difficult to openly breastfeed. These situations varied, depending on where the mother was, or who was around her. For example, a mother who wanted to remain as part of the group, but not actually be 'visible' described her experience of breastfeeding with her peer group. This mother did not feel comfortable about feeding in front of her peers even though they were also learning how to breastfeed:

> *... they were all sitting in the group ... there's a lot of people there ... It's your actual peers in the class learning how to breastfeed type of thing...so I just went and sat over there...I was sort of sitting about outside of the circle ... So I was still taking part in the discussion (E1:4).*

While being part of this group was important to the mother, she needed to withdraw to feel comfortable and able to breastfeed without others watching. Mothers would also sense that others were feeling comfortable or uncomfortable when they breastfed. This caused the mothers to take action to protect others' feelings. For example, a mother who was breastfeeding at her friend's parents' home said:

> *We were all sitting round in a group ... and my friend, I don't think, had ever fed in front of her parents ... and I just felt they would have been*

*more comfortable ... with me on the other side ... it didn't worry me ... and I just went and sat where I could see everybody and still talk to them but just [be] a little bit [less obvious] (P1:5).*

**Withdrawing** was not always an action initiated by the mother. It was a strategy used by others when a mother indicated, either verbally or non-verbally, that she was about to breastfeed her infant. Mothers were aware of others withdrawing from her, either moving away some distance or physically leaving the room. A mother described what happened when she started to breastfeed:

*I said before I was pregnant that there was no way I would ever feed in front of anyone ... but I've sort of made myself ... otherwise it's just too stressful ... you've got to be free to do it ... I think some older people don't come round or leave the room ... I'd prefer they just acted as per normal. But I think ... if their daughters haven't had grandchildren ... they sometimes find it difficult ... I've had one lady [who] obviously left the room when I started feeding ... (P1:6,7).*

In contrast, withdrawing could take place at very close quarters, sometimes when a person approached a mother and had not realised that she was breastfeeding. He or she would very quickly withdraw from the mother. This **withdrawing** was sometimes accompanied by a verbal expression of apology. One mother felt that an apology was unnecessary in the circumstances but interpreted it as a gesture made by others to acknowledge that she was breastfeeding and to protect her privacy. She said:

*... when people would come in [to the room] ... and I'd be feeding ... they'd say, "oh, I'm sorry"... I find a lot of people apologise. A <u>lot</u> ... they're always apologising ... I don't see it's necessary, but maybe I would do the same thing if I had never breastfed ... it's a polite thing, it's not an annoying thing ... (B2:9).*

When attending a social function with large groups of people present, for example a

party situation, one mother described how the mothers who were breastfeeding tended to gravitate toward each other and into a separate room, which was warm and comfortable. There were no directions given but it was like an unspoken expectation that this room would be used for the purpose of breastfeeding or attending to the children present. When they had finished breastfeeding and were ready to socialise again they returned to the main room. Schwartz (1968) maintains that "privacy has always been a luxury" and cites the work of essayist Phyllis McGinley (1959) who writes

> ... in each civilisation, as it advanced, those who could afford it chose the luxury of the withdrawing place. Egyptians planned vine-hung gardens, the Greeks had their porticos and seaside villas, the Romans put enclosures around their patios... Privacy was considered worth striving for as hallmarked silver or linen sheets for one's bed (McGinley, 1959, p.56, as cited in Schwartz, 1969, p.363).

'The withdrawing place' for mothers reflected privacy, while the place and the people therein varied accordingly. Deciding which strategy to choose when faced with an uncertain situation, for example, either withdrawing to privacy or postponing breatfeeding, depended on many factors. Knowing their own level of competence and confidence to breastfeed in the presence of others was a critical factor. Only the mother can know how confident she feels about breastfeeding at any time in her experience. Knowing who would be offended and who would not be offended makes the assumption that the mothers come to the situation with prior knowledge of the experience or with their own history and culture and therefore pre-conceived ideas about societal attitudes to breastfeeding. Knowledge of self and a perception of the attitudes of others guided their subsequent actions.

On a recent walk through a quiet, almost deserted park, I noticed a woman and man sitting on a seat in the shade of the trees with a baby stroller beside them. As I came closer, but was still a long distance away from them, I noticed the man move the baby-stroller to position it in front of the woman so that it screened the woman's body and left only her shoulders and head visible. At the same moment as I saw the stroller being

moved, I realised the woman was breastfeeding her infant. She was obviously using the stroller to withdraw to privacy in a place which initially she may have perceived as being 'private' in public.

The mothers in this study would remain where they were and proceed to breastfeed in the presence of others only if the situation was comfortable for themselves and for others and they were with people who supported their breastfeeding. A mother explained her feelings about being supported by her partner, saying:

> *... I know it makes him feel good to be there while I'm breastfeeding ... it makes me feel more comfortable too. It's just to know that he's there ... and he's more or less supporting me while I'm doing it and he's smiling ... he feels very positive about it (B1:10).*

Mothers found that they had more courage to breastfeed away from home if they had the support of another person, usually their partner or their mother. Alternatively, the presence of others, who were less closely related, engendered feelings of lack of confidence and uncertainty in the mother's own ability to breastfeed, as this mother explained:

> *[Infant] needed a feed and I'm sort of like, 'uuhh'! ... - but I wasn't still a hundred percent confident about feeding at that stage and so, ... I just thought, " oh, well I'll just give it a go and if it becomes really no-okay, I can always go up to the bedroom or somewhere else ...(A1:1)*

Mothers made decisions on the basis of their appraisal and interpretation of the situation. For example, a mother described her actions as 'picking and choosing' when faced with the possibility of having to breastfeed away from her usual home environment. Mothers came to know ways in which they needed to act to preserve their privacy or their own or the infant's comfort. They made choices about how they would handle situations when they were unable to feed their infant away from home. This mother said:

> *I just pick and choose where I go ... to breastfeed. [There are] certain places I wouldn't ... I've got certain stop-offs that ... people won't mind me doing it ... As time's gone on, I've felt more comfortable with it and other people have accepted it too (G1:10).*

'Picking and choosing' implies that there is an element of contemplation about subsequent actions of choosing or selecting what is convenient or whatever serves the person's comfort or interest. In breastfeeding, both the interests of the mother and infant needed to be considered. Selecting an option which provided some freedom from potential difficulties or discomfort would be a preferable one. Mothers came to know where and in front of whom they would be able to breastfeed, as one mother said:

> *...and there was one guy there who I know probably would have been offended - he was the old school and would have been, yes, highly upset, I think, and that's when I fed him in the car. That was my choice because I was sure that, really sure that the particular guy I used to work with would have been offended...and there were a lot of people there that I didn't know ... so I made that choice to take myself away from that sort of area (A1:4).*

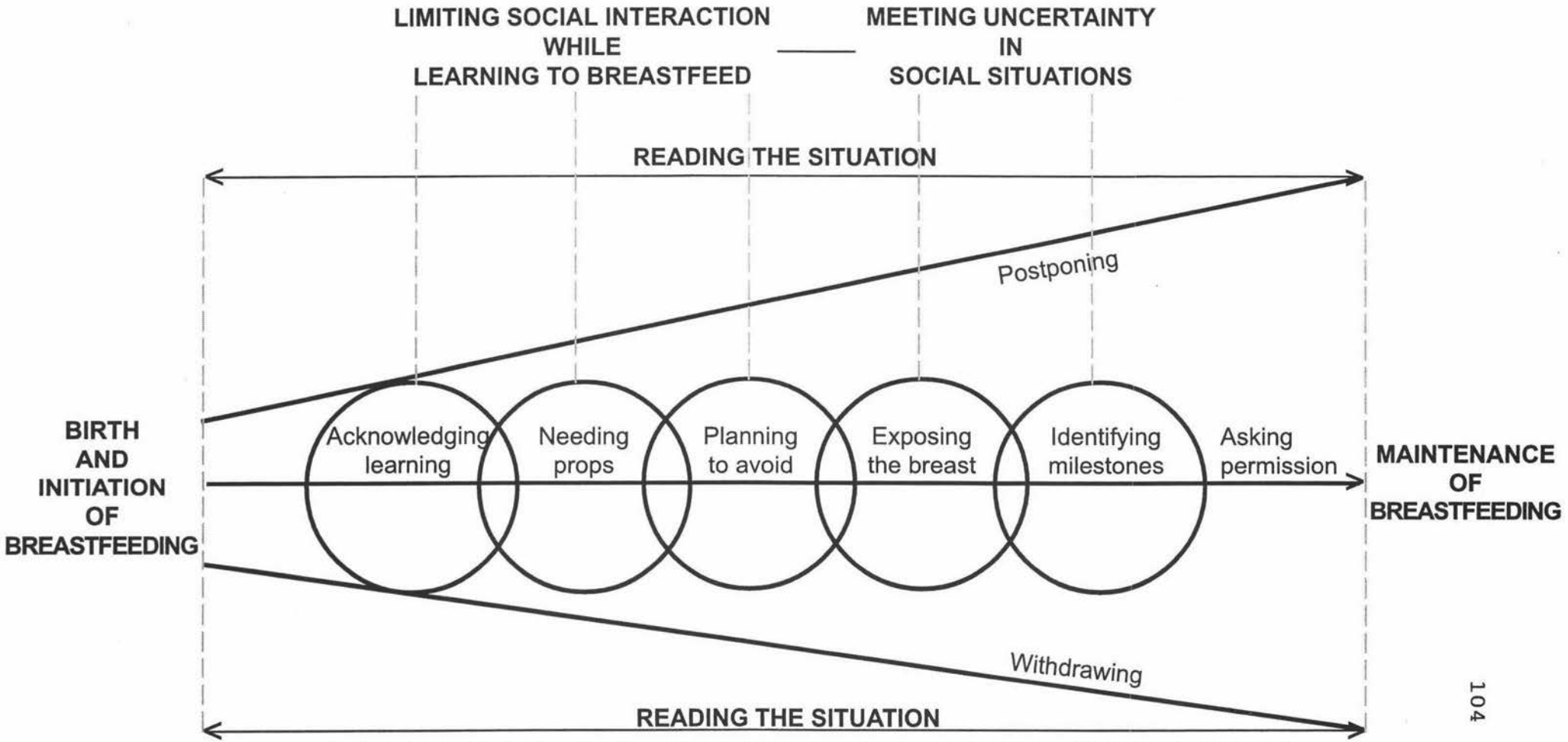
Withdrawing from this situation into the privacy of her car was perceived as the best action to take, at that time, by this mother. She acted according to how she had read the situation which included knowing herself and her perception of others.

**Withdrawing** is a concept which together with the concepts of **Asking Permission,** and **Postponing** reflected what happened for mothers in this study when they set out to meet the challenges of breastfeeding within contexts of learning and social interaction. These concepts represented the processes that they used to enable them to integrate breastfeeding into their daily lives.

## Summary

The concepts of **Asking Permission**, **Postponing**, and **Withdrawing** have been explained to support the category of **Reading the Situation**. This category together with the categories of **Limiting Social Interaction while Learning to Breastfeed** and **Meeting Uncertainty in Social Situations**, presented in Chapter Six and Chapter Seven, respectively, emerged from analysis of the data gained from interviews with nine first-time mothers. Together, these categories with their respective concepts as properties of the category, show what was happening for the mothers in this study in the process of learning to breastfeed in the context of their daily lives. A model of the relationship between the categories and their properties is presented on the following page. In Chapter Nine, **the basic social process (BSP) of learning** is discussed.

# 'DOING WHAT'S BEST AT THE TIME'




**MODEL: FIRST-TIME MOTHERS LEARNING TO BREASTFEED AWAY FROM HOME**

*(Kennedy, 2000)*

# CHAPTER NINE

# THE BASIC SOCIAL PROCESS OF LEARNING

## Introduction

This chapter begins by presenting the basic social process that was happening as the mothers in this study breastfed their infants in the early days and weeks following the birth of their infants. The chapter will conclude with a summary of the findings, the limitations of the study and implications for practice, education and future research. When presenting the methodology of grounded theory in Chapter Two of this study, it was explained that basic social processes are discovered in the data and emerge to indicate, that something is getting done "which takes time" or is "happening over time" (Glaser, 1978, p.75). In this chapter, the basic social process (BSP) of **learning** is discussed.

## Learning

When a person learns, they are gaining "knowledge of or skill in" a particular domain "by study, experience or being taught" (Thompson, 1995, p.774). The learning that was taking place for the mothers could be said to have taken place by all three of these ways: Study about breastfeeding during pregnancy or postnatally of books, magazines, health promotion leaflets or antenatal classes; experience through actually breastfeeding in many different situations; and being taught by health professionals and other mothers who have previously breastfed. Learning is a process that happens over a period of time when the knowledge or skill required for a certain purpose is being gained.

One mother described her early experience of learning to care for her infant which included learning to breastfeed as *"a massive learning curve" (F1:21)*. The mother

emphasised that as time went on she came to know what to do and began to feel confident, the more practice or experience in breastfeeding in different situations that the mother had, the more confident she felt. In explaining the concept of 'the learning curve', Jackson (1994) says that "practice/experience (the basis of learning involving skill) is a cumulative phenomenon" (p.462). He refers to the introduction of the idea of the learning curve by Thurstone (1919) in a study which showed "how (mathematically and statistically) to relate improvement in typing speeds to practice in typing since the start of the course" (Thurstone, 1919, as cited in Jackson, 1994, p.462).

Learning the art of breastfeeding, particularly in relation to positioning and attaching (latching-on), began when the mothers were 'taught' to breastfeed by health professionals in hospital when breastfeeding was being initiated. This beginning experience is crucial to the success of breastfeeding but significantly takes place at a time when the mother is also recuperating from the physical and emotional experiences of labour. Knowledge gained at this time was in the form of support and advice which continued when the mothers were visited by midwives or Plunket Nurses in their own homes.

Observing other mothers breastfeeding was also a way of gaining knowledge and learning about breastfeeding. This social learning (Bandura, 1977) had the potential to influence future breastfeeding behaviour. One mother spoke about times when, by using herself as a model, she had helped another mother who was struggling with breastfeeding. Using her own learning experience as a way of teaching, she invited the mother to her house while she herself was feeding so that the mother could breastfeed her infant at the same time and gain some tips on breastfeeding from her.

The basic social process of **learning** happens in everyday life in many contexts and is representative of growth and development and improvement in performance. Learning relevant to breastfeeding away from home is situated within contexts of new motherhood and social interaction. In the previous three chapters, the categories **Limiting Social Interaction while Learning to Breastfeed**; **Meeting Uncertainty in Social Situations**; and **Reading the Situation**, were explained. These categories reflected a

process of learning taking place as a result of what was happening for the new mothers in various situations since giving birth to their first infant and may also reflect what happens in learning generally. Firstly, there is the time when little is known about a skill, for example attaching the infant at the breast. Secondly, having overcome initial struggles, there is the time when there is excitement about meeting challenges and learning from mistakes and difficult situations (Peterson, Beck & Rowell, 1992). Thirdly, there is the time when the person is able to read the situation and do what they know works, or "not only sees what needs to be achieved, but also how to achieve it" (Dreyfus & Dreyfus, 1996, p. 42). This model of learning was relevant to the nine mothers in this study, but may be useful for antenatal education classes where mothers are being informed about breastfeeding. Knowing the reality of breastfeeding for first-time mothers and the learning required for the breastfeeding experience, may assist mothers and their families to understand what the possibility of breastfeeding away from home may entail.

At the beginning of this study, I aimed to find out what was happening for first-time mothers when they breastfed away from home. As a midwife, I had noticed the difficulty that most women had in the postnatal period, when faced with breastfeeding for the first time and also trying to come to terms with being a new mother. Whatever the birth experience, the first-time mother needed support to initiate breastfeeding and to care for her infant generally. Mothers who had previously breastfed an infant, sometimes needed assistance to get the infant attached at the breast, simply because each infant is different and each birth is a unique experience and brings with it learning about breastfeeding. But the first-time mother was also learning about the new craft of caring for an infant such as changing the napkin, bathing, holding the infant safely as well as becoming emotionally used to the reality of 'being a mother' and recovering from the birth. Getting the infant to attach at the breast for the first time was not straightforward for most women. This was a skill about which the mothers knew very little, in the sense that they had not had the experience of doing it before.

The infant is born with a sucking reflex, which through the cognitive process of 'accommodation' is adapted to the type of sucking, needed to obtain nourishment from

the breast (Piaget, 1952, as cited in Berger, 1983, p.48). While the sucking reflex is present it does not necessarily mean that every infant is immediately able to attach at the breast effectively. This is a learned skill for both mother and infant. Therefore, the mother needs expert support to encourage her when things are not going well and to ensure that the infant is attached properly. Incorrect attachment may cause sore nipples and ineffective suckling (Lawrence, 1989).

The research, which points to 'insufficient milk supply' as being the most likely reason for mothers stopping breastfeeding (West, 1980; Gunn, 1984; Renschler, 1991; Essex et al., 1995) places the emphasis on the product of lactation and not on the process of breastfeeding where it needs to rest. If the process goes well, the milk production has the potential to be adequate for the infant. When the infant is not well attached at the breast, the milk production and 'let-down' may be inadequate because of lack of neuro-hormonal stimulation.

Once a mother has learned how to get the infant to attach properly at the breast, the process may not necessarily be without problems as the breast adjusts to the demands of the infant. Mothers do not necessarily understand that breastfeeding is not a regimented process like bottle feeding and that the four-hourly rules inherited from bottle-feeding regimes do not apply to breastfeeding. When an infant demands to be fed in a short space of time after the previous feed, the mother can be disturbed by the frequency of breastfeeding especially until breastfeeding becomes established. To highlight what mothers need to learn about the meaning of demand feeding, a midwife once suggested that "pregnant women [should] try feeding themselves only when they are hungry for a two-week period and note the times and the quantity of their intake to see how erratic 'unsocialized' feeding is" (Inch, 1987, p.57). This 'unsocialized' feeding is what mothers come to learn about when they are initiating and establishing breastfeeding.

As the process of learning emerged in this study, an assumption could be made that some mothers may never breastfeed away from home if they choose not to place themselves in situations where they may feel that they are offending others or simply

are unable to breastfeed in the presence of others. The mothers in this study needed, and were willing, to integrate breastfeeding into their daily lives so they were motivated to breastfeed in a variety of everyday situations. This motivation enabled them to meet challenges of uncertainty, gain confidence and learn by these experiences.

Learning to breastfeed whether at home or away from home is a special kind of learning because it involves actions and interactions which involve two human beings in a very intimate relationship. When examples of learning are used to attempt to explain the knowledge and skills needed, such as, for riding a bicycle (Polanyi, 1958,) or driving a car (Dreyfus & Dreyfus, 1995), it needs to be acknowledged that the person is interacting with a machine. A mother in this study pointed out, *"I'm not a machine" (A2:24)*, when being questioned about regulation of breastfeeding (see Chapter Six). Polanyi (1958) explains that riding a bicycle is a complex combination of balance, movement and speed on the part of both the rider and the bicycle. He has come to the conclusion after consulting with experts such as engineers, physicists and manufacturers of bicycles, "that the principle by which the cyclist keeps his balance is not generally known" (p.49). Polanyi (1958) explains that even if a person was to know this rule it does not mean that the person would necessarily be able to ride a bicycle following this rule. He proposes that there is much more to knowing the rules or 'maxims' saying that

> Rules of art can be useful, but they do not determine the practice of the art; they are maxims, which can serve as a guide to an art only if they can be integrated into the practical knowledge of the art. They cannot replace this knowledge (p.50).

There are basic 'rules' about riding a bicycle but being able to ride it has to be learned by experiencing the whole process. Experiencing breastfeeding and practising it in many situations, reflective of their daily lives, was a way that the mothers in this study became competent and gained confidence as new mothers. The following three categories explain the different aspects or phases of learning relevant to the mothers in this study.

## Limiting Social Interaction while Learning to Breastfeed

Acknowledging learning, the mothers chose to remain close to home when they knew that they were more comfortable breastfeeding within that environment. This category was relevant to a period early in the mothers' breastfeeding experience following the birth of their infants when they were still needing props and did not feel confident with their breastfeeding. Facing the perceived scrutiny of 'experts' or the risk of offending others at a vulnerable time was more than they were prepared to do. This led them to plan their days around feeds thus planning to avoid unwanted difficulties with breastfeeding. It was essential that the mothers felt comfortable with their own ability to breastfeed and with the situation in which the breastfeeding would take place. They had not learned to breastfeed sufficiently well to want to try doing it in front of others with the potential for risk of failure or judgement present. A human response would be to protect themselves from certain situations of social interaction.

## Meeting Uncertainty in Social Situations

There were many situations which were uncertain and challenging for the mothers. The experiences of exposing the breast while commencing the breastfeed for the first time away from their own home, while often stressful because of the uncertainty of the situation, was seen as an achievement. The excitement for the mothers of realising that they could and would breastfeed away from home came in many and varied situations where they were 'forced' to do so by virtue of addressing the demands of a crying hungry infant. Identifying milestones amidst uncertainty of the social situation gave them a sense of achievement and also gave them confidence as mothers. Going out, prepared to meet challenges of uncertainty, was contingent on learning having taken place, particularly in how to get the infant to correctly attach at the breast.

## Reading the Situation

These are the actual words spoken by a mother in the study as she described how she managed to continue breastfeeding. As the mothers read each situation, they learned to choose ways in which they felt most comfortable to breastfeed. As 'situation' includes the physical, psychosocial and cultural environment in which the mothers found themselves on any one occasion of breastfeeding, they took account of the people who

were there at the time, how they themselves felt about the people and whether those people might or might not be offended if the mother breastfed in their presence. Reading the situation enabled the mothers to choose strategies of asking permission, postponing and withdrawing, whichever would best suit their own situation and their level of confidence. This category recognised that the mothers had learned that there were situations which might be difficult for them so they chose ways to protect themselves from stress and acknowledged the feelings of potential embarrassment that they might cause others by breastfeeding in their presence. This contributed to learning about breastfeeding as well as learning to breastfeed. Reading the situation, unlike the other two categories, could happen at any time in the learning process, enabling the mothers to either continue to breastfeed or look for alternative strategies to delay feeding until they were in a situation more conducive to breastfeeding.

Overall, the mothers portrayed a sense of 'knowing' what they needed to do to enable breastfeeding to happen. More than 'knowing how' to breastfeed, it was 'knowing when', 'knowing who' and 'knowing where' that was located in their overall understanding of themselves as breastfeeding mothers. The mothers already knew their limitations, their 'comfort zones' and had thought about where they could or could not breastfeed prior to giving birth. Sometimes the reality of breastfeeding in many situations was different from what they had previously thought they would do. Knowing that they should or would ask permission to breastfeed was not considered unusual but a courtesy. Postponing breastfeeding was commonplace and withdrawing to privacy was done when the mothers felt the need to do so on their own and on others behalf.

Learning was identified as the basic social process (BSP) which was happening over time as the mothers integrated breastfeeding into their daily lives. In the early weeks following birth they acknowledged their need to gain confidence, that breastfeeding had often been a 'struggle. They nevertheless tried to breastfeed away from home when they could. Being able to breastfeed either at home or away from home was contingent on learning to attach the infant correctly at the breast, a skill which mother and infant both needed to learn. Learning took place as a result of many different experiences including: 'being taught' by health professionals, friends, family members and other mothers;

observation of other mothers breastfeeding; and actual practice in the art and skill of breastfeeding in varied contexts of social interaction.

## Conclusions

Grounded theory methodology was the research approach used to explore the reality of breastfeeding during the first three months following birth for nine first-time mothers. In Chapter One, breastfeeding was set in context of its physiological, socio-cultural and historical perspectives. This set the scene for a beginning understanding of the complex nature of breastfeeding within Western society at the end of the twentieth and the beginning of the twenty-first century.

The study had two aims. The first aim was to explore with the mothers what was happening for them when they breastfed away from home at a new phase in their lives when they were adapting to caring for a new infant, and to being a mother who was breastfeeding. The use of grounded theory methodology enabled me, as researcher, and the mothers, as participants in the research, to meet on a one-to-one basis at each interview. By audio-taping the interviews, the actual words, nuances and expressions of feelings engendered by the mothers' experiences were able to be captured.

Although the intention of the study was to focus on breastfeeding away from home, the mothers described situations of breastfeeding when others visited them in their homes. They felt these situations to be significant in terms of breastfeeding in the presence of others who were not usually part of the family. As the mothers told their stories about breastfeeding in a variety of situations, they reflected on the learning that had taken place and showed a sense of achievement about their ability to continue breastfeeding. The data provided during interviews became the catalyst for further conceptualisation and comparison of what was happening for each of the mothers, while still remaining faithful to the mothers' interpretations of events.

Acknowledgement must be made of the commitment of the mothers to continue to breastfeed, in spite of difficulties during the initial period of learning to breastfeed. The mothers in this study were able to speak openly about their feelings and experiences,

express their ideas and thoughts in ways which highlighted this special, but vulnerable, time for them. They were recuperating from the birth process while also learning the ways of a new life situation called motherhood.

The second aim of the study was to find out how breastfeeding away from home impacted on their breastfeeding experience. Implicit in this aim was to gain information which would benefit other first-time mothers, those who live with them and others who support mothers in their efforts to breastfeed. These aims were met since the mothers were able to bring to the study a range of information reflective of their varied experiences in social situations and how these impacted on their ability to breastfeed. This information was analysed and out of it emerged a basic social process which reflected what was taking place for mothers as they breastfed within the context of their daily lives.

The ways in which the mothers in this study continued or managed their breastfeeding showed distinctly that the mothers wanted to breastfeed and tried to make this happen if possible in the many different situations in which their infants needed to be fed. Breastfeeding is perceived differently by people as either a socially acceptable or a socially unacceptable practice in a public place, and with this comes the potential for conflicting messages about breastfeeding to be given and used either in its defence or in its support.

The message of health promotion arising from the global health body, the World Health Organisation, should lend some weight in deciding what is good and healthy for the newly born and growing infant. But people bring their own values, beliefs and attitudes to their views about breastfeeding and these have the potential to influence positively or negatively this method of nurturing the next generation of human beings.

## Implications for Practice

Health professionals, particularly midwives, doctors and nurses, provide care and work closely with mothers and their infants during pregnancy, birth and the postnatal period. They therefore have the opportunities and the potential to empower women to breastfeed

through the ways that they provide guidance and support in the early initiation, establishment and maintenance phases.

What was evident from this study was that the mothers were not all necessarily well supported when learning to breastfeed, particularly in the early days of initiation of breastfeeding. While this study focused on first-time mothers, there is always a need to support any mother in the early stages of breastfeeding either following birth in hospital or at home. Conflicting messages and advice still seem to be prevalent in maternity settings. This led one mother in the study to disregard all the advice and do what she herself thought to be right. While the 'Ten Steps to Successful Breastfeeding' and 'Baby Friendly' initiatives are being implemented there is the potential to improve the quality and consistency of information given to mothers about breastfeeding. At the early critical stage of initiation of breastfeeding, expert guidance in helping the mother to correctly attach the infant at the breast is not only sound practice, but would enhance the mother's well-being at a very vulnerable time. Some mothers in this study chose to go home because of being given conflicting advice, while others stayed until they were comfortable with breastfeeding.

As can be seen from this study, it is not necessarily the length of time that a health professional spends with a mother giving advice and support, but it is the quality of the support given, the encouragement to continue at a time when she may feel like discontinuing breastfeeding. This is particularly relevant when the mother does not have the same access to a health professional as she had in the maternity ward. Once the mother goes home the health professional may visit on a daily or weekly basis. Support needs to continue through the difficult times of establishment and maintenance of breastfeeding which often occur at about three weeks after birth. If mothers are to be enabled to continue breastfeeding, support and understanding from family, friends and the general public are essential.

Health professionals can also help mothers by supporting innovative ways of encouraging breastfeeding within our society. The weight of the voice of the health professional on matters pertaining to health would be usefully given when new public

buildings are being planned. The lack of suitable places for mothers to breastfeed when out carrying on their daily lives was evident from this study which focused on breastfeeding within a context of social interaction often in very public places. Most mothers would have wanted a quiet place to which they could withdraw for privacy when faced with breastfeeding in a public place. The lack of facilities limits the movement of breastfeeding mothers when wishing to continue breastfeeding.

This study highlighted the need to change the perception of the general public, but particularly local government, employers and the media, that breastfeeding facilities do not equate with toilets - that feeding, while connected, is different from elimination. Suitable breastfeeding facilities need to become common place in supermarkets, restaurants and other places of business in order to provide support for breastfeeding mothers. Breastfeeding facilities and new philosophies about breastfeeding within the work culture could well be supported by health professionals within their own personal practice or their professional organisations.

A commitment to breastfeeding need not lie only with the mother but also with the health professionals who are committed to improve the health of future generations of children. As first-time mothers, the women in this study talked about what was happening for them during breastfeeding. It is important that health professionals become aware of what happens beyond the maternity wards and out in the world where mothers live their lives while integrating breastfeeding into a new way of life. The frustrations, stresses, and joys of these times can be better understood when mothers are able to talk about them as these nine mothers have done in this study.

## Implications for Education

Antenatal and postnatal classes are key sources of breastfeeding education for mothers and fathers. But while there is much that can be learned, in theory, about breastfeeding, it is not until the mother experiences it that she realises the need to be able to breastfeed effectively to adequately nourish her infant. Mothers in this study also felt that breastfeeding was promoted very heavily at antenatal classes, to the extent that it would make mothers feel guilty if they chose to bottle-feed their infants. Basire (1997), in a

focus group study which was aimed at investigating a range of mothers' attitudes towards infant feeding, also found a similar association with negative attitudes of health professionals towards bottle-feeding.

Morse and Harrison (1987) suggest that the support given in the early stages of initiation of breastfeeding, while very important, may not be linked to the duration of feeding. They suggest that:

> the nursing experience is a dynamic, open relationship occurring within a social context, and it is the attitude of *others* towards breastfeeding that modifies the mother's choice of how the infant is fed, where the infant is fed, and for how long breastfeeding is maintained (p.205).

If the breastfeeding experience proves to be 'successful', first-time mothers would be more likely to breastfeed other following children (De Vanzo, Starbird & Leibowitz, 1990).

Education in schools and of parents could contribute to the idea that breastfeeding is an everyday occurrence and that children need to be exposed to it to realise the importance of breastfeeding as a health promoting behaviour. Cultural differences within society which represent varying attitudes, values and beliefs about breastfeeding, need to be acknowledged with regard to mothers breastfeeding away from home.

The education of the health professionals in the importance of breastfeeding as a health promoting strategy and how to support a mother and her family during this time is crucial. A co-ordinated approach to breastfeeding education, which provides consistent and current advice to mothers, also requires a commitment of the providers of undergraduate nursing, midwifery and medical programmes to include breastfeeding in their curricula.

## Limitations of the study

This study was intentionally limited to first-time mothers because of the nature of my

assumption that newness carries with it stresses and strains that familiarity does not necessarily do. Early reading of the literature around this topic pointed to the idea that if first-time mothers had had a successful experience of breastfeeding they were more likely to breastfeed a subsequent infant (Da Vanzo, Starbird & Liebowitz, 1990). I, therefore, wanted to find out what was happening specifically for first-time mothers which might influence their approach to breastfeeding and continuance of it beyond the early days and weeks following birth.

Grounded theory methodology imposes a process of researching which takes time - time to gather data which generates lengthy transcripts and time to read the data and conceptualise them. The process of 'constant comparative analysis' guides the next sources of data collection through a process of theoretical sampling. The processes of conceptualisation and re-working the data require patience, to enable a core category or basic social process (BSP) to emerge. With the existence of a time limit, which is necessarily imposed by the University for study at Masterate degree level, there was the potential for premature closure of the study. When I decided that there was no new data which would usefully add to the understanding of the basic social process of learning which had emerged, I brought the study to a close. The number of participants in this study, was determined by saturation of the data.

## Future Research

While this study focused on first-time mothers, further research studies could explore what happens for mothers experiencing a second or subsequent birth when they approach breastfeeding away from home not as an entirely new experience. Nevertheless, it is acknowledged that each mother's experience with each child will be unique and if the mother has had previous experience of breastfeeding, it may not necessarily follow the same pattern as before. It would have been interesting to follow this group of mothers as they breastfed their second child. Some of the mothers have given birth to a second child. The fact that this group of mothers became confident in breastfeeding away from home in most places or worked around it if not able to do so, is potentially encouraging for future breastfeeding experiences.

Aspects of support for mothers as they initiate breastfeeding would be well worth researching. Mothers spoke about their feelings of inadequacy and lack of confidence particularly in the early days in hospital and for days or weeks after they came home. For mothers who leave hospital without breastfeeding being initiated or established, it would be valuable to see what effect leaving the support of the readily available health professional would have on the continuance of breastfeeding toward four to six months of age. Support from health professionals in the community may be either through visits to the home or telephone contact. Such support is given by, for example, midwives, Plunket Nurses, lactation consultants and La Leche. Telephone access to support is also available through Plunketline and the maternity wards in the immediate period following discharge. Future research could focus on the availability of breastfeeding support in the community and its relationship to the continuance of breastfeeding, particularly beyond three months after birth.

The need to hear consistent advice was important to the mothers in this study. The most difficult times were experienced in hospital in the early days of learning to breastfeed, when they were being cared for by different staff throughout the day and night. In planning postnatal care for the first-time mother, midwives and nurses would be expected to give high priority to educating the mother to care for her infant and to providing assistance and guidance with breastfeeding until breastfeeding is established. Future research could explore the impact of the Baby-Friendly Hospital Initiative (WHO/UNICEF, 1991) on breastfeeding mothers' experiences of consistency and adequacy of advice given both in hospitals and in the community.

Breastfeeding facilities in the community and in places of employment were either non-existent or limited for mothers in this study. In order to raise awareness of society in general, and employers in particular, about the need to have appropriate facilities for mothers who want to continue breastfeeding, future research into the breastfeeding facilities provided by business houses and places of work could be explored. For example, an assessment of the accessibility to and suitability of facilities offered in the community for breastfeeding could be carried out.

## Concluding Statement

The advantage of using a qualitative research approach, such as grounded theory offers, enabled the reality of how mothers deal with varying situations to be heard through their own stories. The way in which the responses and words of others influenced their breastfeeding and guided their thinking into actions was evident in the study. This either enabled them to breastfeed when the infant needed to be fed or made them avoid or postpone breastfeeding until the situation was right for themselves and others. This highlighted the way in which the theory of symbolic interactionism works in everyday social interaction.

As a mother, a midwife and a nurse educator, there was the potential for me to already have a vast amount of knowledge from which to draw conclusions and make assumptions of how situations might be for mothers who chose to breastfeed their infants. This research has opened my eyes to many aspects of a mother's life following birth which I had not previously had the privilege of knowing. I have a great admiration for the way in which the mothers in this study, and other mothers with whom I have come in contact during the study, are able to continue breastfeeding for the good of their infant amidst challenges of learning and social interaction.

> **Whether one points his [her] finger, or points with the glance of the eye, or the motion of the head, or the attitude of the body, or by means of a vocal gesture in one language or another, is indifferent, provided it does call out the response that belongs to that thing which is indicated. This is the essential part of language (Mead, 1934/1972, p.175).**

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## APPENDIX 1

## EXAMPLE OF LETTER SENT TO ANTENATAL AGENCIES

(Address supplied)

(Date supplied)

Dear _____

I am a Masters student at Massey University in the Department of Nursing and Midwifery, carrying out a study of first-time mothers' experience of breastfeeding away from home.

I am writing to ask for an opportunity to meet with women who attend your antenatal education classes to find out if some of these women would be interested in participating in this study. If possible, I would like to meet with women who are expecting their first baby in the next one to two months.

I would need approximately fifteen to twenty minutes to give a preliminary explanation about the study and to leave an Information Sheet with any interested women. The women would not be expected to consent to the study at that time. The purpose of this meeting would be to gauge the level of interest in participation. I would then explain to interested women the process of contacting me at a later date for further information about the study.

If you feel that there would be an opportunity within your programme for me to meet with a group of women, I would appreciate it if you would contact me to arrange a convenient time.

I can be contacted during weekday evenings and weekends at my home:-
(Phone number supplied)

Yours sincerely,

Angela E. Kennedy.

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## APPENDIX 2

# FIRST-TIME MOTHERS' EXPERIENCES OF BREASTFEEDING AWAY FROM HOME

## INFORMATION SHEET

My name is Angela Kennedy and I am studying for a Masters degree in Nursing at Massey University. At present I am carrying out a study of women who are breastfeeding their first baby. I am interested in hearing about the times when they have had to breastfeed their baby away from their own home. This information could be helpful to other new mothers and may be included in education programmes. The study will be supervised by Dr Cheryl Benn, Department of Nursing and Midwifery, Massey University, Palmerston North. Dr Benn may be contacted at Ph.(06) 350 4322.

I invite you to take part in this study and share your experiences with me but you do not need to decide about taking part just now. For this study I need to interview women who are expecting their first baby in the next one to two months.

### ABOUT THE STUDY

This study involves being interviewed two times, once when your baby is at least six weeks old and again when your baby is about ten weeks old. Each interview will last about sixty to ninety minutes and you can choose where you want to be interviewed.

Each interview will be audiotaped using a tape recorder. If you do not agree to having the interview taped you can still take part in the study. If you have to attend to your baby during an interview, the interview can be stopped and started again at a later time or on another day. You can ask for the tape recorder to be turned off at any time during the interview.

A typed copy will be made of each recorded interview. This is called a 'transcript'. You will be given the opportunity to read the transcript of each interview to see if you would like any words removed from the tape and transcript, or have any part(s) changed. You may choose to have the interview tape returned to you or kept by the researcher in a secure place for the duration of the study and destroyed at the end of the study.

You will need to give your written consent to taking part in the study. You will be asked to sign a Consent Form which is attached to this Information Sheet.

please read over ...

If you take part in this study, you have the right:-

* to refuse to answer any particular question;
* to withdraw from the study at any time;
* to ask any further questions about the study as they occur to you during your participation;
* to provide information on the understanding that your identity is completely confidential to the researcher, my supervisor and the transcribing typist. All information transcribed from the tapes will only include pseudonyms of any names of people. It will not be possible to identify you in any reports prepared from the study.
* to be given access to a summary of the findings of this study when it is concluded.

If, after reading the information on the previous page, you are interested in taking part in this study, please read the following section carefully. This outlines the steps we would follow before commencing the study.

STEP 1
Complete and sign the attached form with the heading "CONSENT TO BE CONTACTED BY THE RESEARCHER AFTER THE BIRTH OF MY BABY". I want to make it very clear that, by returning this form to me, you are NOT consenting to take part in the study. **This is only giving me permission to contact you after your baby is born.** Please return the form in the stamped addressed envelope provided.

STEP 2
If I receive your completed form, I shall contact you about three or four weeks after your baby is born, to find out if you are still interested in taking part in the study.

STEP 3
If you are still interested in taking part, I shall arrange to meet with you at a time which is most convenient for you. At this meeting you can ask any further questions about the study.

STEP 4
If, at this meeting, you feel satisfied that you have enough information about the study and wish to take part, I shall ask you to sign the form headed "CONSENT FORM" which is also attached to the information sheet.

STEP 5
If you do consent to taking part in the study, we could have the first interview on the day you sign the CONSENT FORM, if it is convenient for you. If not, we would arrange a time and place for the first interview.

please read over ...

If you need to contact me at any time during the study, my telephone number is:-

(telephone number supplied)

If you have any queries or ethical concerns about this research you may contact :-
The Chairperson, Central Regional Health Authority Nelson Marlborough Ethics Committee (name, address and telephone number supplied).

## APPENDIX 3

## FIRST-TIME MOTHERS' EXPERIENCES OF BREASTFEEDING AWAY FROM HOME

CONSENT TO BE CONTACTED BY THE RESEARCHER
AFTER THE BIRTH OF MY BABY

I_____ consent to you, Angela Kennedy, contacting me to arrange a meeting to explain your study about first-time mothers' breastfeeding their baby away from home. I understand that I am not consenting to take part in the study by signing this form.

My baby was born on:- _____19___

I can be contacted by telephone. My number is :- _____

The best time to contact me is:-

_____a.m. or_____p.m.

The best days to contact me are:-_____

SIGNED:- _____DATE:____/___/_19____

Please return in the stamped addressed envelope to:-

Angela E. Kennedy (address and telephone number supplied).

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## APPENDIX 4

## FIRST-TIME MOTHERS' EXPERIENCES OF BREASTFEEDING AWAY FROM HOME

### CONSENT FORM

I have read the Information Sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I also understand that I have the right to withdraw from the study at any time, and to decline to answer any particular questions in the study. I agree to provide information to the researcher on the understanding that my identity is completely confidential.

I agree/do not agree to the interview being audiotaped. I understand that I can ask for the tape recorder to be turned off at any time.

I wish to participate in this study under the conditions set out in the Information Sheet.

Signed:- _____

Name:- _____

Date:- _____

Statement by Interviewer:-

I have discussed with _____(Participant) the aims of and the procedures involved in this study.

Signed:- _____(Interviewer)

Date:- ___/___/_____

(Print Name)

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