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BREASTFEEDING FOR THE FIRST TIME:

A CRITICAL-INTERPRETATIVE PERSPECTIVE ON

EXPERIENCE AND THE BODY POLITIC

A dissertation presented in partial fulfilment of the requirements for the degree of Master of Arts in Social Anthropology at Massey University

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ABSTRACT

Biomedical discourse constructs the process of breastfeeding as purely physiological, assessing and understanding individual experience by its proximity to or divergence from a norm which biomedicine itself defines. Through a process of medicalisation, this discourse has taken on hegemonic status. This thesis explores the constitution of the breastfeeding body as a body politic, as the site where a number of discourses - hegemonic and counter hegemonic - converge and articulate with physical processes. The study draws on three sets of data: first, a survey of the literature on breastfeeding which demonstrates how even the best intentioned cultural studies are permeated and formed by the biomedical hegemony; second, the experience of the author as a mother who has breastfed all her children with the growing realisation of her own body as the site of struggle; and third, the experiences of four first-time breastfeeding mothers and their reflections on this experience during the first three months of their infant's lives. The investigation presents an experiential account of the process of breastfeeding focusing on the experience of physiological functioning, relationships with significant others and experiences of conflict and resolution. It adopts this strategy deliberately as a counter hegemonic one to demonstrate the irreducibility of the experience of breastfeeding to that constructed by biomedicine.

KEYWORDS: BIOMEDICINE; BODY; BREASTFEEDING; DISCOURSE; ETHNOGRAPHY; EXPERIENCE; HABITUS; HEGEMONY; MEDICALISATION; SOCIAL RELATIONSHIPS

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INTRODUCTION

> [Breastfeeding]...It is the message embodied classically in the Madonna and Child, in the proverbial Yiddishe Mama, and the gentle mothers of the world rocking and nursing their babies. It is that mystic relationship which cannot be quite defined, only felt.
>
> Applebaum (1969:88)

> Lactation is the physiological completion of the reproductive cycle. The breast, the body, and the psyche are prepared for lactation during pregnancy. The newborn is prepared to suckle at the breast at birth.
>
> Lawrence (1984:9)

> Mammals have two characteristics - the presence of vertebrae and the nourishing of the young with milk from special milk-producing organs (mammae) of the mother. For lactation to succeed, the first essential is that soon after birth the young should be able to find and suckle the mammary gland, and, second, the mother should accept the young.
>
> Ebrahim (1978:1-2)

> In the presence of an infant and in the act of breastfeeding, a woman experiences her world in a new way. She directs herself towards the environment as a nursing mother and responds to that environment not as a single person but in relation to her infant. Thus, breastfeeding itself is a project, a chosen way to act in and on the world.
>
> Bottorff (1990:201-202)

The upward trend in breastfeeding that has occurred in the Western world since the mid-1960s has been accompanied by a wealth of research into various aspects of human lactation and the process of breastfeeding.[1] The above quotations, ranging from the romantic, through biomedical and biological to the maternal, provide examples of the range of perceptions of the phenomenon of breastfeeding. Academic investigation of breastfeeding also reflects a researcher's construction of reality, influencing and constraining findings and conclusions generated from studying the topic.

Until very recently studies on breastfeeding have been dominated by biomedical thinking which focuses on physiological functioning, emphasising the biological nature of the

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[1] Throughout this thesis I shall distinguish between the terms 'lactation' and 'breastfeeding'. This distinction is very deliberate. From a biomedical perspective, lactation refers to the physiological process of producing milk, and its 'removal' by the infant for nourishment. It is a process which can, to some extent, be studied in accord with positivist ideals of empirical science. The term 'breastfeeding' is much more holistic, referring not only to the process of producing milk and suckling a baby but also to the complexity of social, cultural and experiential factors involved in this practice.

human body. As a uniquely Western mode of thought, biomedicine rejects non-sensory experience in favour of tangible, sensory knowledge, distinguishing between the cognitive and physical aspects of human experience. The human body is perceived as an autonomous biological organism, functioning independently from the mind which is deemed empirically unknowable and therefore disregarded. Significantly, there is an assumption of commonality of experience of bodily function. The biomedical perspective, while facilitating the identification of cause and effect relationships and the development of general laws based on observation and experiment, must be recognised as presenting only partial and indeed culture-bound 'truths' on the reality of human experience in general and the experience of breastfeeding in particular.

The objective of this thesis is to address and redress the problem of biomedical bias in our understanding of the process of human lactation. My intention is to present an alternative perspective which complements and enhances biomedically orientated studies through a focus on the social, cultural and experiential aspects of breastfeeding. This objective involves exploring the politics of the body, and its manifestation in a woman's perception of her breastfeeding experience. Such a goal requires extending recognition of the body beyond the notion of a functioning biological organism to include social and cultural influences. That is, understanding of bodily experience involves identifying the body as the site for struggle and conflict between a number of contending discourses.

My interest in this subject stems from the experience of breastfeeding all five of my children. Arising out of this experience has been a frustration with inherent limitations of a biomedical understanding of the process of breastfeeding (and indeed other aspects of childbearing and rearing) which I encountered: as a woman, mother and housewife; as a La Leche League counsellor to other breastfeeding mothers; and latterly as a student of social anthropology. As a young mother, I sought guidance and approval from my own mother and was influenced by her unwavering conviction that medical science provided the model and solutions for scientific childbirth and infant care. Accordingly my attempts at breastfeeding my first two children (in 1969 and 1971) conformed to prevailing beliefs concerning rigid adherence to a four hourly routine, the

need to provide supplements of vitamins and fruit juices, sleeping separate from one's baby and so on. The assurance that I "was doing it right" and "being a good mother", in accord with the criteria established by my own mother (and endorsed by such organisations as the Plunket Society), was tempered with an underlying dissatisfaction with "not being allowed" to feed a crying baby when it appeared hungry, the regime of strict routines and the lack of fulfilment of my desire to have my baby closer to hand at night. The fact that on the advice of the Plunket nurse I weaned both of these babies onto formula at about three months of age (the nurse suggested, incorrectly, that I had "run out of milk") compounded my dissatisfaction, particularly when my second child resisted this transition, refusing a bottle for a number of days, and I realised that I was emotionally unready to sever this bond. At that time, however, it never occurred to me to challenge or to go against this 'authoritative' opinion. But as each of my remaining three children were born, I gradually came to question the prevailing conventions and embarked on a discovery of breastfeeding as a practice which involved more than mere biological functioning and which was more than an alternative means of nourishing an infant.[2]

I began to recognise that breastfeeding facilitated a unique process of interaction with my baby, one which was intense, mutually satisfying and extended into a wider relationship with other family members. This understanding was accompanied by an temporarily extended sense of self, one which was dependent on my nursing baby for completion. My 'new' sense of self was manifest in feelings of anxiety and inexplicable restlessness whenever I was separated from my baby, and avoidance of situations requiring separation. In other words I chose to relate to the world around me in tandem with my baby, rather than as a single individual.

---

[2] My decision to breastfeed conformed to the upward trend in breastfeeding commencing in New Zealand in the late 1960s, prior to which the majority of mothers formula fed their infants. Royal New Zealand Plunket Society records, for example, show a steady increase in the percentage of women breastfeeding on discharge from hospital over the period 1974 to 1983, rising from 56 to 80 percent (Roberts,1980). More specifically, with reference to cohort breastfeeding trends among Manawatu women reported by Trlin and Perry (1982), I can identify myself as a member of their third birth cohort (born 1945-1949) which led the resurgence in the incidence and duration of breastfeeding for first-born infants.

Breastfeeding generated in me an intense sense of pride in what I was accomplishing, a sense of confidence as a person and mother, and a sense of fulfilment as a woman. From a more practical perspective, breastfeeding allowed me a legitimate excuse to put my feet up for periods of twenty minutes or so during a normally hectic day; my children were fairly closely spaced, being born within an eight and a half year period. Breastfeeding thereby provided an opportunity for revitalisation and also allowed me to be available to the older children undistracted by household activities. In short, although there were times when things did not go smoothly (when I felt tied down, physically uncomfortable or even very tired from broken nights and demanding days), I found breastfeeding (once I had mastered it) to be a very convenient, rewarding and enjoyable way of nurturing an infant.

As my awareness of the convenient and pleasurable nature of breastfeeding developed I became involved with the La Leche League[3] and eventually qualified as a Leader. My role as a La Leche League Leader included leading monthly discussion meetings for mothers seeking help and support, providing telephone counselling, visiting mothers experiencing difficulties and taking part in occasional educational programmes for medical professionals. Through the role of breastfeeding counsellor I developed a heightened awareness of the inability of biomedical knowledge to adequately define, explain and provide solutions for many of the breastfeeding problems faced by the breastfeeding mothers I knew. Frequently these difficulties appeared to concern a variety of social and cultural factors which fell beyond the scope of biomedical thinking.

My sense of dissatisfaction with the limitations of biomedical knowledge was confirmed when I took up academic study. As I developed an interest in social anthropology and explored its application to studies on breastfeeding, I was dismayed to find the same biomedical bias evident in the majority of studies (Chapter Three discusses these

[3] La Leche League is an international organisation, originally founded in the United States of America in the mid-1960s. It's aim is to provide mother to mother support for women wishing to breastfeed their babies. It's history, organisation and ideology are worthy of further investigation - a task which would be appropriate for a more extended study of discourses surrounding breastfeeding (see Cable and Rothenberger,1984; Merrill,1987; Van Esterik,1989:92-94).

studies and the reasons for this biomedical orientation). This motivated me to seek alternative and more holistic ways of explaining phenomena associated with women's experience of breastfeeding. That is, ways of understanding which allow for those experiences excluded from the view of biomedicine.

My experiences have taught me that breastfeeding does not occur in a vacuum and that it is not experienced in the same way by all women. As a counsellor, I frequently encountered determined mothers persisting with breastfeeding despite severe pain or very difficult circumstances, while others gave up for what appeared to be the most trivial of reasons. Such contrasts alerted me to the fact that the determinants of the breastfeeding experience extend well beyond the physiological and are intrinsically linked to both the woman's immediate and the wider social contexts. In other words, breastfeeding occurs not in isolation but within the context of a myriad of social and political forces, pressures and influences. Van Esterik (1990:192) argues that the process of breastfeeding must be considered as "part of a complex system that interacts with many facets of the environment". Thus studies of breastfeeding need to cross disciplinary border zones, traverse realms considered distinct from and irrelevant to biomedical thinking, and firmly locate the embodied experience of the breastfeeding mother within the context of her social environment.

OUTLINE OF THESIS

Chapter One presents an overview and critique of a range of cultural studies on breastfeeding published since the mid-1970s. The discussion identifies apparent biomedical bias in research on this topic, and examines alternative perspectives and hence directions for research which allow a wider understanding of the process of breastfeeding.

Set against the backdrop of the literature review in Chapter One, this thesis presents an ethnographic study of the breastfeeding experience of four, first-time Manawatu mothers. The aim of the study is to obtain insight into each mother's perceptions of her experience of breastfeeding. Understanding the latter requires recognition of a woman's experience of breastfeeding as a phenomenon shaped and constrained by her position

within a field of discourses as a woman, mother, wife, patient, and so on. Central to the process of understanding a woman's experience of breastfeeding is acknowledgement of the body as a site where physical facts meet cultural values and beliefs (Comaroff and Comaroff,1992:40). In other words, the breastfeeding mother's body is the site of struggle: first, between contending discourses, constructing breastfeeding in different ways; and second, between physical processes and social forces.

The ideas outlined above are developed in more detail in Chapter Two which addresses the implications of the dominant biomedical construction of the body for an understanding of the experience of breastfeeding. Central to this chapter is the argument that an understanding of the body involves a recognition of the link between nature and culture, the latter constructing and defining the body and its processes. As a particular cultural construction, biomedical thought presents constrained understanding of the process of breastfeeding, its focus on physiological functioning overlooking the social, cultural and experiential aspects of this event.

Chapter Three introduces the four respondents in this study and reflects on the experience of fieldwork. The expectations and attitudes expressed by each mother before the birth of her baby are detailed as a basis for later comparison with their actual experience and shifts in perception. This chapter also addresses issues relating to the fieldwork process, including background to the setting up of the study, the interview format and an examination of my relationship with each respondent. Finally, issues concerning fieldwork methodology are discussed, in particular the advantages and difficulties associated with conducting and writing up research within one's own culture.

Chapters Four, Five and Six present the ethnographic data obtained from the fieldwork process. Chapter Four discusses the physical aspects of producing milk and nursing an infant, with particular emphasis on each mother's perception of this facet of her breastfeeding experience. In fact, the (predominantly negative) physical aspects of breastfeeding emerged as a major theme among the mothers. This chapter also discusses the feeding patterns, behaviour and routines of each infant. The latter are

identified as a potential source of conflict and tension between socially defined norms, a mother's desires and practices and the actual requirements of her infant.

The focus of Chapter Five is on each mother's relationship with significant others. The majority of relationships proved supportive and encouraging, however negative experiences with others severely impacted on the respondent's self confidence as a breastfeeding mother. Associated with the latter was the issue of breastfeeding in public. This issue is addressed in the second section of this chapter, identifying a clear link between a woman's social location and experience, and her attitudes towards nursing her baby in front of other people.

Finally, Chapter Six explores each mother's perceptions and reflections contributed at various times throughout the interview period. Contextualised by the previous chapters, the positive and negative perceptions of each mother reflect her location within the social field, the struggle between the demands of physical processes and social forces, and the discrepancy between expectations and actual experience. Thus a mother's perception of her breastfeeding experience is seen to reflect the nature and extent of tension and conflict she encountered.

To sum up, this thesis presents a case study of the politics of the body, through a study of breastfeeding. It examines the physical, social, cultural and experiential aspects of a woman's breastfeeding experience, thereby identifying the body as the site of convergence and struggle between physical processes and social forces, and between both contending and analogous discourses.

CHAPTER ONE

CULTURAL STUDIES ON BREASTFEEDING - A REVIEW OF THE LITERATURE[1]

This literature review surveying the scope and orientation of cultural studies on breastfeeding, provided my induction into research on this topic. As already discussed in the introduction, my interest in breastfeeding was kindled by personal experience involving a sense of dissatisfaction with the dominant discourse on the process of breastfeeding. Indeed, I embarked on this critique in possession of an implicit theory which I was unprepared to recognise, articulate or make explicit at the time. On reflection it is now obvious that my search of the literature amounted to a desire to discover work consistent with or at least similar to my own ideas on the subject. In this regard I was disappointed. The literature, with very few exceptions, reinforced my sense of dissatisfaction.

Accordingly, the following review carries within it the implicit theory I was bringing to bear in an attempt to understand this field of research. Integral to this theory and the structure of this thesis, is therefore, a process of discovery stimulated by personal experience and dissatisfaction. My implicit theory is now articulated and detailed in Chapter Two, a development resulting from my recognition that this review represented more than a survey and critique of cultural research on breastfeeding, but was in fact part of the reality that I was engaging with and attempting to understand. The implications of this realisation will be discussed at the conclusion of this review.

In the following pages it is argued that the majority of cultural studies on breastfeeding, although contributing valuable insights into this phenomenon, are nevertheless dominated by biomedical discourse. Indeed, they are part of the technology of this dominant discourse. The papers included in this review were identified from a search of relatively recent titles (published since the mid 1970s) which indicated the possibility

[1] This chapter is based on an earlier published version of this review. See Beasley (1991).

of a cultural perspective[2] on breastfeeding. From those titles found in the search a number were selected as representative of those sharing the same methodological classification. Accordingly all the studies selected can be allocated a position on a grid constructed from intersecting axes. Each axis represents a continuum of study methods: the x-axis represents the continuum from 'quantitative' to 'qualitative' methodologies; and the y-axis represents the continuum from 'biomedical-cultural' to 'cultural' methodologies (see Figure 1).

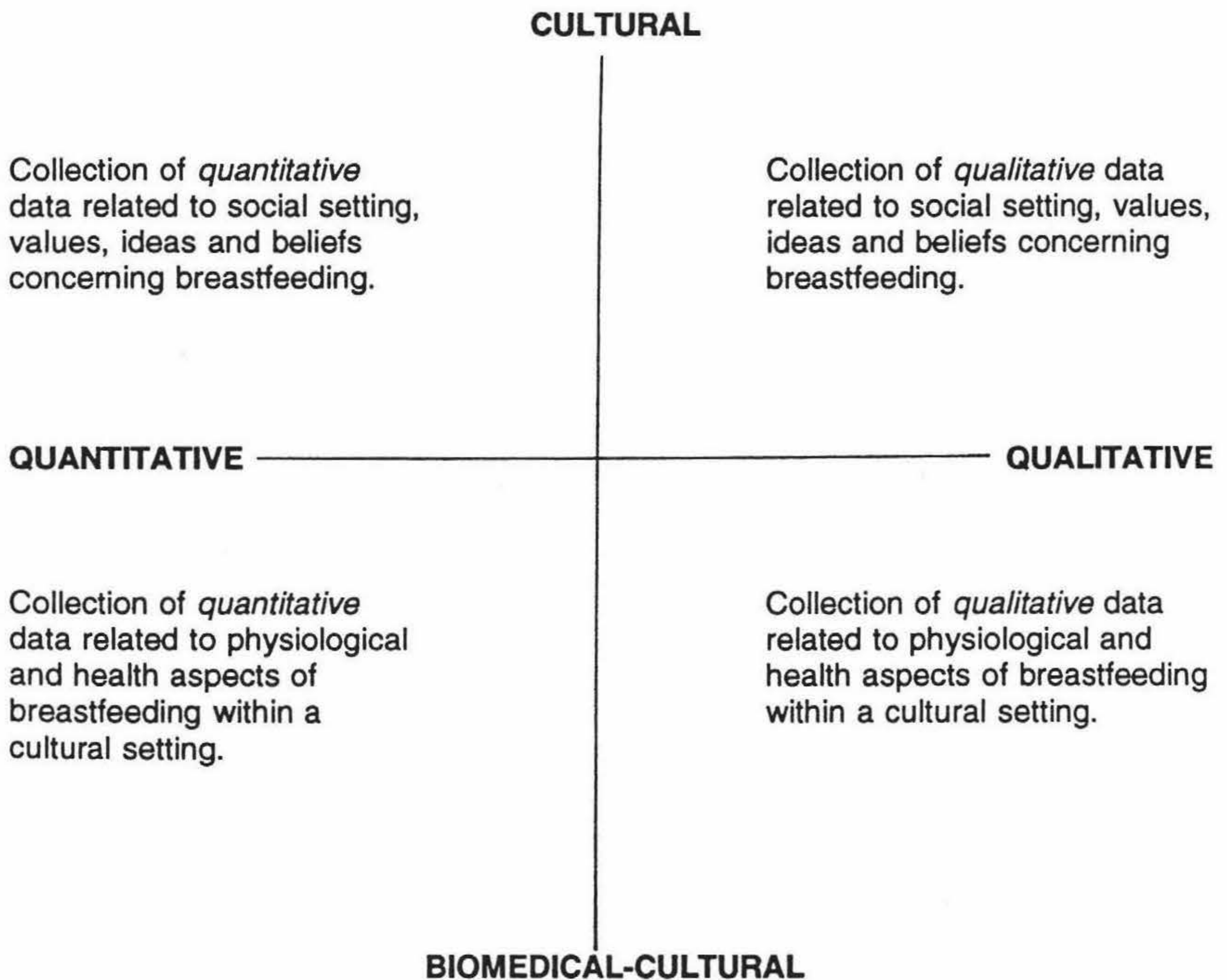

FIGURE 1. Axes of Cultural/Biomedical-cultural and Quantitative/Qualitative Elements

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[2] A number of papers identified through this search were found to be unavailable in New Zealand, while others were classified as purely biomedical in orientation and therefore rejected as outside the scope of this review.

The 'biomedical-cultural' arm of the y-axis refers to the combination of biomedical and cultural approaches; studies located around this arm emphasise the *physiological* and *health* aspects of breastfeeding within a particular cultural context. Purely cultural studies, arrayed around the 'cultural' arm of the y-axis, examine the influence of *social setting, values, ideas* and *beliefs* on breastfeeding practices. 'Quantitative' and 'qualitative' (the x-axis arms) refer to the methods employed in the studies. The quantitative methodology emphasises the collection of information via the use of techniques such as preformulated questionnaires, detailing of precise measurements and so on. Such data can then be converted into statistical information which is typically presented in the form of graphs and tables. Qualitative methodology refers to less structured methods of information collection, chiefly obtained through participant observation, thereby offering a more subjective and interactive insight into the subject's experiences and perceptions.

It can be argued that the 'biomedical' emphasis on detached, impartial, objective and 'cause and effect' orientated research is best accomplished through, and suited to, 'quantitative' methodology. The latter's employment of specialised language and formal methodological procedures reinforces the objectives of positivist science fundamental to biomedical thought. In contrast, there is an affinity between 'cultural' and 'qualitative' approaches. Both draw on traditions recognising the value of subjective aspects of empirical research and are less constrained by specialised language and rigid methodological procedures.

BIOMEDICAL-CULTURAL/QUANTITATIVE QUADRANT

Twenty one studies which gathered quantitative information relating to health aspects of breastfeeding were identified. Accordingly these studies fall within the biomedical-cultural/quantitative quadrant (see Figure 2), and within this quadrant in the region defined by the extremes of the two axes. One study, representative of this group, compared two surveys conducted in Sao Paulo in 1974-75 and 1984-85 (Monteiro et. al., 1987). These surveys involved the random selection of mothers of children aged between six months and five years, with the intention of establishing the median duration of breastfeeding in this city. The results confirmed an *upward* trend in

breastfeeding duration, and identified those groups most in need of more effective education and support. A similar study by Omer et al. (1987) is located closer to the middle of the y-axis. It examined breastfeeding patterns in the Sudan. The authors, members of a joint Sudan-Sweden cooperation programme on health, sought to determine the duration and pattern of breastfeeding and weaning among groups within and outside Khartoum and how this behaviour was affected by socioeconomic status and traditional attitudes. Using answers to a questionnaire, they developed a comprehensive account of demographic characteristics, ante- and perinatal practices, and patterns of breastfeeding and of mixed (breast and bottle) feeding. From their account they derived recommendations designed to encourage a higher rate and longer duration of breastfeeding among the Sudanese. The Khartoum study does focus slightly more on the cultural determinants of breastfeeding. This is reflected in the data-gathering technique which employed both closed-ended and open-ended questions, the latter giving respondents a limited opportunity to convey their subjective perceptions, experiences and interpretations to the researcher.

The Sao Paulo and Khartoum studies both 'set the scene' for further investigations. Both studies document patterns and trends, the authors of the former acknowledging that (Monteiro et al., 1987:966):

> ...it may be necessary to ensure that conditions exist that make breast-feeding compatible with other activities in the community.

However, as this aspect falls outside the scope of both studies, neither study attempts to identify these conditions or to make recommendations as to how change could be implemented.

The Khartoum study also identified local breastfeeding patterns and trends, but differs because it attempted to ascertain mothers' attitudes, personal opinions and beliefs concerning a variety of infant feeding and other related health practices. However, these *expressed* beliefs and the open-ended questionnaire technique provide no mechanism that verifies the accuracy of these responses (in terms of actual behaviour), nor are the responses located within a broader cultural context. Furthermore, the intent

of both studies is to enable change by health practitioners to improve breastfeeding rates and duration. The fact of this intended audience raises questions about the method and focus. Because these two studies are directed primarily at health practitioners they must be structured to obtain empirically verified evidence and adhere to a biomedical perspective. In other words, the target audience's professional recognition of 'legitimate' research restricts the scope and findings of this type of investigation.

A study by Popkin et al. (1986) is located closer to the middle of the x-axis origin of the axes because the authors (nutritionists and medical researchers) question the limitations of researching infant feeding practices solely in terms of the latter's relationship to infant morbidity. They propose that the effects of breastfeeding extend beyond the mother-infant pair and affect the whole household, which they view as a complete ecosystem. Accordingly, they see infant feeding practices as more than (Popkin et al., 1986:2):

> ...a biological process in response to metabolic demands of a baby. It is also a complete web of behaviours involving actions and reactions of other people.

The result is a text that commences with an overview of infant feeding practices and discussion of theoretical considerations and problems of data collection, the remaining sections being devoted to the infant, mother and household. The emphasis of this text is on "developing hypotheses to be tested in future studies" (Popkin et al., 1986: 7). The authors seek to highlight or bridge the gaps that have existed in this field of research to date. Although several of the authors recognise the need to identify and close research gaps, they nevertheless confine themselves to biomedical considerations of the 'infant triad'. By overlooking the contribution of a cultural approach, Popkin et al. (1986) forgo the opportunity to examine what underlies these identified patterns and trends and how cultural perceptions affect feeding practices and relationships.

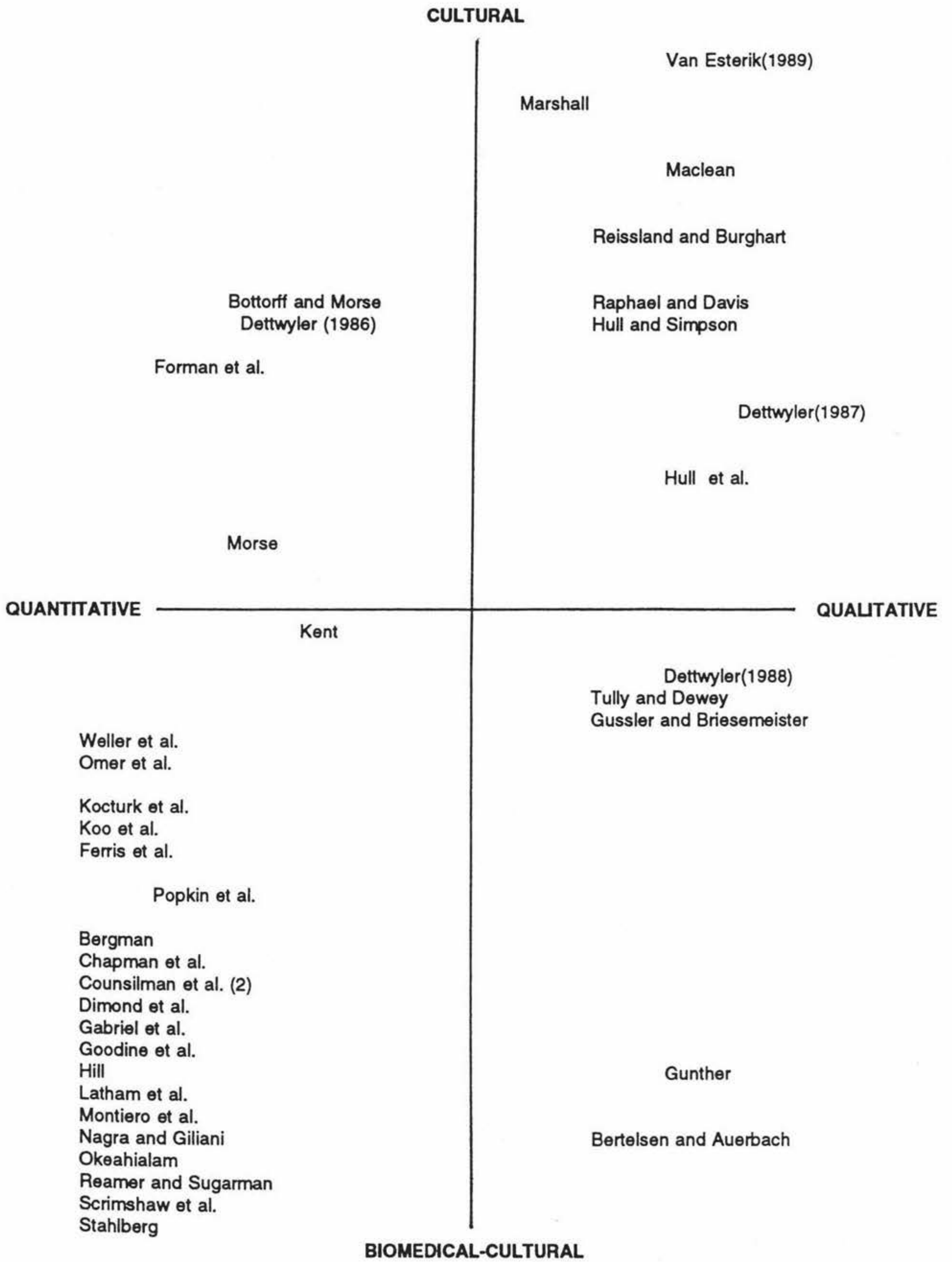

FIGURE 2. Grid Locating Position of Work by Different Authors

Note: individual authors published in edited books are not represented on this grid.

BIOMEDICAL-CULTURAL/QUALITATIVE QUADRANT

Very few studies employ a 'biomedical-cultural'/'qualitative' perspective (see Figure 2). However, among those that do is Gunther's (1976) examination of the relationship between attitudes of mothers to breastfeeding and their self-perception, particularly in view of the biological changes associated with pregnancy and lactation. Heavily influenced by her medical background, Gunther makes no distinction among the cultural backgrounds of the mothers she worked with. Indeed, Gunther assumes that a new mother's view of her embodied self is a cultural universal, linked with perceptions of female sexuality (Gunther,1976:9):

> ...the part played by the outward shape of the mammary gland in attracting and arousing the male seems to be a mechanism peculiar to humans and to have become more operative this century.

Gunther's assumptions are questionable given that they are made solely on the basis of her observations of British culture. Moreover, they illustrate an inherent contradiction between biomedical assumptions of commonality of experience of physiological functioning (breasts are universally sexual to males), and cultural and individual variation of perception and experience of the body. In other words, breasts cannot be assumed to be universal instruments of sexual arousal if they have "become more operative this century".

Bertelsen and Auerbach (1978) investigate the cultural connections between breastfeeding and maternal nutrition. Written primarily for lactation consultants, the paper details human nutritional requirements (which the authors assert are unaffected by cultural influences) and specific food beliefs and practices among several groups in the United States.

Gussler and Briesemeister (1980) and Tully and Dewey (1985) focus on the Insufficient Milk Syndrome (IMS), a term associated with the decline of breastfeeding in countries experiencing urbanisation. IMS is reported as the most commonly stated reason for early termination of breastfeeding. Gussler and Briesemeister (1980) examine what they describe as a biocultural explanation, noting that Insufficient Milk Syndrome is a

transculturally recognised phenomenon that has attracted much attention and generated considerable debate. They contend that the prerequisites of successful breastfeeding rest with continual feeding and carrying of the infant, a bio-behavioural response to the lower fat and protein content of human milk that requires "easy accessibility of mother and milk, and frequent feeding of the young" (Gussler and Briesemeister, 1980:151).

Gussler and Briesemeister (1980) further suggest that in societies where breastfeeding is traditionally practiced in this manner, IMS does not exist. Rather it is associated with cultural change brought about by urbanisation which makes continual feeding difficult and undesirable. Factors such as the intervention of technology, hospital practices which routinely separate mother and baby, babies in strollers, and maternal perception of time or other pressures may all interfere with the mother's perception of the baby's indications of hunger. The end result is the mother's incorrect interpretation that she lacks the ability to produce sufficient milk for her baby. Thus, Gussler and Briesemeister (1980:161) assert:

> ...[breastfeeding] is no longer biological...the biological component of the bio-behavioural system has not changed, while the behavioural component has.

The assertion that IMS is due to lifestyle changes associated with urbanisation, contrasts with Tully and Dewey's (1985:226-227) conclusion that the causes of IMS remain unclear:

> ...although the evidence established IMS as a common reason for terminating lactation, little is known about the reasons which prompt a mother to believe that her milk is insufficient or the actions she takes once insufficient milk is perceived.

Tully and Dewey (1985) describe a range of maternal perceptions associated with IMS among four cultural groups and investigate a possible relationship between insufficient milk and sociocultural variables (namely, maternal knowledge of breastfeeding practices, hospital practices before and after delivery, and psychological variables). They obtained data from women attending antenatal and postnatal clinics who were interviewed using questionnaires which allowed "a detailed description of any incident of perceived insufficient milk" (Tully and Dewey,1985:229). Their findings led them to conclude that (Tully and Dewey,1985:240):

> IMS is a transcultural phenomenon apparently independent of maternal nutritional status... the cues most commonly interpreted as insufficient milk were that the infant cries after nursing and that the mother's breasts did not feel full...Only 3 percent of all mothers indicated that the baby was not gaining enough weight. Because the first two cues do not necessarily reflect a real inadequacy of milk, IMS may be primarily a 'perceived' phenomenon in many cases.

However, Tully and Dewey fail to explain why this perception persists among so many mothers. Their conclusions are directed at improving professional awareness of IMS and hospital practices so that breastfeeding success is encouraged. Like others, Tully and Dewey assume that biomedical research and information will explain all factors underlying breastfeeding practices. Thus underlying social and cultural factors are largely overlooked. My classification of Tully and Dewey (1985) is therefore 'biomedical-cultural'/'qualitative', although their study's location on the y-axis is toward the centre of the grid, due to its emphasis on obtaining the mothers' stated perceptions.

QUANTITATIVE/CULTURAL QUADRANT

As an example of research in this quadrant, Dettwyler's (1986) work combines survey methodology (involving regular collection of physical measurements, condition of health, motor development and dietary recall) with her cultural knowledge obtained over the same period as an ethnographic fieldworker. She examines why some children appear to thrive under environmental and economic conditions that result in malnutrition in other children. The answer, she concludes, lies with those beliefs which involve maternal attitudes to infant feeding and weaning and therefore have a direct effect on the child's nutritional status and growth patterns. Thus, subtle differences in maternal attitudes toward infant feeding and child care may lead to varying practices which result in differences in children's growth and nutritional status. She argues that if the nutritional status of infants is to be improved (Dettwyler,1986:664):

> ...details of the cultural organisation of infant feeding must be documented and understood, and any changes suggested should be within the range of variation of, or at least complementary to, the traditional belief system.

Once again, however, the overriding emphasis is on biomedical factors for which the author seeks a cultural explanation.

Bottorff and Morse (1990:4) identify and describe "belief systems related to breastmilk from the mother's perspective". To obtain this information they adopted what they term the 'ethnoscience' method, the identification of "how people construct their world experience from the way they talk about it" (Bottorff and Morse,1990:5). Detailed and lengthy interviews with respondents selected "according to their ability and receptivity", provide data rich enough "to allow the researcher to discover the cultural beliefs that surround the use of breastmilk" (Bottorff and Morse,1990:5).

This study has a clearly stated cultural focus but its method, confined to interviewing and the recording of the mother's descriptions and stated perceptions and beliefs, is restricted to an explication of the notion that beliefs surrounding breastmilk influence feeding practices. The aim was to investigate these beliefs so that culturally appropriate intervention could be developed by health care professionals in order to encourage and sustain breastfeeding. This method presents serious disadvantages if cultural insight is to be gained on women's perceptions of breastfeeding. For example, the dependence on language alone divorces the mother's responses from an understanding of her actual practices, precluding any opportunity to observe if stated beliefs and actual practices are consistent. Moreover, the authors accept the predominance of the biomedical model in Western culture and its effect on the mother's perceptions of breastmilk and breastfeeding, but fail to investigate the influence of alternative discourses on the perceptions of the women in their study. For instance, mention is made several times of the feelings of guilt and selfishness the mothers experienced when their baby became upset or colicky. These events were commonly perceived by the respondents as resulting from their own actions and/or dietary intake in the case of weaning (Bottorff and Morse, 1990:7-8):

> Mothers who believed that breastmilk was an essential food up until six months and beyond were often mothers who suspected children were prone to allergies or who saw their infants as babies that still needed the nutritional and immunological benefits that only breastmilk could provide. The strength of their conviction was often reflected in the guilt they experienced as they thought about stopping breastfeeding. To remove the comfort that breastfeeding provided for the baby and to remove nutritious food from the infant's diet for a mother's selfish personal reasons (e.g. freedom) was difficult to justify.

While the dominant biomedical discourse may contribute to the development of these convictions and give rise to situations fostering the development of these sorts of emotions, other questions are left unanswered. For example, why do the mothers see a direct relationship between their actions and the infant's well-being; why do they experience guilt and how is this related to their perception of themselves as women and mothers; why do they desire freedom and what does it involve, etc.? The ethnoscience model does not allow for the acquisition of such insights. The information gathered records the mother's stated perceptions but offers no real insight into how or why they are shaped or constrained by social and cultural forces.

CULTURAL/QUALITATIVE QUADRANT

In this quadrant, Dettwyler's (1987) study is based on the author's ethnographic fieldwork. Although her focus on the nutritional status of infants and children would appear to indicate a biomedical orientation, Dettwyler acknowledges the limitations of total compliance to this perspective. Indeed, she argues that a complete understanding of infant health requires identifying beliefs which have persisted or changed and ascertaining how these affect or alter practices. How is this to be done? The answer according to Dettwyler (1987:633):

> ...is to collect data about cultural beliefs and observe patterns of infant feeding and analyse the relationship between the two.

Accordingly, Dettwyler (1987) combines empirical and ethnographic research techniques, employing mixed longitudinal data[3] on growth and development, unstructured or semi-structured interviews, and participant observation. The result is a detailed account of feeding and weaning practices in the culture studied and their relationship to infant growth. The author notes that "breastfeeding is revealed as a complicated, variable process, defined and circumscribed by culture" (Dettwyler,1987:644), and warns that stated beliefs and actual practices do not always coincide, necessitating both qualitative and quantitative methods of research if an accurate account of what is occurring is to be obtained. Thus the reader is presented

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[3] This study allowed children to enter and leave at different ages in contrast to a purely longitudinal study where all would enter at the same time and remain until it was completed.

with a mixture of 'hard' and descriptive data, the latter providing contextualisation for the former and a depth of insight not possible in studies classified as 'quantitative'/'biomedical-cultural'. Accordingly this study can be classified as 'qualitative'/'cultural', its inherent biomedical bias (evident in the paper's format) placing it towards the centre of the x-axis (see Figure 2).

Most of the contributions to a volume edited by Hull and Simpson (1985), result from ethnographic field work conducted in Papua New Guinea, Kenya, Mexico, Java, Thailand, Iran, Australia and Canada. There is a blending of quantitative and qualitative research methods. The result is a more comprehensive range of information that relates cultural beliefs to patterns and trends and at times provides fleeting glimpses of the women's feelings and perceptions of themselves as mothers and infant caregivers. While located in the same position in the quadrant as Raphael and Davis (1985), some of this volume's individual chapters can be placed at different points on the grid. For example, Van Esterik's "The cultural context of breastfeeding in rural Thailand", because of its method of participant observation and emphasis on the effect of the cultural context on individual practices and beliefs, should be located further towards the 'cultural' pole on the 'biomedical-cultural'/'cultural' axis and the 'qualitative' pole on the 'quantitative'/'qualitative' axis. In contrast, Cosminsky's "Infant feeding practices in rural Kenya", emphasises identification of patterns and trends. Because this study uses a survey methodology similar to that employed by Omer et al. (1987) it occupies a similar position in the 'biomedical-cultural'/'quantitative' quadrant.

Only Mothers Know (Raphael and Davis, 1985) is a book based on ethnographic studies of infant feeding undertaken during 1976 in the Philippines, India, Sardinia, St. Kitts, Jamaica, Egypt, and the United States. The focus is on recording actual infant feeding practices within a particular culture and identifying their determinants. While Raphael and Davis provide clear descriptions and anecdotal accounts of infant feeding practices within each cultural context, little insight is offered into the cultural values and beliefs that underlie and influence mother/infant interaction and breastfeeding practices in the cultures studied. Moreover, the authors' underlying argument that "over time most feeding episodes are rooted in the economics of the family" (Raphael and Davis,

1985:147) presents an unconvincing, simplistic and culture-bound explanation of breastfeeding practices and trends.

In contrast, Maclean's (1990) study of 122 Toronto women, presents a much more holistic view of women's experience of breastfeeding. Maclean interviewed all respondents at least once in the last trimester of their pregnancy and thereafter fifty of them for up to fourteen times until their baby was six months old or had weaned. Half of the follow-up interviews were conducted on the telephone while the remainder were conducted in person. Maclean's (1990:3) aim was "to examine breast feeding from the perspective of those who know it best: the women themselves." Hence the first and final interviews of this study were structured, with the remainder being designed to "encourage the women to describe and discuss their experience of breastfeeding" (Maclean,1990:13).

The data collected from tape-recorded interviews was transcribed, coded and discussed according to themes and categories ranging from the reasons underlying the choice of infant feeding, through physical discomforts to the rewards of breastfeeding and the decision to wean. Liberal use is made of transcript excerpts which provide the reader with colourful firsthand insights into the experiences of the women being studied. Maclean acknowledges the importance of the interaction between social and cultural factors and the choices a woman makes concerning breastfeeding, noting that it is unusual for health professionals to pay attention to such issues (Maclean,1990:204). This book therefore represents an important attempt at adopting a more holistic approach to the topic by a biomedically-orientated researcher (a Professor of Nutritional Science, Faculty of Medicine, University of Toronto), focusing on the actual experiences of individual mothers within the context of their social location.

Some of Maclean's conclusions can be challenged as assumptions drawn from the experiences of a select group, particularly as all the women involved in extended interviewing were volunteers and as such not necessarily typical of Canadian breastfeeding mothers. However, this shortcoming is compensated for by Maclean's (1990:203) recognition that:

> We can see from the material presented in this book that breast feeding is a complex activity intimately tied to a woman's sense of herself.

Indeed it is Maclean's realisation that decisions concerning the choice and duration of breastfeeding involve attitudes, values and character traits (of the mother, baby and those close to them), as well as wider social and cultural factors, that merits location of this study in a central position in the 'cultural'/'qualitative' quadrant.

The majority of contributors to the third volume in the Food and Nutrition in History and Anthropology series, edited by Marshall (1985), are anthropologists. The orientation of these contributors is reflected in the book's placement near the 'cultural' pole, despite its biomedical emphasis on infant and child health. The classification of this volume is due to its acknowledgement of the need for studies that integrate ethnographic details with different types of biomedical data (such as individual health status, food intake, dietary practices, weight-by-age measurements) in order to obtain a clear picture of actual infant feeding practices, their relationship to a particular culture, and implications for infant and child health and development. For example, Schieffelin (1985:2), in her chapter "The importance of cultural perspectives on infant care and feeding", states:

> The major questions here are not only what is the relationship between what people say they do and what they actually do, but also why there is such a difference and what it means for the way people feed and care for their children. Inquiry should proceed on the assumption that there is a relationship between the different cultural statements and practices, even if people say there is not.

She further emphasises the role of cultural ideology in shaping infant feeding practices, acknowledging that (Schieffelin,1985:3):

> ...only by understanding a set of practices can we make sense of the meaning that such actions and events have for the participants.

However, the interpretative accounts of actual infant feeding practices and associated beliefs detailed in many of the chapters by other authors tend to present the reader with a detached 'still life' impression of what is occurring. This is because they present only the researcher's description of what is happening and little or no attempt to interpret what is observed from the mothers' point of view. This creates a gulf between observed

practices and recorded beliefs on the one hand, and insight into individual experience and perception of infant feeding practices on the other. One notable exception can be found in Barlow's (1985) chapter, in which the author presents a composite description (obtained from various local people) of the ideology of pregnancy, birth and infancy. This description is followed by an actual case study of the sequence of events surrounding the preparation for birth, detailing the mother's practices in caring for her infant. These events are recorded together with the impressions and comments of the mother, family members and villagers involved. Overall, the case study provides an insight into the reality of everyday events and the compromises that must of necessity be made between the ideal and desirable and what is actually achievable. This difference between stated ideals and achieved reality offers an alternative insight into the perception of individuals toward commonplace events and practices and an explanation of the underlying reasons for the presence or absence of infant feeding practices.

Beyond the Breast-Bottle Controversy (Van Esterik,1989) can be located as the closest to the 'cultural' pole of all the studies. This book is unique among the studies critiqued in that it presents a critical-interpretative approach to the issues it addresses in order (Van Esterik,1989:3):

> ...to go beyond the breast-bottle controversy and return to the 'real' problems facing mothers in developing counties - poverty, powerlessness, hunger, and the unequal distribution of resources.

Van Esterik successfully achieves this objective via an interdisciplinary study (conducted by research teams in Kenya, Colombia, Thailand and Indonesia) which combines community ethnographies with survey, marketing and medical infrastructure sub-studies. She argues that (Van Esterik,1989:145):

> Research on the determinants of infant feeding is decidedly empiricist and informed by a biomedical model of evidence and 'truth'.

Four case studies are presented of mothers residing in Bogota, Nairobi, Semarang and Bangkok and their experience of infant feeding is discussed within the context of poverty, empowerment of women, medicalisation of infant feeding and the

commoditisation of infant food. The result is a clear demonstration that decisions made at the level of individual practice are constrained and influenced not only by the immediate social and cultural context, but also by international or macro cultural, social and political forces. In other words, the significance of Van Esterik's book lies in its ability to link interpretation of data at the level of individual practice with events identified at the level of social structure. In so doing, Van Esterik identifies more than just patterns and trends, presenting the reader with insights into and interpretation of the problems and difficulties confronted by each mother, in a way that identifies causes and possible strategies for change.

Although Van Esterik did not personally conduct the ethnographic research, and is therefore unable to present an interactive interpretation of the data collected, she at least met three of the women in their own homes "and could therefore picture their circumstances more clearly" (Van Esterik,1989:33). She strives to overcome the disadvantage of 'second-hand' ethnographic data through reflexive inquiry into how her own life experiences have influenced her interpretation of the experiences of the four mothers, and concludes by locating herself (as an anthropologist) in the role of advocate. Van Esterik argues that her professional knowledge puts her in a position to contribute to change, and challenges other anthropologists to become involved in advocacy discourse. By addressing not only issues of global power and politics associated with Western industrial expansion into the developing world, but the role and place of individual researchers as part of a Western academic discourse, Van Esterik also challenges the reader to reflect on the limitations and culture-bound nature of academic research.

This volume, not available at the time of my original literature search (Beasley, 1991), represents the type of orientation I was seeking among cultural studies on breastfeeding and has been significant for my own thinking. In particular, Van Esterik's linking of individual practice with immediate and wider social and political constraints and forces contributed to my awareness that the strategies and practices of the breastfeeding mother reflect complex interaction between physical process, and social and cultural forces.

CONCLUSION

The vast majority of studies which focus on the cultural aspects of breastfeeding can be classified as 'biomedical-cultural'/'quantitative' in orientation and fall near both the 'biomedical-cultural' and 'quantitative' poles of the grid axes (Figure 2).

The Western view considers breastfeeding to be a biological process, its success or failure easily ascertained through empirical measurement. It is conceived of as a physiological process and product and is, therefore, subject to biological and biochemical analysis and explanation. Such a focus is limiting, resulting in a series of replicative studies (albeit set against different cultural backdrops), providing no fresh insight or knowledge. It is time to cease the ploughing of this exhausted field and to commence the exploration of fresh pastures in the way Van Esterik (1989) has done.

Biomedical thought, with its emphasis on examining individual, detached parts of the whole as separate entities, presents a fragmented approach which fails to acknowledge the interdependence, interaction and complexity of the whole. Documenting patterns and trends obtained by recording the expressed beliefs of mothers presents a very fragmented, narrow glimpse of what is actually occurring. The perception of breastfeeding as a biological event may lead to it being conceived of as a process governed by presumed universal laws. Moreover, because a biomedical orientation represents a distinctly Western mode of thinking, it offers the potential for misunderstanding and misinterpretation when data are collected from a culture adhering to different philosophical and ideational perceptions and values. This problem is not unique to studies on breastfeeding, but reflects the generally thorny philosophical issue concerning the relationship between truth and reality. Thus the perceived 'truth' of a biomedical construction of breastfeeding is no more or less valid or logical than those presented by alternative perspectives. That is, differing or opposing constructions of breastfeeding need to be recognised as reflecting a diversity of assumptions underlying various perceptions about the nature of reality.

In an entirely different context, Levi-Strauss (1963) refers to the dilemma faced by Quesalid, a practising shaman aware of the deception of his power, who is challenged

by another appearing even more blatantly deceptive than himself. Levi-Strauss (1963:176) notes that the problem becomes one in which:

> Two systems which we know to be inadequate present (with respect to each other) a different validity, from both a logical and empirical perspective. From which perspective shall we judge them? On the level of fact where they merge, or on their own level, where they take on different values both theoretically and empirically?

Additionally, most studies that adopt a biomedical approach to cultural studies on breastfeeding are 'interventionist' in so far as they hold an applied perspective. The question to ask is: Does this targeting distort research or divert attention from areas that might otherwise warrant examination? Such a question highlights a major problem; that is, the lack of acknowledgement of the researcher's bias in approaching the topic. All researchers are influenced by their particular cultural context and this is reflected in both the methodology they adopt and the particular aspect of a topic selected for study. Breastfeeding studies to date have largely been prejudiced in favour of the dominant Western mode of thought and its accompanying methodology. In order to achieve a less culture-bound approach, recognition needs to be given to the credibility and validity of other more subjective orientations which can offer alternative and complementary perspectives (see Figures 1 and 2). Although one must acknowledge that in some absolute logical sense it is impossible to shed the spectacles of one's own culture, the ethnographic method of participant-observation (falling within the 'cultural'/'qualitative' quadrant) counters this in a fruitful way. It does so by saying that it is possible to see things from the position of others and that it is possible to translate the cultural experience of others.

Knowledge and ways of knowing are constantly changing. A good starting point is acknowledgement of the importance of the total cultural context. Thus, ideas, values, emotions, perceptions and symbols associated with the particular culture to which a woman belongs need to be related to the social context. This context involves complex personal interactions in which the mother assumes diverse roles, all of which affect her self-perception and ability to feed and interact with her infant. Consideration of the significance of the social context, might provide insight into what mothers feel and why they do what they do. For example, Raphael and Davis(1985:21) state that:

> I [Raphael] began to see breast feeding as many Third World women saw it - perhaps pleasurable but certainly quite ordinary. In the Western world many of us turn to breast feeding as a little gem: as a divine opening up of emotional contact, as something important that we can do with our bodies and not be ashamed, as a way of validating our womanlyness.

Such a statement is laden with assumptions regarding the emotional needs of Western women, their self-perceptions and the abyss between them and Third World women. Understanding the reasons underlying these differences requires consideration of divergent cultural values, beliefs and ideas which condition and constrain the way women perceive themselves, their bodies and their social roles and practice. Moreover, it requires recognition that the experience of breastfeeding, although culturally shaped, varies between individuals and cannot be generalised in the way Raphael and Davis suggest.

Stated perceptions need to be recognised as revealing more than face value; that is, the obvious may be overlaid with the symbolic. Moreover, we need to be aware of the 'observer effect' - the fact that informants may structure their responses to meet the perceived needs of the interview situation. An example is found with one of the most commonly stated reasons for weaning: insufficient milk. IMS concerns a woman's perception of insufficient milk to sustain her infant. In a minority of cases this perception can be biologically verified; that is, a mother is physically unable to produce enough milk to satisfy her infant. However, in the majority of women, what starts as a 'perceived' problem represents a labyrinth of emotions, thoughts, self-perceptions and interactions which, unless unravelled and understood, render the statement, initially at least, inaccurate and meaningless (see Gussler and Briesemeister,1980; Greiner, Van Esterik and Latham,1981; and Tully and Dewey, 1985). The problem is that a mother's perception of insufficient milk is created by biomedical assumptions of uniformity of experience. That is, when individual experience is perceived as at variance with common conceptions of 'normal' (the baby wants very frequent feeding or cries a lot; the milk appears 'watery' and so on) a conclusion of insufficient milk is reached. IMS can therefore be understood as a phenomenon created and buttressed by biomedical discourse on breastfeeding. The line of questioning adopted by quantitative studies on

breastfeeding has the potential to suggest insufficient milk when a mother's responses fail to conform to preconceived constructions of 'normal'.

What we are seeking is an interpretation of the meaning underlying the stated perceptions of mothers of their breastfeeding experiences. The 'facts' presented in positivist studies reflect the ideational system of the researcher and are therefore 'facts' only within the confines of this epistemology. Even when investigations proceed from a less biomedical perspective, there still remains the problem that all the information obtained is already culturally mediated by the respondents involved and this in turn is reinterpreted by the anthropologist. Rabinow (1977:151), for example, asserts that:

> The fact that all cultural facts are interpreted...is true for both the anthropologist and his informant, [who] must interpret his own culture and that of the anthropologist.

This point is particularly pertinent in some studies fitting the 'biomedical-cultural'/'quantitative' quadrant. The authors of the Khartoum study (Omer et al., 1987) indicated that some of the researchers were known locally in their capacity as health professionals; this association may (as per the observer effect) have swayed some of the respondents toward presenting information that they considered the researcher expected to hear.

With respect to cultural studies on breastfeeding, a more reflexive, interpretative approach to the problem would at least allow the possibility of obtaining some insight into the emotions, thoughts and interactions that underlie the stated perceptions and experiences of mothers. If the researcher has at some stage been a breastfeeding mother, her own experience presents a base from which to reflect and understand perceptions and beliefs on a level unavailable to other researchers. While the physical process associated with breastfeeding an infant is universal to all mothers, this process is experienced in culturally and socially divergent ways. The unlocking of this experience presents an opportunity for understanding many of the patterns and trends documented among the world's breastfeeding mothers.

The identification of the dominance of biomedical thought and bias in cultural studies on breastfeeding provides an important body of data for this thesis. It demonstrates that despite the best of intentions, biomedically orientated thought unconsciously permeates much of the literature and Western attitudes towards the body and its functions. Indeed, not even the best intentioned of these studies (for example, Dettwyler, 1987) are free of underlying biomedical assumptions, the pervasive nature of this discourse alerting me to the dominance of biomedical thought. Associated with this realisation was a recognition that my own thinking and use of language also relies on biomedical metaphor and thought. Thus engaging in this literature review was a significant and important step in the process of discovery and investigation of an alternative understanding of a woman's breastfeeding experience.

This thesis restricts its critique of the dominance and limitations of biomedical thought to the case of breastfeeding, but acknowledges that there is scope to broaden the argument through a critical examination of the place of biomedicine within Western culture. Such a project goes beyond the scope required for this thesis but presents a possible future challenge. The focus here is restricted to the data obtained from this literature review, the experiences of the mothers in this study and my own experiences as a woman, mother, counsellor and student. The following chapter presents an alternative theoretical strategy allowing a critical-interpretative investigation of the experience of four, first-time New Zealand mothers.

CHAPTER TWO
THE BODY, BIOMEDICINE AND BREASTFEEDING

> Women's experience is an overlooked source of wisdom that needs to be shared among us. The difficulties women experience when breast feeding are the consequences of...the social norms of our culture. To understand the factors that influence women's experience of breast feeding it is necessary to understand the influence of socio-cultural factors that reflect women's place in society.
>
> Maclean (1990:4-5)

Central to the process of breastfeeding is the human body which is perceived and constructed in culturally diverse ways. Thus, if an understanding of bodily practice and action is to be realised, various perceptions of the body need to be recognised as comprising the juxtaposition of culture with nature.

The objective of this chapter is to provide a theoretical foundation for this thesis, one which allows for an alternative to a biomedical understanding of the breastfeeding experience of women. Of particular relevance is the impact of an individual's social context on their perception, action and practice, and corresponding issues of politics and power. Integral to the latter is the notion of the body as a site where physical processes confront social forces, and conflicting and analogous discourses converge.

Lock and Scheper-Hughes (1990:50) in considering cultural constructions of the body, identify three integrated levels, referred to as the realms of the individual, the social, and the body politic. The authors define the individual body as a person's intuitive sense of embodied self as separate from others.[1] The social body concerns the transformation of the body as a natural symbol into an entity of social and cultural significance. And the body politic refers to the realm of power, control and regulation over individual bodies and social groups.

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[1] Lock and Scheper-Hughes(1990:50) drawing on Mauss(1985) state: "We may reasonably assume that all people share at least some intuitive sense of the embodied self as existing apart from other individual bodies".

The Western[2] concept of personhood[3] is centred on the notion of the individual person or 'moi' (Mauss,1985:2). That is, the person is valued as a conscious, rational, legal, moral and autonomous individual entitled to certain recognition and rights as a moral entity. This conception of personhood draws on a tradition of dualist thought, which distinguishes between mind/body, spirit/matter and real/unreal, facilitating the separation of the physical body from the intangible realm of mind and spirit.

The concept of the body politic is the most central to this thesis. The body politic concerns the body as a site of conflict arising from tensions created in the struggle between individual and social desire for control over and of the body. The body politic has the potential for distortion of the human anatomy in a situation where the physical body is perceived as incompatible with the predominant values, world view or practices of a particular society or culture. Examples may include the Chinese custom of footbinding, and male and female circumcision practices present in many cultures. Thus the body politic encapsulates forces of power and control which can constrain and shape physical appearance and individual experience of the body, either directly or indirectly in very subtle ways. For the breastfeeding mother, cultural constructions of the female body define, regulate and constrain action and practice associated with suckling her infant. An example is evident in the attitude of some mothers towards

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[2] Throughout this thesis, the term 'Western' refers to the world view currently but loosely shared by the dominant fractions of the industrialised nations of the First-World. Obviously within this group of predominantly Euro-American sub-cultures there is considerable diversity and interpretation of outlook. However, there is also a loosely shared sense of historical heritage drawing on Greek, Roman and Judaeo/Christian ideas and ideals, enlightenment philosophy, and experiences associated with the industrial revolution and colonial expansion.

[3] Drawing on Dumont (1985:95-96) the Western notion of personhood refers to the conception of the individual as a value. Linking the emergence of individualism to the mode of eighteenth and nineteenth century thought, Dumont argues that "the essentially non-social moral being, who carries paramount values..is found primarily in our modern ideology of man and society," in contrast with "those societies where the paramount value lies in society as a whole". Moreover, Dumont(1985:95) distinguishes between the "inwordly" and "outwordly" self, arguing that the Western notion of the individual is confined to the former. That is, Western personhood acknowledges the individual as located within a temporal, spacial context, imposing interdependence between individuals. In contrast, an outwordly concept of personhood, incorporates a tradition of social renouncement allowing 'true' individualistic distinction through the path of asceticism. However, it must be acknowledged that in spite of the notion of individuality being firmly embedded in social thought, in practice there may be huge variations associated with class, race and gender differentials. Nevertheless, it is possible to speak of a dominant Western conception of the individual.

breastfeeding in a public situation, their inhibitions reflecting cultural attitudes towards the female body and sexuality.

POWER, PRACTICE AND HEGEMONY

Comaroff and Comaroff(1992:28-29) argue that power (as the determining capacity of the social and cultural) is an integral aspect of any culture and its history. Distinguishing between *agentative* and *nonagentative* power, they confine the former to overt control of others through domination of access to material resources. However, it is nonagentative power that is of particular significance to this discussion. Immersed "in the forms of everyday life, forms that direct human perceptions and practices along conventional pathways" (Comaroff and Comaroff,1992:28), nonagentative power permeates such realms as aesthetics, ethics, bodily representation and medical knowledge, being manifest negatively as cultural constraints, and positively as cultural values. Nonagentative power underlies many aspects of cultural practice and belief, transforming into hegemony once the latter become internalised and unconsciously accepted as 'what is right', 'natural' or common sense within a particular cultural field. Of particular relevance is the role of hegemony in constraining individual perception, and defining the body and appropriate individual practice.

Biomedicine constitutes a dominant influence in Western society, consciously and unconsciously affecting the way we view our bodies, health and disease. Biomedical construction of the human body as a functioning biological organism is evident in common usage of the mechanistic metaphor as a means of articulating physical experience. For example, commonly heard expressions are "feeling run down", "worn out", " functioning in slow motion", "tuned in", etc. (Lock and Scheper-Hughes,1990:64).

More subtle examples of biomedical hegemonic influence are evident in notions of "public good" and "the nation's health", underlying the establishment of the New Zealand School Medical Service shortly after the end of World War I. Described by Tennant (1991:133) as "propagandist", this Health Department strategy:

> ...amassed a varied ideological weaponry which was to wage war against the 'frying-pan, white-bread-and-jam brigade' (as unenlightened parents - or, more accurately mothers - were termed).

In addition to providing advice (as the 'experts' of course) on diet, hours of sleep, clothing, the treatment of specified anti-social diseases and so on, the school health team of a doctor and nurse represented medical authority to parents and the community, possessing knowledge and providing public scrutiny of correct parenting in the interest of 'healthy' children. Parents were encouraged to attend annual school clinics and expected to defer to the authority of the health professionals. The role of the school nurse was to (Tennant,1991:138):

> ...report on the religious, moral and intellectual atmosphere in which the child functioned.....[as] the leading of a healthy life is...a moral matter, and exercises the powers of discrimination, self-control, and obedience to the law.

As will be discussed later in this thesis, New Zealand breastfeeding mothers have a unique exposure to biomedical influence through the Plunket system. The Plunket organisation was established by Sir Truby King in 1907 with the goal (similar to that of the School Health Service) of rearing infants to become "normal useful citizens" (Wickes,1953:499). King's declared aim was "to help the mothers and save the babies" (the official Plunket motto), which he believed was achievable through the 'science' of mothercraft. His belief underlies this movement even today and for many breastfeeding mothers serves to transform the body into a site of conflict and struggle.

MEDICALISATION

The phenomenon of medicalisation identified by Illich (1976), redefines physical functioning, health and illness from a biomedical perspective. Lock(1989:43) notes that:

> Medicalisation has traditionally been depicted in the literature as a process in which the medical community attempts to create a 'market' for its services by redefining certain events, behaviours and problems as diseases.

In other words, medicalisation, as a process of control over resources, is a form of agentative power. However, Lock(1989:45) further argues that this view fails to acknowledge that medical systems develop within a particular social and cultural context. The majority of medical systems reflect their culture's values and beliefs in the

way they define and explain the world, thereby buttressing the existing social order.[4] Thus definition of the process of medicalisation involves acknowledgement of both the control of access to resources, and hegemonic influence.

Biomedical knowledge draws on Western assumptions of scientific thought and the dualistic nature of personhood. These characteristics are inherent in the process of medicalisation which involves certain distinguishing features. For example, because biomedicine constructs the body as a biological organism, processes previously recognised as falling within a range of 'normal' conditions may be redefined as pathological, requiring medical intervention, management and control. Medical professionals (as recognised experts) become the custodians of specialised knowledge concerning diagnosis, treatment, prevention and definition of individual and collective health. The latter is accompanied by a devaluing of the knowledge and skills held by non-professionals and general disregard for lay knowledge, judgement and opinion on health related matters. Moreover, a specialised vocabulary (describing treatment and conditions) develops, much of which becomes incorporated in the vernacular, reconstructing popular conceptions of particular events and mystifying others due to the specialised nature of the discourse. Finally there is increasing technological intervention and the relocation of body-related events to purpose-built venues such as hospitals and clinics which through the process of becoming 'institutionalised' act to reinforce the power and judgement of medical professionals (Van Esterik,1989:114).

The process of medicalisation is particularly evident and far-reaching in the area of women's reproductive health, where everything from menstruation and childbearing to menopause, has been redefined (in some cases by law) and made subject to 'control' by biomedical experts. Breastfeeding has not escaped this trend, often with far-reaching results. For example, Van Esterik (1989) has identified medicalisation as one of the underlying causes of the high infant mortality associated with infant feeding practices in the Third World. Arguing that the impact of medicalisation on Third World countries is both complex and varied, Van Esterik(1989:125) acknowledges that

[4] Tennant's(1991) example of the New Zealand School Medical Service provides a good illustration of this process.

medicalisation has been beneficial in certain areas (for example, health education of mothers concerning management and treatment of infant diarrhoea) but detrimental in the realm of infant feeding. Van Esterik's point is that medicalisation of infant feeding converts a 'normal' process into a pathological event, redefining common perceptions of events such as reduced milk supply as problematic and therefore in need of intervention by trained experts. Accompanying this process is the removal of breastfeeding management from the community to the health professionals who attempt to relieve 'symptoms' through implementation of formula feeding, with well documented effects on infant health and mortality.

Relevant to this thesis is the fact that medicalisation creates tensions between the three realms of the body, confirming it as a site for struggle and conflict. Frequently associated with the process of medicalisation is a sense of fragmentation of the body. Medical focus on the breast as a biologically functioning part, serves to detach it from the rest of body. Redefined as a 'lactating gland', the breast is of biological interest because it functions at 'parturition' and is the site of a series of perceived pathological malfunctions which are defined as a 'cracked nipple', 'engorged breast', 'inadequate let-down reflex', 'mastitis' and so on. Underlying the isolation of the breast as an 'affected part' is an assumption that some form of mechanical correction will rectify any perceived dysfunction.

Biomedical construction of the body as a collection of separately functioning but inter-related parts, counteracts an integrated, holistic sense of self. Thus the breastfeeding mother may be denied a complete sense of womanliness, because she has come to recognise the process of bearing and nurturing her baby as events involving specialised parts of her body, rather than as integrated aspects of embodied personhood. Martin(1987:79) comments that medicalisation of childbearing processes reduces the mother to a medical phenomenon, because her sense of personhood is located outside the field of medical discourse. Martin's research highlights the influence of biomedical hegemony on the way many women perceive and experience events such as childbirth as something that happens to the body; that is, as something separate from the conscious self. In seeking to redress the situation, Martin(1987:87) points out that even

feminist literature is dominated by themes urging women "to repossess their bodies, control their own labour etc". Martin's point is that acts associated with the bearing and nurturing of children are "acts a woman *does*". In other words, the physical sensations associated with the act of childbearing, menstruation, breastfeeding and so on, are intrinsic aspects of being a woman, of her embodied self, rather than merely events affecting an isolated part of her body.

HABITUS, SOCIAL FIELDS AND DISCOURSE

Significant to an understanding of a breastfeeding mother's experience of her body as a body politic, are notions of habitus, social field, and discourse. Internalised through socialisation, habitus exhibits "an objective basis for regular modes of behaviour" (Bourdieu,1990a:77) and can be recognised as the "embodiment of history", "society written into the body"(Bourdieu,1990b:60). The importance of habitus is that it defines the process whereby agents occupying similar positions in a social field tend to possess and share a particular sense of place and understanding of the world which appears as common sense, 'natural' and imaginable (Bottomley,1992:122). Habitus informs, and is manifest through, an agent's practice and action, choices being drawn from those available within the boundaries of an agent's social field.

The social field can be defined as the space within which the individual carries out strategies and engages in relations (Bourdieu,1990b:108). A social field is formed from the specific focus and common interests of a collectivity of people, and an individual's habitus may straddle a number of social fields. This situation may be illustrated by the experience of a person (the key individual interviewed in this study) whose background as a nurse locates her in an entirely different, and largely incompatible, social field to the one she occupies as a breastfeeding mother. In other words, as a nurse she is doubly subject to the influence of hegemonic discourse, namely as a woman and mother, and as a nurse. The point is that the social fields contributing to an individual's habitus are not necessarily integrated, complementary or harmonious, hence the potential for the body as a site of struggle and conflict.

For the purposes of this study the concept of discourse may be defined as "a domain of language use, structured as a unity by common assumptions" (Abercrombie, Hill and Turner,1984:70). It is understood that there may be competing discourses which will change over time. Discourse defines, constructs and positions the subject within a complex field of social forces (Lemert and Lemert,1982:130). There is an essential and dialectical relationship between discourse and individual practice (a person's actions and language), the former being shaped by and dependent on practice for its identification, while practice in turn is defined by and conforms to the particular discourse within which it occurs. Integral to the concept of discourse is the notion of power, as discussed earlier in this chapter.

PHYSICAL BODY/SOCIAL SUBJECT?

Biomedicine as the dominant Western discourse on health, clearly represents a formidable force. It is instrumental in constructing and defining a woman's experience of breastfeeding. Within biomedical discourse the breastfeeding mother is constructed as female and patient, and her positioning is subordinate to male and doctor/health professional. These two constructions thus situate individuals in opposing and frequently contradictory social fields which inevitably converge on the body, transforming it into a site of conflict between individual desires and practices, and social expectations.

Implicit in this discussion is the recognition that understanding a woman's experience of breastfeeding goes beyond the detailing of the physical process of 'lactation'. It requires an attempt to unlock important elements of meaning generated from past experience, current situation, future desires and the woman's construction of self as female, mother, wife, patient and so on. More significantly it requires acknowledgment that the body as the locus of all experience is more than just a physical entity. The body is a place where physical, social and political elements converge, transforming it into a site of harmony and conflict, understanding and misunderstanding, action and inactivity, power and control, creativity and destruction.

Comaroff and Comaroff(1992:39) draw attention to the recent importance and prominence given to the body in Western social thought. They suggest that this arises

from the body being recognised as one of the few stable points in a shifting world. The body has been fetishised, accredited with the animation of social life and yet remains strangely elusive as an enduring physical object. Comaroff and Comaroff's point is that many social theoreticians assume idealist notions of the physical body, disallowing its existence outside constructs employed to explain social phenomena. As a result the physical body becomes (Comaroff and Comaroff,1992:40):

> Displaced by the text, by a concern with representation severed from material being, the body actually loses all social relevance.

Rejecting idealist denial of linkage between human experience and material facts, Comaroff and Comaroff(1992:40) argue that:

> ...there is undeniable evidence that biological contingencies constrain human perception and social practice, albeit in ways mediated by cultural forms.

The significance of this realisation lies in acknowledgement of the body as both a physical object *and* subject, that is, the site of convergence of physical facts and social values. Thus hegemony resides within the human frame, manifesting itself in a variety of tangible, historically locatable, manipulations of body physique and individual action. Indeed, social reform and bodily modification are frequent consorts. Comaroff and Comaroff (1992:41) note that in the "forging of empires" and the "remaking of existing worlds" hegemony is evident in such phenomena as styles of shaving and clothing. Thus modification of the body may express corporeal indications of self awareness relating to group subordination, ethnicity, class, status, religious affiliation, and so on. The socially correct body (and accompanying practice and action) conforms to, and expresses, the dominant values and beliefs of a particular group or culture.

Central to the process of breastfeeding is the physical functioning of a woman's body. While it must be acknowledged that physical/biological contingencies constrain human perception and social practice (Comaroff and Comaroff,1992:40), it is also arguable that social attitudes, values, beliefs and practices impinge on, modify and may even manipulate the physical body. Thus understanding a woman's experience of breastfeeding requires admission of complexity and recognition of the interaction

between the domains of physical process and social forces. A woman's perception of her experience of breastfeeding *is* constrained by dominant cultural values and her location within a particular social field further contributes to her appreciation of this experience. Cultural and social forces are manifest in a mother's actions and practice, and may inhibit or enhance the physical process of producing and delivering milk to her infant. Accordingly, understanding a woman's breastfeeding experience requires acknowledgement of the significance of the interaction between physical process and social forces. That is, the body must be recognised as the site of convergence of these two domains, a site of struggle and conflict which encompasses the social at the heart of the individual, the impersonal beneath the intimate and the universal buried deep within the particular.

SOURCES OF DATA

My own personal experience, the fundamental motivation for this project, is an acute sense of frustration and dissatisfaction at the way a woman's experience of breastfeeding (and other reproductive-related events) is commonly perceived, constructed and defined within the New Zealand (and broader Western) cultural context. A review of the anthropological literature on breastfeeding revealed that the majority of studies assumed or adopted assumptions characteristic of biomedical discourse, privileging the physiological at the expense of the social, cultural and experiential. The result is a focus limited to cultural comparison of aspects of breastfeeding such as duration and suckling frequency, physiological difficulties, relationship with a woman's fertility and so on. Thus the majority of cultural studies on breastfeeding are reductionist and restricted in their ability to recognise breastfeeding as involving interaction between social, cultural, physiological and experiential factors.

The dominance of biomedical discourse in anthropological studies of breastfeeding, demonstrates unconscious and uncritical acceptance of and participation in a particular cultural construction of this event by supposedly 'objective', 'impartial' researchers. In other words, cultural studies on breastfeeding present a particular perspective and as such can be identified as an important source of data. Accordingly, I adopt the unusual

step of classifying the literature review in this thesis as one of the three sources of data, as it provides access to the workings of the dominant discourse on breastfeeding.

Identification of the biomedical discourse as the dominant means of 'knowing' a woman's breastfeeding experience accentuated the need for alternative research. In fact, inherent limitations apparent in the anthropological literature on breastfeeding provided the impetus for this study. I therefore decided to explore the experience of breastfeeding from a mother's perspective, selecting four first-time Manawatu mothers as the focus for this investigation. The experiences of these mothers provide the primary source of data for analysis and comparison with alternative discourses on breastfeeding.

The third source of data became apparent during the fieldwork process. While interviewing the mothers I frequently found myself drawing on my own experiences as a mother and counsellor as a means of establishing rapport and understanding the experiences of these women. Expressions or remarks made by the mothers would often evoke comparisons with situations I had encountered either personally or as a counsellor. It was my role and practice as a counsellor that contributed a further source of experience to draw on, thereby distinguishing my own experiences as a significant source of data. This third source of data is included throughout the text in the form of personal reflections, clearly identified as such by the use of italic script.

CONCLUSION

This discussion has argued against the limitations of a biomedical perspective in understanding experience of the body. As the site where physical facts meet social values, and both conflicting and analogous discourses converge, the body needs to be recognised as more than a biological organism. Understanding a woman's experience of breastfeeding involves recognition of the relationship between nature and culture, and that breastfeeding as a physical process is constructed and constrained by social and cultural forces. Thus a study of a woman's breastfeeding experience involves an investigation into the politics of the body.

CHAPTER THREE

INTRODUCING THE MOTHERS AND REFLECTIONS ON FIELDWORK

This chapter introduces each of the four mothers involved in this study and discusses issues relating to the process of fieldwork. The first section backgrounds the setting up of the study and presents a profile of each mother, including her initial ideas and expectations about breastfeeding. The remainder of the chapter discusses methodological issues associated with the collection and processing of data obtained in the course of contact with each mother.

RESPONDENT SELECTION AND INTERVIEWING

There are two key points that must be made clear at the outset with regard to the design of this project. First, it was never my intention to randomly select a representative group of mothers for this study, as the focus of the project is to gain insight into the individual experience of breastfeeding rather than documenting overall patterns and trends (see Chapter One). Second, it was decided to limit the project to first-time mothers.

The rationale for the decision to deal only with first-time mothers may be briefly summarised as follows:

i) studies on breastfeeding indicate that Western, first-time mothers have a higher breastfeeding failure rate than those feeding subsequent children. This phenomenon is generally associated with a lack of breastfeeding knowledge and support and the fact that many new mothers have had no experience of, or contact with, a baby until their own infant is born;

ii) breastfeeding, pregnancy and childbirth are (in critical ways) entirely new experiences for first-time mothers. Any preconceived ideas these mothers hold are therefore generated through the influence of others and observations rather than through their own direct experience. Such perceptions may be quite at variance with the lived reality of breastfeeding, a dimension I was interested in exploring;

iii) the fact that all respondents were first-time mothers provided a basis for meaningful comparison of their breastfeeding experience.

The mothers involved in this study were contacted through two sources. The first was the local La Leche League group and the second, a group medical practice. The La Leche League connection proved to be of limited value because I required first-time, pregnant mothers and only a small minority of League mothers fitted this category. However, working from this source I managed to identify four possible respondents and contacted them by telephone. Two of these women (Maria and Anna)[1] enthusiastically agreed to become involved in the study. My second source of possible informants, through the group medical practice, was facilitated by one of the practice partners, a general practitioner who was aware of and supported the aims of the project. On my behalf he approached several of his maternity patients and gained Rachael's interest in being a participant. The fourth respondent, Kathy, was one of the nurses employed at this practice and personally known to me. Kathy and I had occasionally worked together to help patients experiencing breastfeeding difficulties. Kathy was very happy to be a participant and eventually emerged as the key respondent.

Following each mother's indication of interest in the study, I called on them to introduce myself and outline the project in detail. During this initial meeting a consent form was signed (see Appendix) and confidentiality discussed and assured. Each mother was also reassured that she was free to withdraw from the project at any time should she wish to do so, an option that none of the mothers chose to exercise. Finally, the opportunity was taken in the course of this first meeting to get each mother talking about her ideas and expectations with regard to breastfeeding. Information gained on this subject provided a basis for later comparison with the mother's actual experiences (positive or negative) and shifts in her attitudes and beliefs.

The selection of respondents took place over a six month period in 1991. The first baby (Kathy's) was born in May, followed by Maria's in June, while Anna and Rachael gave

[1] To preserve their anonymity, all the mothers in this study have fictitious names and some of the details about their lives have been altered.

birth in August and October, respectively. As each mother felt settled enough to have me around within a fortnight after the birth, it was then that the interviewing process began in earnest. I visited each mother weekly until her baby was three months old, the duration of these visits varying, although it was rare for them to last less than an hour and some continued over a whole morning or afternoon.

The interviews were always conducted at a time selected as convenient by the mother herself, but they generally occurred at the same time each week. The timing of visits reflected my reluctance to intrude too noticeably on the lives of these mothers. My reluctance to intrude stemmed from my own experience with my first baby, which I recognised as a time of intense emotion, tiredness and adjustment to a very foreign role involving an enormous sense of responsibility and at times panic regarding the implications of parenthood. I also realised that it is commonly a time of intense feelings between partners and I was loath to intrude on or upset this relationship. Hence my flexibility in allowing each mother to determine the timing of my visits.

My original intention was to spend between one and two hours a week with each mother, recording our conversation, taking photographs and generally observing her breastfeed and performing her normal daily routine. I was fully prepared to help with any chores being done while I was there. As it turned out, however, the interview format was, without exception, determined by the mothers who perceived the research process as being too important to allow the distractions of daily activities or chores. Unless the circumstances of a particular day were exceptional (with washing to be hung out, a baby to be bathed), the time was usually set aside so that we could sit and talk about the activities, difficulties and successes of the previous week, generally over a cup of coffee. As we talked, I also observed and photographed the mother and her baby.

The photographs I took each week usually focused on the breastfeeding couple, although I did photograph the babies being changed, bathed, sleeping or kicking on the floor. My use of photography during the research process served two purposes. First, it provided a means of reciprocating the commitment given by the mothers by presenting them with a visual record of their baby's progress over the first three months.

Second, the photographs were a means of eliciting reflexive comment about the experience of breastfeeding. An example concerned the photos documenting the difficulties Kathy had during the early weeks in positioning her baby on the right breast. Presenting Kathy with this series of photos stimulated reflexive comment regarding her feelings and reactions at this time, thereby enhancing the data already recorded. On reflection it seems reasonable to conclude that both aims regarding the use of photography were fulfilled.

The way in which the mothers defined and performed their role as respondents appears to have been influenced by at least two general factors. First, they were all very interested in the project and seemed to feel that it demanded their full attention which could not be freely given if they were involved in other routine domestic activities. Second, they appeared to enjoy the opportunity to have a break, cup of coffee and most importantly to reflect over the events of the previous week. Anna expressed it this way:

> ....I was thinking that everybody should have a regular visitor once a week....Well I think helping to review each week as it goes past, you can see that progress has been made and you tend to take a step back from your circumstances. Sometimes that's helpful because if you feel that you are heading for that dark hole you can step back and think "Oh no I have achieved one or two things this week". And even if it is only one or two...then you can think "Well that is better than nothing, better than going backwards"....it does make you realise that time goes on and you do advance in your relationship with your child.
>
> (week twelve)

The quality of the relationship between myself and each mother took time to establish and affected both the duration of interviews and the type of information obtained. Because Kathy and I had worked together on previous occasions, we quickly slipped into a relaxed sense of mutual understanding and trust. From my perspective it was fortuitous that Kathy was my first respondent as the spontaneous nature of our relationship gave me confidence about the process of doing field research. Kathy was a particularly reflexive person and extremely articulate at expressing how she felt. Communication, therefore, was never a problem and her interviews yielded very 'rich' data. For this reason it soon became apparent that Kathy was the key respondent in the study. In contrast, Maria, Anna and Rachael were previously unknown to me and the first few interviews were a time of establishing a relationship. Consequently these

early interviews tended to be of shorter duration and involved considerable questioning to stimulate the mother's reflections on the events of the previous week.

As the weeks passed the meetings with each mother gradually became more relaxed, a sense of friendship and trust developed and the mothers commented more openly on their feelings. The element of trust was necessary before a mother was prepared to 'bare her soul' and reflect on the meaning of her experiences. During these early interviews I found the skills acquired as a breastfeeding counsellor extremely useful. As a La Leche Leader helping breastfeeding mothers, I had learnt that many women are reticent about expressing their feelings and articulating problems relating to breastfeeding. A large part of my counselling role required an ability 'to read between the lines' and to be observant of any signs indicating unexpressed problems. It was through my ability to recognise the presence of a particular phenomenon being experienced by a mother, that I was able to establish trust and a sense of mutually shared experience. This process involved my reflecting on similar experiences either while feeding my own children or helping other mothers, thereby allowing the mother some basis for comparison with her own experience. Thus regular visits, sharing news and reflections on the baby's progress and the mother's trials and tribulations, in addition to the taking of photographs, all served as a means of establishing a rapport between the individual mother and myself.

KATHY: DYNAMIC, ARTICULATE, REFLEXIVE

Kathy was the only one of the four mothers to have a home birth. She had not particularly intended to have a home birth, but did arrange a midwife to attend to her while in labour both at home and in hospital (her intention being to remain in hospital for only a few hours following the delivery). In the event, Kathy felt very comfortable at home and with her labour progressing normally and satisfactorily the decision was made to remain at home where Ben was born in early May, 1991. Kathy was thrilled to have her mother present to witness and assist in the birth of her first grandchild.

Kathy is in her early thirties, and has enjoyed a career as a nurse. She grew up in a provincial town where her father ran a successful family business. Kathy's mother was

also a trained nurse, although once married she did not return to this profession. During her school years she attended a private girls' boarding school and still maintains important contacts with the friends she meet there. She married Robert, a city businessman, several years ago. Kathy and Robert have a wide circle of friends and enjoy an active social life, entertaining frequently at their attractive, modern town house. She freely admits that she had always hoped to marry a farmer as the life style greatly appealed to her. Her kitchen is a testament to this ambition, housing an array of brightly coloured, ornamental hens created from materials ranging from porcelain to papier mache. Kathy laughingly admits that they represent her yearning for the country life.

Kathy's home is very attractive, reflecting her love of the bold and daring in a combination of modern furnishing and oriental rugs, bright colours and pale grey walls. The living area is built around an enclosed pool and deck area, its expanse of glass providing a sense of indoor/outdoor living in a very private setting among predominantly native trees. A notable feature at Kathy's home is a clone of Telecom's 'Spot'. Mac, as Kathy's Jack Russell terrier is called, was always a dominant force when I visited Kathy and would bark, growl and whine unless given total attention for at least part of the time. On some occasions I found it tricky to write with Mac on my knee and his presence was clearly audible on a number of the tapes. Mac is very much part of Kathy and Robert's household and accompanies them wherever they go. He quickly adapted to, and became very possessive of their baby, Ben.

Kathy's parents, now retired, continue to reside in the provincial town she grew up in and keep in very close contact with their daughter. They arrived in time for Ben's birth and stayed on for the first week to help their daughter adjust to her new baby. Kathy is very close to and fond of her mother, and enjoys having her around and returning to her family home. She also has a married brother and single sister living in other areas of the North Island and makes a considerable effort to keep in touch with them. As a family they regularly get together for a weekend. Because Ben was the first grandchild in the family, Kathy was very anxious that her siblings should share in his babyhood as much as possible. One of Robert's brothers lives very close by with his wife and two little children, the youngest being about a year older than Ben. Although they maintain

contact with this couple, Kathy's relationship with her sister-in-law is not a close one. Robert's mother also resides within the city, but she was overseas throughout the period I was visiting Kathy.

Kathy is very friendly, gregarious, articulate, has a good sense of humour and enjoys contact with other people. Her home always seemed to have someone either staying or passing through, a feature reflecting her normal busy lifestyle. In fact, Kathy found it rather strange as a new mother to be quietly at home all day, missing the contact with people that she was accustomed to as a practice nurse. She discovered that getting out for a daily walk was a very important and necessary activity, and made the effort to do so everyday. This, she felt, helped her to adjust to her very altered lifestyle.

The relationship I established with Kathy was relaxed, frank and very open. We enjoyed each other's company, the opportunity to talk and share experiences and frequently found ourselves laughing over some aspect of Kathy's experience. The empathy between us was such that, from the first interview, Kathy was very open about her feelings and perceptions. Moreover, Kathy was by far the most reflexive of the four mothers, providing interesting insights into what she was going through. The visits with Kathy, although usually lengthy, seemed to pass very quickly and we each looked forward to the next one. Frequently these visits would be interrupted by another visitor or the telephone ringing, so I often had the opportunity to observe first hand the type of lifestyle and friends Kathy normally enjoyed. She has kept in touch since the interviewing period and regularly uses one of my daughters as a babysitter.

Kathy's prime motivation for breastfeeding, perhaps reflecting her medical training, was her perception of its benefits for her baby, the most significant being the natural immunities in breastmilk. Underlying this perception was the knowledge of a particular susceptibility in the family's medical history. As Kathy put it:

> ... Robert's father died of an asthma attack when he was quite young, in his forties, and all sorts of cousins, nieces and nephew's have asthma and I know that if you breastfeed you get a better immunity and things like that....

Kathy also saw some advantage for herself. She noted that breastfeeding was very convenient because it eliminated the need for sterilising and heating bottles, and she had heard also that it helped with weight loss.

Some difficulties with breastfeeding were anticipated by Kathy:

> ...I also know that it is a learned technique and [I] think I am a bit concerned with that at the moment. It's important that I get it right to start with. I know that it doesn't just come as easy as it sounds.

She was also anxious as to whether or not she would like the sensation of breastfeeding. However, at this stage her main problem was an inhibition about handling and exposure of her breasts while feeding:

> ..I don't like handling my breasts....I just don't feel comfortable doing it, and also I am worried about feeling uncomfortable feeding in front of other people especially when I am learning! I would really like to just go away and learn how to breastfeed for a few days and then come out and have got it mastered and just feel comfortable.

Despite these misgivings, Kathy acknowledged that breastfeeding in public was acceptable among some groups (particularly among those of her own age) but not others:

> ...I definitely know with my mother's age group they find it unacceptable... I have heard Mum and her friends talk about it and I have heard them comment about "Oh that woman, she's always got her breast out feeding that child !" I know that friends of mine that have mothers similar to my mother, have expressed disapproval in the past. Like taking the baby to Aunt Maude's and [being told that] "You can't breastfeed here, you can't breastfeed here". You know, like its not acceptable to feed in Aunt Maude's place.

Kathy's nursing background meant that she was biomedically well informed about the process of breastfeeding, although she did express concern about the usefulness of this knowledge. When I asked her whether her medical training had influenced her view of breastfeeding, she replied:

> You can't help that...because you have got that on board already and...what I learnt over the years as a Practice nurse, I think it all jells together. What you have got medically, jells together with what you have learnt socially.

However, Kathy also recognised the difference between her professional knowledge as a nurse, and her anticipated experiences as a breastfeeding mother.

> ...well it is the first time you know. So, much as I appear to be quite confident [in my capacity as a nurse advising other mothers]...it all goes out the window when it comes to me...now I feel quite nervous about the whole thing because its...[time] to do it myself...

Overall, Kathy's expectations regarding breastfeeding can be summarised as focusing on the benefits for her baby, rather than on her own pleasure or satisfaction. She was anxious about the sensation of breastfeeding, the views of others (such as her mother and some friends) and her ability to master the technique. She expected the early weeks of breastfeeding to be time consuming, involving frequent episodes of feeding with little or no set routine. Kathy was thus anticipating that breastfeeding would tie her down and change her lifestyle at least in the short term, although she did admit to looking forward to the experience with her baby.

MARIA: YOUNG, SINGLE, 'NATURAL'

Being much younger and a single mother when her baby (Rose) was born, Maria's personal circumstances and background contrast with those of the other mothers in this study. Maria left school before completing her sixth form year to join the workforce. She was "fed up" with school but did not have a specific career in mind, although she quite liked the idea of training to be a nurse. Maria took on a number of unskilled jobs, and was employed on a Government work skills programme (Access Scheme) in another city when she found she was pregnant. Eighteen years old and living away from her family, Maria was initially shocked, but quickly decided that she really wanted to raise her own baby. She subsequently moved back to reside with her parents until her baby was born and she felt ready to manage on her own.

Maria's baby was born in the local maternity hospital in mid-June. After a week in hospital, Maria returned to her parent's home where she and her baby lived until the following November. Maria was fortunate in having parents who were young, supportive and in a position to assist her at this time. Both her parents hold professional qualifications, her father managing a company research farm just outside the city

boundary, while her mother, a former nurse, is employed part-time at a local creche and is doing some university papers. Two other members of Maria's family also lived at home at this time; her younger brother (16 years), who had just left school, and younger sister (11 years), who was still at school. The family also has other relations in the region, including a grandmother.

An adopted child, Maria had recently managed to establish contact with her birth mother (residing in Australia), as well as her natural father, grandmother and other immediate relations. She placed considerable emphasis on this contact and often referred to things that her 'birth' mother had shared with her about the other women in the family, including their experiences of childbirth and breastfeeding. However, Maria was also very close to her adoptive parents, especially her mother whose support she freely admitted that she relied on. Rose was the first grandchild in this family, and although there were the inevitable stresses and strains associated with Maria moving back into the family home with a new baby, it was nevertheless clear that the entire family was very devoted to Rose and supportive of Maria.

Maria's parents live in a company house, on one of the farms her father manages. The setting is rural with cows in adjoining paddocks and the farm dog (Ned), tethered to the gate, barked every time I visited. Maria's mother relinquished her third bedroom, used as a sewing room, to her daughter and the new baby. It was a fairly large and pleasant room, big enough for a bed, cot, television and other assorted bits of furniture that Maria has collected. However, as it was winter while I was visiting, most of Maria's day was spent in the sitting area at one end of the large farm-style kitchen. This alcove, complete with a solid fuel fire place constantly alight, had windows looking over the farm. It was a pleasant, warm and sunny place to spend the day.

Maria was a very welcoming respondent and admitted that she enjoyed having someone there for company. We very soon reached a point where she was sharing fairly personal details about herself, past experiences, friends and acquaintances. Maria was very open about all that she was doing and never appeared embarrassed or inhibited in our discussions. In many ways she was very perceptive about what was

occurring in her life, particularly with regard to the needs of her baby, but unlike Kathy she was not particularly reflexive or inclined to ponder the meaning of events. This trait, I suspected, was at least in part a reflection of her comparative youth and lack of life experience.

I always visited Maria in the mornings, as she was usually (though not always) alone in the house at this time and preferred to talk to me without the family around. Maria's parents both came home for lunch each day and on a number of occasions I joined the family for this meal, remaining afterwards to chat to her mother. This gave me the opportunity to observe another aspect of Maria's life and to gain her mother's impressions of how things were going. As my time with Maria passed I sensed that she viewed our relationship in a way similar to some aspects of the relationship with her mother. That is, I was an older person to confide in and gain support from, but also one from whom, unlike her mother, she could be emotionally 'detached'. This was particularly apparent on one occasion when Maria laid bare details of her life that she was reluctant to discuss with her mother. Clearly, confidentiality and trust were significant aspects of my relationship with Maria. It was also apparent at the end of the interview period that Maria was unwilling to severe all contact, which she maintained by telephone or calling at my home. Gradually, as Maria continues to reestablish her life, contact has diminished. I only occasionally see her now (late 1992), although recently we had lunch together and I saw Rose as a busy toddler.

Maria was very positive about breastfeeding, perceiving it as having distinct advantages. Her immediate response to my asking why she intended to breastfeed was because it would save her money, give the baby antibodies and allow her to bond with and feel closer to her baby. She also remarked:

> ...I just couldn't see me bottle feeding, not at two o'clock in the morning trying to make milk.

Maria was really looking forward to breastfeeding, expecting it to be an enjoyable experience. She stressed that it was a natural thing to do, noting:

> I never really considered bottle feeding, never did. It just never occurred to me. Because I mean your breasts are there, to feed your baby I guess.

Unlike Kathy, Maria was completely uninhibited about handling or exposing her breasts, although she was a little concerned that she might be susceptible to cracked nipples because she had developed this problem while pregnant. Revealing a measure of confidence and pragmatism, she felt she would be able to avoid this situation by paying attention to the baby's positioning at the breast.

Maria attended La Leche League meetings while she was pregnant and had read a lot of books in preparation for nursing her baby. She felt quite well informed and prepared for breastfeeding, but admitted "I will probably have heaps of questions when the baby is born ". When I asked her if she felt that breastfeeding would affect her lifestyle, Maria replied:

> ...having a baby [affects your lifestyle]...I mean I don't think it matters whether you breastfeed or bottle feed. Well I mean bottle feeding is the same, [it] ties you down more, because when you go out you have to make sure that you have somewhere to heat the milk.

Maria intended to demand feed her baby and hoped Rose would sleep through the night by three months of age. Although she recognised that during the early weeks frequent feeding both day and night was not abnormal, Maria hoped her baby would be reasonably settled at nights. She also wanted to have her baby to sleep with her whenever possible, despite having a separate crib for the baby to use.

Summing up, Maria was really looking forward to having her baby to cuddle and hold and perceived breastfeeding as a way of ensuring this contact. She was eagerly anticipating the experience of breastfeeding which she expected to be relatively problem-free, but recognised that it might involve some minor physical discomfort. Like Kathy, Maria also believed that breastfeeding would be beneficial to her figure and noted, with a laugh, that she hoped to get "nice and skinny" while feeding her baby.

ANNA: PLACID, PRACTICAL, THOUGHTFUL

Anna's baby (Lauren) was born at the local maternity hospital in early August, 1991. Anna and her husband (Dave) live in a rural town close to Palmerston North, where he is employed as a motor mechanic. Anna is in her early thirties, Dave is about eight years her senior, and they have been married for about ten years during which time Anna has worked as a bank clerk.

Anna's parents are farmers, still working the family property a couple of hours drive away, and Anna displays many of the practical, self-sufficient qualities associated with a rural lifestyle. Anna's father helped Dave build their home and during the interview period her parents stayed over several weekends to help them complete the interior decoration of their house. Dave's parents live close by and maintain regular contact, as do his four brothers and their families. Anna was therefore in a situation of being able to have regular contact with close relatives all of whom have children and were prepared to offer help and support when her baby was born. In contrast with Kathy and Maria, however, Anna did not feel in need of her mother's support and help at this time, preferring to turn to Dave's relations if the need arose.

Anna and Dave's house is located on the outskirts of the town, in a fairly new housing area. The area has yet to become established in terms of vegetation, but because they live on a large, well fenced back section the house has a real sense of privacy and the close proximity of farm land and hills gives it a rural feel. Inside the yard is a large wire enclosure for their black sheep dog, Jet, who was always pleased to see me. Jet is not supposed to go inside the house although he sometimes sneaks in while no-one is looking. Anna clearly loves animals, and in addition to Jet has two large, ginger cats who seem to dominate the living area, sprawling over the floor and furniture according to the position of the sun.

The main open plan living area is a pleasant and sunny L-shape that opens out onto a veranda. Anna has a large number of pot plants and numerous 'knick knacks' around the room and frequently has her sewing machine out on the dining room table with something half made. She is very practical and made much of the baby's layette,

including a quilted cot cover and changing rug. Both Anna and Dave are very involved in the local indoor bowling club (Anna was president) and the odd certificate on the wall reflects this interest.

Right from the beginning Anna was very warm, friendly and welcoming, a positive, thoughtful person happy to share with me her thoughts and expectations about her pregnancy and breastfeeding. Dave too was helpful, co-operative and interested in what I was doing. I found that as the interview period progressed Anna became more and more reflexive about her experiences and it was obvious that she thought about what she was doing. My visits usually lasted for an hour to an hour and a half, although on some occasions they were considerably longer. I enjoyed the contact with Anna and the relationship that grew between us. When she got in touch recently to tell me how much she had enjoyed reading the transcripts of our interviews, I was delighted. On this occasion she remarked that she was surprised at how much she had forgotten and felt that the transcripts would be helpful to refer to when her next baby came, something she hoped would not be too far in the future. I have not maintained regular contact with Anna, but suspect that she will probably get in touch when she is pregnant again.

Anna's decision to breastfeed involved two factors: first, that it hadn't occurred to her to do anything else; and second, her realisation that she was "...quite well endowed". The latter observation prompted me to ask if she felt that larger breasts were an indication that a woman was more likely to be able to successfully breastfeed? Anna replied:

> Yes, I did feel that way, although I have since learnt that it is no indication at all!

For Anna the perceived advantages of breastfeeding were the closeness it fosters with the baby and being free of formula preparation and bottle sterilisation.

Anna prepared for breastfeeding by attending antenatal classes and reading various books about childbirth and infant feeding. She also went to a La Leche League coffee morning during which a Leader demonstrated the correct ways of positioning a baby at the breast. She acknowledged that she would have liked to attend more of these

meetings but the distance and night-time programme made this impossible. However, there were other women available, locally and within the family, that she felt she could approach about any breastfeeding difficulties encountered. When I asked her if she had enough information, she responded: "Yes, I think so. I wonder sometimes if I have got too much!" My impression was that Anna was very calm and confident about feeding her expected baby. As a normally healthy person, and having experienced no difficulties with the pregnancy, she was hopeful that "everything will just flow from there". She did anticipate, however, that breastfeeding would initially be a bit painful, at least while she was learning how to latch the baby on.

Dave intended to take time off work to help run the household and assist Anna with the new baby when she came home from the hospital. Anna's mother had indicated that she did not want to come and stay at this time, preferring to wait until Anna and Dave had settled down with the new baby. Unlike Kathy and Maria's mothers, Anna's mother felt that things had changed so much since having her own babies that she would be out of touch and wouldn't know what to do.

Anna was expecting that for the first few weeks the baby would need to be fed every four hours, but acknowledged that she was prepared to be guided by the baby in establishing and modifying, as required, a demand feeding routine. Anna had no preconceptions regarding the age at which the baby would sleep through the night. Nor was she worried about being tied down, remarking:

> ...I am not really a social person who goes out every single day or who belongs to so many clubs that there is always a morning or afternoon [function] to go to.

Nevertheless, she did intend to continue with a number of her interests, once she felt settled enough to do so:

> ...I think there are things I will be continuing with, like Plunket meetings and going to visit family and that sort of thing. [They] are the places where breastfeeding is acceptable anyway.

Although breastfeeding in public was not really an issue for Anna she did feel that it was for some women who may therefore have elected to formula feed:

> One girl I met at a Plunket meeting had bought along a bottle with expressed milk in it because she felt quite embarrassed about feeding in public.

Overall, therefore, Anna's expectations of breastfeeding appeared to be fairly flexible and relaxed, and she was anticipating an enjoyable experience. She was not expecting any major difficulty but was aware that there might be a degree of physical discomfort involved or that other unforeseen circumstances could arise. She appeared very reassured by the presence of Dave's family as a source of support and help if needed.

RACHAEL: EASYGOING, UNREFLEXIVE

Rachael and her husband Andrew are both in their mid-twenties and live in the same rural town as Anna and Dave. Rachael worked as an insurance underwriter until shortly before her baby's birth, and was considering returning to the workforce when her year's maternity leave was over. Andrew commutes daily to Palmerston North where he is employed as an electronics technician for a large company. Like Dave, Andrew was intending to take time off work to be at home with Rachael when she returned with the new baby.

Rachael's parents live in Palmerston North, are in daily contact and enjoy a close relationship with their daughter. However, Rachael was anxious about her mother's health and did not want to overtax her when the baby arrived by having her stay with them. Rachael and Andrew have no other close relatives living in the local area as most of their immediate family members reside overseas.

Rachael and Andrew attended Parent Centre antenatal classes before the birth of their baby and through this contact established a close relationship with the other expectant parents. The women in this group continued to meet regularly each week after the birth of their babies and developed an important source of mutual support and social contact. Rachael's baby, Toni, was born at the local maternity hospital in mid-September 1991 and they returned home after one week.

Rachael's home is on a large section with a totally enclosed backyard. Their doberman dog, Charlie, is never in the house, but is friendly, playful and provides adequate

warning of any approaching stranger. As Rachael has fairly poor hearing, she finds that the dog alerts her to answer the door and provides a sense of security. Rachael and Andrew are very proud of their home which is immaculately kept and very comfortable. On my first visit, Rachael showed me the baby's room which was newly painted and curtained in readiness for the baby's arrival. The living area of the house steps down from the kitchen-dining area and is full of interesting artifacts collected by Andrew's father whose job takes him to many out of the way places in the world. Perhaps the most striking of these artifacts is a Japanese ceremonial sword.

Rachael was always warm and welcoming when I visited, appearing to enjoy the opportunity to sit and talk over a cup of coffee. She was not a particularly reflexive person and admitted that she "just did" things, not thinking about them afterwards. She was very anxious to provide me with anything I required and always had her Plunket book and any new photographs, including those of herself and the baby shortly after the birth, ready for me to look at. However, our relationship did not develop in the same way as I experienced with Kathy, Maria and Anna. It was cordial but did not penetrate to a level of common empathy and understanding, and because Rachael was less reflexive I found it difficult to gain an insight into how she actually felt about what she was experiencing. After a while I realised that Rachael, unlike the other mothers, did not verbalise these things and that the key to 'knowing' about her breastfeeding experience lay in observing her and her interaction with the baby. My visits to Rachael tended to be of a shorter duration, generally lasting about an hour. During the visit, Toni was usually fed at some stage and on one occasion she had a bath. It was this event that made me realise that watching Rachael in action was the key to her feelings about breastfeeding her baby.

On her own admission, Rachael is a very easygoing, "take it as it comes" type of person. She freely admits that she does not ponder or worry too much over the things happening in her life. Her decision to breastfeed was not based on any firm convictions about the advantages and benefits but concerned a vague notion that it may help with bonding to her baby, that it was a bit cheaper than formula feeding, and the idea that it was:

> ...just something I have always wanted to do. I've always said that I was going to do it if at all possible...that's what my aim is.

But Rachael did also indicate that she believed breastmilk to be better for the baby as it was more "natural" and would build up the baby's immune system.

In some respects, Rachael appeared ambivalent about breastfeeding. A remark that she would not feel distraught or guilty if she was unsuccessful, contributed to this impression. Like Kathy, Rachael also had ambivalent feelings about breastfeeding in public. She felt that it was an acceptable thing to do but was unsure if she would be able to do so discreetly in a public place. Furthermore, she was aware that there were others who did not feel comfortable with a woman breastfeeding a baby in their midst:

> ... my husband does not feel comfortable if he sees a woman breastfeed. Say like in a tea shop at lunch time, if he is sitting eating a meal....Even if it is discrete, I think he feels that he is prying on somebody's private rituals. I'm a sort of person that would perhaps go out of their way to look for a ladies' rest room or whatever.

She was hoping, however,that she would find it an enjoyable event, commenting:

> ...I think it will be. All the other mothers that I have talked to have said that it is wonderful, it is a wonderful experience.

As indicated earlier, Rachael and Andrew attended the Parent Centre antenatal classes and it was from these lectures and the group library that Rachael gained most of her information and knowledge of breastfeeding. In addition, Rachael purchased Shelia Kitzinger's book **My Baby and Me** to have in the household as a ready reference. When I asked her if she felt she had enough information, she replied:

> I am not concerned that I don't know enough. I think a lot of it is trial and error, and experience and practice on my behalf.

In fact, being very relaxed about possible problems, she noted she would be very surprised if she didn't have any.

On the subject of possible disadvantages, Rachael's reply indicated that she perceived breastfeeding to mean that a woman was tied to her baby. It was also likely to be time consuming.

> I am prepared for all the so-called interruptions during the day and night. For each time the baby needs feeding...you realise that you can't get somebody to [do it, by saying] "It is my turn to sleep in , Andrew, [so] up you get and feed the baby!" I know he won't be able to do that.

Rachael planned to overcome this by having a supply of expressed milk on hand for certain occasions. She was also hopeful that she would quickly be able to get the baby into some sort of routine, even if it changed week by week, perceiving a routine as a helpful but not essential development. Despite such strategies, Rachael acknowledged that at least one aspect of her lifestyle would be affected; she enjoyed dancing, but felt it was an activity she would probably have to forgo for a while.

In addition to the above, Rachael was aware that breastfeeding might be a little painful or uncomfortable for the first few days but did not appear concerned about this. Indeed, her overall attitude toward breastfeeding her expected baby was relaxed, and she appeared unconcerned about any difficulties she might encounter, preferring to face these when and if they arose. Rachael was generally optimistic, looking forward to breastfeeding her baby, and expecting it to be an enjoyable experience, but acknowledged that:

> ...to start off with, I know that it is going to be a bit awkward, but I think I will get the hang of it...It will be fine.

SUMMARY OF RESPONDENTS' SOCIAL CHARACTERISTICS

Kathy, Maria, Anna and Rachael all shared certain misgivings, assumptions, preconceptions, expectations and ideas about their anticipated experience of breastfeeding a baby. The importance placed by each mother on different aspects of breastfeeding affected her expectations and perceptions of this experience. The diversity of anticipation exhibited by these women can be understood as reflecting individual habitus, positioning within the social field and immediate personal circumstances relating to feelings of preparedness, ability to cope, support from family

and friends and so on. Overall, all four women were quietly confident of their ability to breastfeed successfully and all appeared to be looking forward to this event, albeit with some reservations.

With regard to their preparation for breastfeeding, similarities and differences identified between each of the four mothers also reflect their positioning within the social field. For example, all four mothers mentioned reading at least one book on breastfeeding, however Anna (unable to attend La Leche League meetings) relied almost entirely on information obtained from books as her means of preparation. As a person brought up in a rural situation, Anna's reliance on books can be understood as reflecting a tradition of independence and self sufficiency. In contrast, both Rachael and Kathy attended Parents Centre antenatal classes. Kathy's scant reference to her involvement in these classes signalled a lack of enthusiasm for them and a preference for the knowledge gained from her nursing training and experience. Kathy clearly perceived the latter as more significant and valid. Rachael on the other hand, placed considerable emphasis on her attendance at the antenatal classes, perceiving this group as her (and Andrew's) most important source of information and support. Maria's preparation likewise also involved antenatal classes which, in contrast with those run by the Parents Centre Association, were hospital based and expressly for single mothers. Maria also obtained some information through contact with the La Leche League, but more significant were the experience-based comments of her birth and adoptive mothers. Overall, Maria's preparation reflected her circumstances as a single mother and daughter, residing with her immediate family.

In general, the four mothers can be seen to share certain basic social characteristics which classify them as middle class, pakeha, urban, New Zealanders. For example, all four mothers belonged to nuclear families linked into a wider network of relations and (with the exception of Maria) were continuing this tradition in their own lives. Kathy, Anna and Rachael had careers in nursing, banking and insurance, respectively, and were married to men with commercial (Robert), technical (Andrew) or trade (Dave) training. All three maintained family traditions of residing in self-owned homes. Maria's family background also identifies her as middle class. As a single mother, however,

with minimal work experience and formal qualifications, and living off a Domestic Purposes Benefit, Maria's social status is at risk of change once she departs the family home.

REFLECTIONS ON FIELDWORK

The process of collecting and writing up the data generated from this project has raised a number of issues concerning my position as a researcher 'doing anthropology at home', and the advantages and difficulties associated with this type of research. Clearly I possessed the advantage of an area of common ground from which to establish a meaningful relationship with the mothers (shared culture, experiences as a woman, mother, etc.) and was spared the need to become familiar with a different language or cultural attitudes and practices. However, my background as a breastfeeding counsellor, while providing insight into the type of question(s) to ask, was counterbalanced by an awareness that my line of questioning might subtly influence a mother's perception of an event.

I was also concerned that familiarity would dull my recognition of incidents deemed significant by the respondents. Furthermore, familiarity carries the risk of prejudicing interpretation because of preconceived assumptions generated from personal experience or common sense knowledge. As the period of fieldwork progressed I gradually began to recognise that the mothers were teaching me a great deal about myself and my attitudes and assumptions in relation to the experience of breastfeeding. I began to appreciate that I had embarked on this project with my own set of experiences, biases and preconceived ideas, some of which were ultimately confirmed while others were thoroughly shaken and revised or rejected.

Strathern (1987:19) argues that domestic research involves the dilemma of seeking to know more about ourselves as *both* subject and object. This quandary requires the researcher to confront two issues. The first, concerns the need for epistemic reflexivity. That is, a strategy of critical evaluation of culturally constructed thought which explores beyond the boundaries of what is being observed in order to challenge "the collective scientific unconsciousness embedded in theories, problems and categories of scholarly

judgement" (Wacquant,1992:40). This process is necessary if 'common sense', 'natural' perceptions are to be recognised, challenged and understood. The second issue concerns the argument that the research process traditionally involves conversion of the commonplace into the complex, abstract and theoretical 'language' of anthropologists. In other words, everyday events become mystified and are placed beyond the recognition of the very people whose lives they concern. For example, Rosaldo's (1989:46-48) lighthearted account of his in-law's to be breakfast ritual ably demonstrates the absurdity of converting everyday events into "distanced, normalizing description". Arguing that such a process presents false impressions of objectivity and authority, Rosaldo notes that the solution lies with alternative ways of presenting ethnographic interpretation, achievable through the adoption of methods which minimise the gap between the "technical idiom of ethnography and the language of everyday life" (Rosaldo,1989:51).

As my involvement in the process of attempting to understand the experiences of the mothers in this study intensified, I became increasingly aware of the conventions of mystification associated with the writing up of ethnographic research. A fundamental problem presented itself, especially since a prime motivation for this project was a feeling of frustration and dissatisfaction with the dominant biomedical objectification and mystification of breastfeeding. My problem was how to present an understanding of the research data so that it remained meaningful to each mother, but nevertheless conformed to accepted academic criteria.

Satisfactory resolution of both issues, namely the need for epistemic reflexivity and avoidance of mystification, is difficult. The first, requires a critical awareness of culturally formed assumptions regarding the nature of reality. This thesis, as a response to inherent biomedical bias evident in the majority of cultural studies on breastfeeding (see Chapter One), attempts to critique and redress commonly accepted assumptions regarding the process of breastfeeding. For the second issue, progress was made by adhering to four relatively simple guidelines. First, by avoidance of traditional ethnographic conventions which serve to establish authority but in fact distance the ethnographer from the subject; for example, by avoiding the use of authoritative, third

person language and copious jargon. Second, by grounding all understanding in actual experience, rather than in esoteric theoretical conception. Third, by presenting salient excerpts from transcripts of the mother's accounts of their perceptions and experience and by using my own experience as a further source of data. And fourth, by recognising quite explicitly that what is presented in this thesis can never be more than my own understanding of the experiences of the women concerned. In other words, what is presented here should be somehow familiar to, and recognisable by, each respondent but will never faithfully capture exactly what each mother experienced or felt. At best, all this study will provide is a glimpse into the experience of each mother and an appreciation of the pressures and influences that constrained and shaped her perceptions of the experience of breastfeeding.

CHAPTER FOUR

BREASTFEEDING AND THE BODY - THE PHYSICAL EXPERIENCE

> In most anticipated normal pregnancies, a woman finds that the hormonal milieu triggers latent maternal instincts leading to anticipation of holding the infant closely to the breast and providing continued nourishment. Parenthood potentially provides the opportunity for psychologic growth from the egocentricity of adolescence to an adult self-concept in which the mother cares for and nourishes this new being. The mind, however, is not controlled by body function alone. Many societal, community, family, and individual forces influence attitudes and feelings about breastfeeding.
>
> Lawrence (1984:12)

> Orlando, Florida - Denise Perrigo, a single, 29-year-old mother, sought an answer to the question: Is it normal to feel sexually aroused when breastfeeding?
> The immediate response saw Perrigo arrested, charged with sexual abuse and neglect, and deprived of her child, then two years old.
> The Perrigo case raises so many issues it is hard to know where to begin. Fundamental to the entire conundrum is American society's warped perceptions regarding motherhood, women's sexuality and, above all, breasts.
> Breasts were put on the female body primarily for the purpose of feeding babies and children....It is interesting that, in our society, breasts are considered quintessentially sexual all year long....but never when a baby's mouth is attached.
>
> Parker (1992:5)

The above quotations reflect the confusion and contradictions inherent in prevailing Western attitudes towards women, the female body and the act of breastfeeding. Fundamental to these constructs is acknowledgement of the physical ability of the female body to nurture an infant by producing milk and a realisation that social forces influence this process. In other words, breastfeeding is recognised as a physical process involving specific functioning of the body but is perceived and experienced in culturally divergent ways. The body is the reference point from which a mother's experience of breastfeeding becomes knowable, but it is also the site where the physical process of producing milk for an infant confronts culturally defined beliefs, traditions and values.

This chapter focuses on two major themes which emerge from the considerable emphasis placed by each mother on the physical aspects of breastfeeding. Accordingly the chapter is divided into two major sections. The first addresses problems associated with the process of producing milk and suckling a baby, and examines physical discomfort, problems of adjustment to the demands of the baby, and difficulties

encountered by each mother during the early weeks. Also discussed are the strategies employed by each mother to overcome problems encountered. The second section explores the behaviour and routine of the baby and its effect on each mother's lifestyle. In this section, feeding frequency, broken nights, colic and beliefs about links between the mother's diet and baby's behaviour are discussed. The purpose of the chapter as a whole is to demonstrate that the process of producing milk and suckling a baby, and the routine and behaviour of the baby, generate conflict between physical processes and social forces. In other words, each mother's body became the site where she confronted and experienced a struggle between socially defined norms, her desires and practices, and the requirements of her baby.

EXPERIENCES RELATING TO PRODUCING MILK AND SUCKLING A BABY

This section examines those aspects of physical functioning perceived as significant by the women in this study. Each of the mothers commented on some degree of discomfort or physical inconvenience associated with the process of producing milk and feeding their baby. Reasons underlying this emphasis are discussed in the conclusion to this chapter. However, the impact and importance of these experiences varied, with pain and discomfort being perceived as mild and generally non-problematic by Maria, Anna and Rachael whereas it was a central aspect of Kathy's experience. Physical problems, such as those encountered by these women, are common to many breastfeeding mothers and well documented in both medical literature and manuals detailing the techniques of breastfeeding (e.g. Lawrence,1985; Renfrew, Fisher and Arms,1990).

Kathy

Throughout the three month interview period, Kathy struggled with bouts of breast discomfort and pain that proved difficult to alleviate and control. Although she had periods when the problem abated, the severity and duration of breast pain and discomfort (particularly in her right breast) was a significant *and unanticipated* aspect of her experience. During my first visit, Kathy alerted me to the problem, remarking:

> Well it seems to be aching all the time, when I am full...its like a toothache, especially after I've fed him from this breast and then go on to the left breast. It just aches and aches...and I rub it and sometimes it settles down.
>
> (week two)

On this occasion Kathy was about to bath Ben when I arrived, having just given him a partial feed (from the left side only). I watched and photographed the bathing and when this was finished Kathy sat in a comfortable chair to complete Ben's feed (from the right side). As she proceeded to feed Ben from her right breast, I noticed that Ben was 'clicking' his tongue with each suck, usually an indication that a baby is not correctly grasping the nipple (a common cause of breast and nipple discomfort and pain). When I remarked on this, Kathy made several attempts to reposition Ben at the breast, finally succeeding by placing him in a 'football hold'.[1] Kathy appeared fairly tense while feeding from this side; this showed up in the photographs I took of her on this occasion and is particularly noticeable when compared with photographs taken much later on.

Kathy's difficulties in positioning Ben on her right breast, triggered reflections on similar problems I encountered when breastfeeding my first baby. I had great difficulty in getting Matthew properly latched on to my right breast and, like Kathy, found the solution lay with using the 'football hold'. I was therefore able to recognise in Kathy some of the awkwardness, anxiety, vulnerability and frustration that I felt when in a similar situation. As a breastfeeding counsellor, I had also been in frequent contact with other first-time breastfeeding mothers, among whom positioning problems, breast and nipple discomfort were fairly common occurrences.

Kathy's problem with breast discomfort continued over the next few weeks with minimal improvement, her sore right breast was accompanied by a tender and sometimes slightly cracked nipple. She admitted that these problems made feeding difficult and uncomfortable. Her nipple was generally quite sore throughout the feed and resulted in her favouring the other breast to feed from. The problem continued and several weeks later Kathy commented that although the crack had disappeared, her nipple was still extremely sore:

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[1] The 'football hold', refers to a position where the baby's body is placed along the mother's side, with the feet pointing towards her back.

> It feels like a serrated knife going across it. It has got worse...The whole feed is painful. But when he is feeding from that [my left breast] it is lovely, I don't even notice he is feeding! Dare I say it, it is almost pleasant!
>
> (week seven)

Kathy attempted to overcome breast and nipple discomfort during the first three months by paying attention to such things as positioning, sucking duration of the baby, and the use of heat and pharmaceutical preparations to relieve the discomfort. However, these measures appeared to offer only limited relief, leaving Kathy puzzled that in spite of her remedial actions improvement was very slow. But there were signs of improvement, although she continued to experience "raw" nipples which she attributed to Ben's pattern of frequent nursing. Kathy remarked that her breasts had settled down and were "almost comfortable", until she encountered a set-back:

> There is something wrong! It just feels as if it [my nipple] has been dipped in acid. It looks perfectly normal. Sometimes it is like a stabbing, sometimes there is a shooting pain up it, at the moment there is just an ache like toothache. On Saturday it felt very swollen. I don't think I have got a breast infection because I have been through it with patients.
>
> (week eleven)

Compounding Kathy's problem with her right breast was a more general discomfort associated with overfull breasts. As with many new mothers, this sensation was particularly pronounced during the first few weeks, settling down as her milk supply gradually adjusted to Ben's needs. For Kathy the discomfort from her overfull breasts was unanticipated:

> ...I wasn't expecting my breasts to be so uncomfortable for so long. It's just something that people don't talk about! I am not at all happy with this breastfeeding, even though I know in my heart that I want to keep doing it. But it makes me quite miserable sometimes; they [my breasts] just ache, ...you know they are so full. They hurt when they are filling up, they hurt when they are emptying. I am very conscious of them, these great bricks...
>
> (week seven)

Kathy's uncomfortable breasts gradually improved however, and several weeks later she commented that:

> ...either I am getting used to that full feeling or they are not as full and as tight as they used to be. I can see that gradually things are getting more settled and I am feeling more comfortable.
>
> (week nine)

Throughout this period of fairly severe breast discomfort, Kathy's main incentive to continue breastfeeding was her over-riding belief that "it had to get better". During the fourth week she was adamant that she didn't want to stop breastfeeding yet, and a fortnight later she commented:

> It is funny isn't it? I think that in the back of my head I know that it will get better. I know and I am just holding out because already I have the odd day that is not too bad. But sometimes I get quite miserable and I think: "That Annette Beasley. When she comes I am going to tell her about that! I am going to tell her I am going to stop!" And then this morning I was feeling quite good and I thought "You can do it!"
>
> (week six)

Associated with Kathy's experience of breast discomfort, was the phenomenon of leaking breasts. One of the outcomes of leaking breasts was irritated nipples from the shields used to absorb the milk. Once this problem had been overcome by substituting men's cotton handkerchiefs for disposable shields, Kathy tended to regard leaking as little more than an inconvenience and in fact felt reassured by this manifestation of a good milk supply.

Kathy's experience with breast discomfort was the most pronounced of the four mothers in this study. Her reaction of complete surprise to this experience, can be better understood by considering Kathy's multiple positioning as a nurse, breastfeeding mother, patient and woman within the field of health and infant feeding. As a former Practice nurse involved in advising and educating breastfeeding mothers, Kathy's biomedical knowledge (emphasising the physiological aspects of breastfeeding) assumed a relatively uniform physical experience (see Manning and Fabrega,1973). As a nurse, she expected to encounter some of the problems observed in her patients, and during the pre-birth interview she specifically mentioned nipple problems which she primarily perceived as resulting from a lack of knowledge and support and therefore easily remedied via management techniques and/or biomedical intervention. What Kathy did not anticipate was that these experiences could involve *prolonged* personal discomfort and even pain. During the seventh week she remarked:

> I wasn't expecting my breasts to be so uncomfortable for so long. I was so looking forward to sleeping on my tummy again...but I still can't because my breasts are too sore. I thought: "Oh, nobody told you its just going [to go] on and on".
>
> (week seven)

Kathy's experience of breast discomfort highlights the abyss between biomedical construction of the body and individual experience, and can be interpreted as involving a tension between her experiences as a nurse on the one hand and as a breastfeeding mother and patient on the other. As a woman and breastfeeding mother, Kathy has been repositioned within the biomedical discourse, her new experiences necessitating personal redefinition of processes that she previously perceived as clear-cut and clinically 'knowable'. At the level of practice, Kathy's embodied experience of breastfeeding (as a woman, mother and patient) conflicts with her previous experience at the level of structure (as a nurse), involving biomedical diagnosis and intervention. Thus for Kathy the meaningful elements of her experience of aching breasts and a sore nipple focused on the prolonged duration of this experience; her inability to alleviate the discomfort; and most significantly, the fact that no one had ever alerted her to this possibility.

Maria

Maria, Anna and Rachael all experienced some difficulties with uncomfortable breasts, sore nipples and leaking. These three women, however, did not encounter the ongoing and prolonged discomfort endured by Kathy. In fact, Maria and Rachael's encounter with such problems were largely confined to the first few weeks of motherhood, particularly during their hospital stay.

Maria developed cracked nipples almost as soon as she started feeding her baby and on the third day following Rose's birth was feeling that:

> [I] just dreaded her [Rose] waking up because it was so sore...I mean, for awhile there, when she spilt [milk], there was a bit of blood in it from my nipple...
>
> (week one)

When I asked Maria what was done to help overcome this problem, she replied that the hospital staff only recommended treatment with ultra sound, believing that the application of creams was ineffective. Maria felt that the application of some sort of medication would have helped to relieve her discomfort but she was strongly opposed to interventions such as the use of a nipple shield, noting:

> My nurse actually said, "Next time you feed ask for a nipple shield", but I didn't want to. At one stage I said "Are there any sort of creams that you can put on them [her nipples]" and they just said they don't recommend creams, but I could have a nipple shield if I wanted one. But I said that I didn't want one. So I just kind of grinned and beared it!

Maria's aversion to the use of a nipple shield was supported by the experience of her friend Margaret, whose baby was born about a month before Rose:

> My friend actually had a nipple shield when she was in hospital, because she got [a] really badly cracked [nipple], and she used it all the four weeks she fed and then she just up and stopped breastfeeding.

Maria clearly felt that intervention with a nipple shield contributed to her friend's short duration of breastfeeding and was anxious to avoid this situation. She mentioned, during the pre-birth interview, that she was expecting to get cracked nipples after the baby was born as she had already had one during her pregnancy, and had worked out her avoidance and treatment strategies:

> I'll make sure that the baby is on properly first and if I do get a cracked nipple I will go up to the hospital and have ultra sound, because that worked last time. But when it is sunny I sit in the sun with no shirt on.[2]

When I asked her how the ultra sound improved the problem, Maria responded:

> Oh well I learned about that in antenatal classes. I can't remember...it helps toughen the nipples and helps heal them up, because the ultra sound I had when I was pregnant for my crack, it was like light and steam, it was basically instant relief. I mean the steam was instant relief, it made me feel really good. I had it twice in one day and that was enough, I didn't need any more.

Clearly Maria was optimistic that any problems with sore or cracked nipples would readily respond to correct management and treatment and indeed this did prove to be the case.

During our first meeting following Rose's birth, Maria showed me the cracks and forming scabs on her nipples, interpreting the latter as an indication that the problem was resolving itself. I commented on the fullness of her right breast but Maria appeared

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[2] Exposing the breasts to the sunlight is believed to speed the healing of cracked nipples. This strategy, apparently widespread in New Zealand, was used by both Maria and Rachael.

relatively untroubled by this phenomenon, attributing it to her over abundant milk supply and to Rose's pattern of suckling from only one breast at a feed. When I queried the discomfort associated with such a full breast, Maria replied that it didn't worry her because she knew that Rose would soon feed again and that would provide relief. But on some occasions her very full breasts were a problem, particularly when Rose went longer than normal between feeds, or in the early morning before the first feed of the day. At these times, though she tended to be very uncomfortable and found leaking a nuisance, she was nevertheless proud of her ability to produce copious amounts of breast milk and felt reassured by its presence.

In contrast with Kathy, Maria's experiences of breast discomfort and nipple soreness were less severe and shorter in duration. The fact that Maria had anticipated some severe discomfort did contribute to it being more tolerable, although it must be noted that her problem responded favourably to the treatment offered. These differences raise a number of seemingly unanswerable questions concerning the relationship between expectations and actual experience, and perceptions and outcome of intervention.

Kathy revisited

From a biomedical perspective, Kathy's problems persisted despite receiving correct management. Biomedical discourse offers no alternative explanation or course of action, and even denies the existence of a problem if tangible evidence is absent. And yet Kathy's problem did persist, causing her to experience prolonged distress. Recognising Kathy's body as a site of conflict and struggle between competing discourses allows an alternative explanation for her experience of pain and discomfort. From this perspective, Kathy's experience of pain can be understood as a means of communicating her experience of being-in-the-world, her body responding to a struggle between physical processes and social forces.

The body as a medium of existential expression is not an unknown phenomenon to social anthropologists. Davis (1988), for example, identifies blood symbolism among the women of Newfoundland fishing communities, where a woman's individual state of well being and suffering is expressed through culturally defined classifications of the

state of her 'blood'. The locals will all agree on the nature of "Betty's low blood" or "Hazel's thick blood" which not only grants Betty and Hazel status and identity but relieves them of any failure to conform to the collective ethos, their actions being seen as beyond conscious control - their blood being responsible. Thus blood is the medium of contextualisation of individuals, granting them a personal identity that is otherwise denied in this close-knit community where women are expected to be hardworking, stoic and self-sacrificing about their lot in life. As Davis (1988:10) explains it:

> Women derive status through suffering, yet they must not blow their own horn, they let their bodies do it for them.

A similar phenomenon is identified by Pandolfi (1990:256) in the case of Maria, a southern Italian peasant, who "suffers from everything - does not sleep". Diagnosis of Maria's malaise appears to fall outside Western biomedical classification, although her behaviour may be classified in terms of psychological maladjustment. Pandolfi argues that Maria's body is expressing her experience of being-in-the-world; that is, a female world of feelings constructed from assimilation of past and present events affecting herself and those close to her. Her illness expresses her fear of the world which is incorporated in the body and transformed, converting it into "bodily humors, fluids, organs...[the] functioning [of which] is regulated by emotions and interpersonal relations" (Pandolfi,1990:263).

Kathy's experience of prolonged breast discomfort can be likened to the sufferings of Pandolfi's Italian peasant, Maria, and the 'blood' conditions of the Newfoundland fishing community women. That is, Kathy's discomfort can be understood as an expression of the tensions created from her experience of her body as the site of conflict between physical processes and social forces. Her unique social positioning as a woman, breastfeeding mother, patient and nurse accounts for the severity of this tension.

Rachael

Rachael experienced difficulties in positioning her baby on the right breast, as well as engorgement and sore nipples during both her hospital stay and the early weeks at home. Her positioning problems were related to a slightly inverted nipple. Initially the

hospital nursing staff encouraged Rachael to use a silicone nipple shield as a means of overcoming the problem. This solution proved to be only partially effective and Rachael became increasingly more uncomfortable due to an overfull breast. Reflecting on her experience a fortnight later, Rachael observed:

> [I] had a lot of problems...[and] I still can't get her on one side, I had to put on [a shield] that looked like a Mexican hat!

Rachael's difficulties in getting Toni on the right breast were compounded by her overfull or engorged breasts (not uncommon among newly delivered mothers) causing her nipples to become very sore. The problem was eventually rectified by the hospital staff providing Rachael with a normal bottle teat to place over the nipple and this allowed Toni to become 'attached' to the breast. After a few minutes of feeding, Rachael was able to discard the teat and suckle Toni directly from her nipple.

Three weeks after Toni's birth, Rachael again experienced difficulty getting Toni onto her right breast and a flare up of tender nipples. At this point Rachael commented:

> ...I haven't been using the bottle teat for about, well five or six days and all of a sudden last night she couldn't [or] didn't know how to take [the nipple]. So I tried the bottle teat and she wasn't interested in that either and when I put her on the other nipple she was fine...and then I changed back to this side and she went on alright. I don't know what happened there!
>
> (week three)

Two weeks later Rachael had a further episode of sore nipples, noting:

> It is very sore and it's gritting teeth time when she goes on.
>
> (week five)

On this occasion she felt that the problem was probably caused by a small crack which she was treating with a cream as well as allowing sun on her breasts for a short period each day. When I asked if she knew how this had happened, Rachael replied that it was probably through Toni not being correctly positioned at the breast for a couple of feeds. Rachael's strategies for dealing with her sore nipple were successful and the problem did not recur during my period of contact with her.

Anna

In contrast with the other three mothers, Anna experienced minimal early discomfort from overfull and sore breasts, or nipple tenderness. Anna's main problem during her hospital stay concerned Lauren's "lack of a clear idea what to do". When put to the breast, Lauren tended to lick the nipple "like an ice cream, as a way of finding where to position her tongue" prior to grasping the nipple in her mouth. The real problem was that Lauren, while trying to draw the nipple into her mouth, tended to place her tongue onto the roof of her mouth, inhibiting a correct sucking action. This resulted in several days of blistered and flaking nipples until the problem was corrected. But it was not until Lauren was about two months old that Anna gave any indication of breast discomfort:

> ...I have been feeding her in the water bed, and that's been quite good because it sort of relieved the aching on that nipple that still seems to be going on.
>
> (week eight)

I was surprised to learn that she had been experiencing such a problem. In fact, Anna now indicated that it had been intermittent right from the beginning, but as it usually went within a few days she had accepted it as part of the breastfeeding process. On this occasion, however, the problem was persisting. Anna was puzzled, noting that the problem was confined to "the nipple itself". She also mentioned that she had recently, for no apparent reason, been experiencing difficulties latching Lauren on the breast, particularly on her right side. On reflection, she conceded that perhaps incorrect positioning was the cause of her tender nipple. Under these conditions she found the waterbed comfortable for feeding because it enabled her to easily position Lauren correctly:

> I don't have to put my arm underneath her... it seems that because I am heavier she just rolls toward me and away we go.
>
> (week eight)

Anna's sore nipples slowly improved, although several weeks later her right breast was again tender. This time she decided to 'rest' her nipple by expressing the milk. However, Lauren was very uncooperative about accepting a bottle teat and Anna was

forced to put her back to the breast. Despite her best efforts to ensure that Lauren was correctly positioned the problem was persisting. She therefore decided to:

> ...try not to worry too much about it because I have sort of come to the conclusion that if after all my best efforts it's still sore and it's still coming back, the best solution to me seems to just let her suckle on it. Because that's supposed to heal it as well! If I am too worried about it, then hopefully I will just sort of relax and we will get back into the right position.
>
> (week fourteen)

Anna's relaxed attitude clearly indicated that the problem was not a persistent one, nor one that resulted in other complications:

> There is normally a little bit of an ache there, but I sort of think "Oh well, it has gone on for quite a while now and I am sure that it is not affecting the rest of my breast...not resulting in a breast infection or anything."
>
> (week fourteen)

From the previous accounts it is apparent that Maria, Rachael and Anna's experiences of breast and nipple discomfort did not involve the tensions or the severity and duration of difficulties endured by Kathy. In part it was due to the fact that they were more successful in alleviating their discomfort through the measures they adopted, although each mother did experience periods of discomfort and frustration.

The contrasting experiences of these four women reminded me of numerous encounters I have had with other breastfeeding mothers. These encounters had often led me to consider why breast and nipple discomfort is accepted and brushed aside as 'part of the deal' by some mothers, while for others it assumes a much greater significance. I remembered being astounded by the determination present in a mother who persisted with breastfeeding in spite of severe discomfort and pain. Indeed, I have frequently encountered women breastfeeding with tears streaming down their face because of the pain involved, who are nevertheless determined to continue if at all possible. These women provide a contrast with numerous others who changed to formula feeding because they felt unable to withstand seemingly more minor difficulties and discomfort associated with breastfeeding.

Clearly the presence or absence of pain or discomfort is only one aspect of a woman's breastfeeding experience, although it must be acknowledged as a significant factor in determining the continuation and hence the duration of breastfeeding. As indicated by the experiences of Kathy, Maria, Anna and Rachael, the intensity and perception of breast and nipple discomfort was unique to each mother. The inadequacy of biomedical

explanations in accounting for this individual difference highlights the fact that physical discomfort cannot be considered in isolation. That is, breast and nipple discomfort needs to be understood within the total context of a woman's breastfeeding experience. For the mothers in this study, breast and nipple discomfort was but a part of a complex whole, related to and interacting with a multiplicity of other factors, the more significant of which are discussed in the following pages.

EXPERIENCES AND CONCERNS RELATING TO THE FEEDING PATTERN, BEHAVIOUR AND ROUTINE OF THE BABY

The focus here is on the feeding pattern and behaviour of each baby and how this impacted on the mother's perception of her breastfeeding experience. It should be noted at the outset that the feeding pattern and behaviour of each baby was different, frequently varying day by day. Three of the babies suffered from colic or wind at various times, a condition that resulted in a distressed, unsettled baby who took much longer to feed and required considerable patience and time with burping. Furthermore, all the mothers were affected by the feeding patterns of their infants, particularly during periods of disrupted sleep or frequent day-time feeding. The decision of each mother to 'demand feed'[3] her baby, meant that during the early weeks feeding times tended to be unpredictable and broken nights were the norm.[4] However, the varied feeding pattern of the early weeks was neither unexpected nor always considered problematic by the mothers.

Kathy

Kathy felt herself fortunate because from the beginning Ben generally slept continuously for six to seven hours at night and was very rarely affected by wind or colic. In this respect, Kathy's baby differed from the other three, although his long period of sleep at night was compensated for by prolonged and frequent feeding during the day. Kathy

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[3] 'Demand feeding' refers to a feeding pattern indicated by the needs of the baby, rather than one scheduled to a predetermined timetable that commonly involves feeding at four hourly intervals.

[4] Tiredness was something all the mothers experienced, on various occasions, throughout my period of contact with them.

found Ben's day-time feeding very demanding and experienced difficulty in coming to terms with this aspect.

On the occasion of my first visit (when Ben was one week old) Kathy remarked on the divergence between manuals and her own experience:

> ...in books and things like that, it says feed for five minutes on one side and then switch over to the other side for five minutes and the baby is to be fed for twenty minutes and then get them down. Yesterday, quite often (I think more often than not), he was awake and at the breast for two hours. He just keeps drinking.
>
> (week one)

At this stage Kathy's main concern centred on her perception that sitting and feeding Ben for considerable periods amounted to doing nothing. She admitted feeling uncomfortable about the frequent feeding and guilty about not doing things around the home. Despite Robert's reassurance that she was "the baby's life support", the perception of breastfeeding as a time spent "doing nothing" continued to plague Kathy. The following Sunday, Ben's feeding schedule was particularly demanding, involving continuous feeding throughout most of the day. Reflecting on how this affected her, Kathy said:

> So at two o'clock I sat here for another hour feeding. At two o'clock I thought, "Oh this is ridiculous. This is just ridiculous. I can't sit here all day, there has got to be something wrong!" So I put him in the pram and he cried and cried. So I said "Oh I'll just take him for a long walk, that'll get him off [to sleep]."
>
> (week two)

The moment they got back home, however, Ben woke again and Kathy realised that she would have to give him another feed. At this point she made an important decision:

> I decided just to relax and if he's going to feed all day today, then he is going to feed all day....well no one's here watching me, that I'm just here feeding my baby all day. I just sat down and fed him for another hour and he went off to sleep!
>
> (week two)

In fact, Ben required frequent, prolonged day-time feeding throughout most of my period of contact with Kathy. Kathy continuously struggled with this routine, finding it trying and difficult at times. Moreover, her reaction was compounded by the problems

encountered with tender breasts and nipples, which tended to be aggravated by the prolonged periods of sucking.

Kathy's experience of "doing nothing but sitting [and] breastfeeding", can be understood as involving a habitus generated conflict between her role expectations as a housekeeper and household manager and the demands made of her as a breastfeeding mother. As the books she had read indicated that a 'normal' feed involved a time span of about twenty minutes duration, Kathy had anticipated that she would be able to allocate a portion of her time to other household activities. Reality, however, provided a marked contrast with expectation and this divergence manifested itself in comments such as the following:

> ...the thing that I almost regret about breastfeeding is that I'm sitting in a big comfortable chair, looking awfully comfortable and I say, "Oh Robert, could you please do....Oh Robert, the washing machine is finished, could you please put [the washing] out, I'm going to be sitting here for another hour".
>
> (week two)

It may be noted here also that Kathy's unease about the time spent breastfeeding was intensified by the remarks made by some of her friends who had babies slightly older than Ben. This aspect illustrates the significance of relationships with others and will be discussed in detail in the next chapter.

Despite her initial misgivings, Kathy gradually came to realise that Ben's frequent day-time feeding did appear to account for his long stretches of sleep at night. When Ben was eight weeks old she admitted:

> I quite like him being up during the day, it's fun. I don't mind feeding him...and I have normal sleeps, going to bed at half past ten. I put him down at half past eight.
>
> (week eight)

Two weeks later Kathy experienced a couple of broken nights:

> Well I had two nights of him waking up at three in the morning. Now he has gone back to sleeping until six again, but I have never had [continuous broken nights] really, which has been wonderful.
>
> (week ten)

Ben's night-time waking proved to be temporary as he soon reverted to his previous pattern, sleeping well at night but feeding frequently during the day, a pattern that Kathy began to accept:

> Over the weekend he has been happy and contented but feeding a lot. That's just us now, he doesn't have feeds, he just grazes the whole time.
>
> (week nine)

Kathy's adjustment to the demands of a baby requiring frequent day-time feeds was something I had experienced myself and observed in many other mothers. I recognised in Kathy a similar sense of guilt associated with apparently "sitting doing nothing all day" and shared with her a desire to be organised and orderly in the household. Moreover, I noticed Kathy's gradual change in attitude toward Ben's feeding pattern, a shift from resistance and guilt to acceptance of it as 'a fact of life'. This change was significant because it dissipated tension generated through the incompatibility of expectation and actual experience, a phenomenon I had both observed and personally experienced.

Kathy's change in attitude toward Ben's feeding pattern reflects changes in both her perception of herself as a breastfeeding woman and the process of breastfeeding. Kathy's habitus generated expectations of herself as a breastfeeding mother and housewife, were confirmed by the 'normal' feeding patterns advocated by books on the subject. Her unease and guilt about herself as a successful breastfeeder, competent mother and housewife arose from the disparity between expectation and outcome. Thus Kathy had to redefine her perception of self and her role before she could comfortably accept that there was nothing wrong with Ben being a frequent day-time feeder.

Contributing to Kathy's tension were common sense notions of 'typical' infant behaviour, involving a routine of long periods of sleep interspersed by regular feeds of approximately twenty minutes duration. Underlying this notion is the hegemonic influence of biomedicine. Various authors (see Beekman,1977; Fildes,1986; Minchin,1986; Wickes,1953) have detailed the role of medical science in the management and control of infant feeding. The notion of infant overfeeding, for example, first emerged in the eighteenth century under the influential doctor William

Cadogan.[5] Palmer (1988:220) notes that such beliefs still underlie the advocation of strict routines for infant feeding, routines endorsed by research into formula-fed infants who take approximately four hours to digest artificial milk. Palmer refers to the "god of routine", making the point that strictly scheduled feeding is peculiar to industrialised societies where discourses of time, technology and scientific knowledge define and construct many daily activities and processes.

Maria

During the first few weeks at home, Maria's new baby (Rose) was initially a hungry, wakeful baby, up most of the day and often unsettled in the early evening. When I arrived for the first visit following Rose's birth, Maria was sitting in an armchair, her baby asleep in her arms. She mentioned that this was how she had been spending most of her days, because Rose was frequently feeding and liked to be near her. Like Kathy, Maria found a demanding day-time feeding schedule allowed her little time for other activities such as household chores. When she was pregnant she had attended to many of the chores while her parents were out at work but things had changed since Rose's birth:

> ...I do my washing and that, and I put the washing out in the morning but she is awake all that time and I don't have time now [for other chores]. I just get so frustrated because I can't do anything!
>
> (week one)

At this stage Maria was experiencing an overabundant milk supply and was leaking milk over bedding and clothing. She associated this phenomenon with Rose's frequent feeding and had, a few days previously, purchased a dummy in the hope that this might reduce Rose's need for prolonged sucking. Rose's initial reaction to the dummy was to spit it out, although gradually she learnt to accept it and was often asleep sucking on a dummy during my visits.

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[5] William Cadogan was influential for his "Essay upon nursing and the management of children from their birth to three years of age". Cadogan's ideas were based on a belief that overfeeding caused diarrhoea in infants. As an eighteenth century medical practitioner he would have been unaware of the problem of hygiene surrounding the common practice of supplementing infants with 'pap', gruel etc. His solution was to advocate four regularly spaced feeds in twenty four hours and to forbid night feeding, although he did not suggest limiting the duration of any feed (Palmer,1988:22-23).

Rose was also showing signs of colic, having previously suffered a bout in hospital. Maria felt that the colic was due to both her abundant milk supply and Rose's greediness - feeding until so full that she would spill milk back up:

> She just pigs out! Real bad, because I have got so much milk and she doesn't need to suck at it all the time. It just squirts in by itself.
>
> (week one)

In an attempt to overcome these difficulties, Maria started limiting Rose's feeds to ten minutes duration, suckling her on one breast only at each feed:

> I know she gets a lot in the first five minutes because...my milk just squirts out so [that] a lot of the time she doesn't need to suck. After that her bottom jaw starts going wobbly, which I know is just play. So I take her off, and if she still wants to suck I give her a dummy and just cuddle her as well.
>
> (week three)

From the outset I was impressed by Maria's ability to identify her baby's needs and to pinpoint reasons underlying variations in Rose's behaviour. Maria was very quickly able to distinguish between Rose's differing cries, confidently identifying them as "hungry", "needing a cuddle", "windy" and so on. Maria's apparently instinctive perception of her baby's moods and needs contrasted with the experience of the other three mothers and indeed my own experience as a first-time mother, when I felt confused by and unsure of the significance of different cries.

Rose's feeding patterns varied daily, some days wanting constant feeding, while on others she was more settled and slept for lengthy periods. Her night-time routine generally involved going to bed mid-evening, feeding at around about two in the morning and again about six. Maria found this routine a little difficult and tiring at times but generally wasn't bothered by it, unless Rose was wakeful at night and unsettled due to colic.

Rose's first bout of colic occurred while still in hospital and was successfully treated by administering boiled water from a bottle. Once at home, the bouts of wind became more regular. When Rose was three weeks old, Maria noted:

> I think she gets quite colicky...she had a really rumbly tummy last night so Mum gave her some gripe water before her feed and she puked real bad, because it bought the wind back up and she had just had a feed!
>
> (week three)

Rose continued to have intermittent problems with wind throughout my period of contact. For example, during the twelfth week, Maria reported:

> Last night I couldn't comfort her....she wouldn't take the breast or anything. I felt really hurt! I thought "Oh no!" Mum came in and took her and walked her and she burped and burped and burped. And she gave her gripe water and she burped and burped.
> (week twelve)

Maria could not always account for Rose's bouts of colic, but did associate a number of them with particular foods she had been eating. On the occasion of my third visit, for example, she mentioned that Rose had had a particularly bad day the previous Thursday:

> She was awful, she was up all night screaming and she slept in my bed! I got some gripe water and we tried that and we tried boiled water. We tried everything but it didn't work. So she just slept on my stomach all night basically.
> (week three)

Maria attributed this episode of discomfort to the kiwi fruit she had eaten at dinner the previous evening:

> There wasn't anything else to put it down to. I just had a plate of raw ones, just you know two or three. Mum cut them up for tea. So I won't eat them again in a hurry!
> (week three)

Maria also associated her eating of peas and cabbage with upset behaviour in Rose, observing that when Rose had been unsettled in hospital those vegetables had been served with a meal. She also avoided lettuce, reasoning that it was similar to cabbage.

Commonly accepted beliefs about certain foods 'tainting' breastmilk or adversely affecting the baby, were a phenomenon I encountered as a mother and counsellor. As a mother, I remember being warned with my first baby to avoid chocolate, grapes, garlic and strong spices such as curry powder, as these would adversely affect my milk, making the baby unsettled, windy or at risk of developing a rash. At the time I did not question this advice and avoided these foods. I was not so diligent with the next three babies who appeared to suffer no apparent ill effects. My fifth child, however, developed severe and extensive eczema which disappeared when she weaned. The implication was that her condition did result from my diet and it subsequently became apparent that dairy products and eggs were the cause, foods that to this day she is unable to tolerate in even minute amounts. As a counsellor, I have encountered diverse beliefs concerning a mother's diet and her infant's well-being. Occasionally the situation was similar to my own experience, as the baby's routine or condition would improve if

the mother avoided a particular food. In the majority of situations, however, the link appeared tenuous and unconvincing. Indeed, I recall an extreme example of a mother so convinced that her baby would not tolerate a wide range of foods in her diet, that she lost an alarming amount of weight - causing concern that her restricted diet was negatively affecting her own health.

Anna

Like Maria, Anna also faced tensions arising from her baby's pattern of frequent feeding in the early weeks and difficulties with wind. For the first few weeks at home, Lauren fed regularly three hourly, day and night. Anna did not regard this schedule as particularly problematic although she did find the disrupted nights a little tiring. She had expected breastfeeding to be very time-consuming, commenting during the pre-birth interview that she had heard some babies wanted feeding every hour during the early weeks. She also realised that Lauren was a "sucky" baby:

> She still wanted to suck even after she had enough to drink. I noticed that after she had actually been drinking and swallowing she was sometimes still latched on, and her jaw would be going backwards and forwards and she would just sort of make little motions. The Plunket nurse said to me, "Well perhaps she isn't getting enough satisfaction from the feed, but she doesn't need any more to drink".
>
> (week three)

The Plunket nurse advised introducing a dummy to provide the sucking satisfaction. This move was unsuccessful because the dummy would fall out of Lauren's mouth after twenty minutes or so, causing her to become very upset. Lauren's need to suck was eventually satisfied by her "finding" and sucking her thumb.

The three hourly feeding pattern continued until Lauren reached four weeks of age, when she went through a period of wanting to feed every two hours. About this time, Anna experienced a particularly distressing afternoon with an inconsolably upset and unsettled Lauren:

> On Saturday she got quite frantic, for...no apparent reason, and it took quite a bit to get her back to sleep. She was really crying...nothing that I would do seemed to stop her from crying. I burped her again and everything. I got very upset and Dave [my husband] just sort of took over.
>
> (week four)

Eventually Lauren fell into an exhausted sleep, waking five hours later for another feed and then resuming her normal feeding pattern. A fortnight later, Lauren again went through a period of being very unsettled and wanting to feed two hourly day and night. Anna found the routine more demanding this time, admitting that she was feeling very tired and puzzled:

> I was very tired. Yesterday morning she seemed to be getting upset for no reason. She takes awhile to go down and there is always a grizzle in between, normally anything up to an hour after she has been put down.
>
> (week six)

Anna tried various things to try and settle Lauren, eventually concluding that the problem was most likely wind related and associated with her rapid let-down.[6] Anna's concern was that the sudden flow of milk accompanying her let-down was overwhelming Lauren, causing her to gulp in too much milk at once and thereby causing wind. In an effort to overcome this problem, Anna restricted each feed to one breast only. She was unsure if this tactic contributed to Lauren reverting to her 'normal' three hourly feeding pattern a week later.

Lauren's unsettled feeding routine was beginning to take its toll, Anna finding it a bit frustrating, and a little trying:

> I feel that there are things that I want to get on and do that I have put off to look after her. And I feel as though perhaps it is never going to end, this feeding her on call. I feel now that I have got a good grasp of the basics of looking after her, so perhaps I should be able to get back to a more normal routine.
>
> (week six)

Having Lauren in a structured routine and having the answers to questions posed by her behaviour was perceived by Anna as a sign that she was in control of the situation as a mother:

> Well I do feel a bit of pressure from Dave that I should know the answer to the question [why Lauren is unsettled]. Because although he doesn't mean to, he is asking those questions...I sometimes feel as if I have got a basic grasp of what is going on. I [also]

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[6] Let-down refers to the hormone triggered release or flow of milk that occurs when the breast is stimulated by the baby's suckling.

> sometimes feel that it is still very much guessing and that you have just got to perhaps take an educated guess, make a decision and just go with it.
>
> (week six)

Anna acknowledged that she was finding "just going with it" a less stressful option, although there was obvious pressure on her to conform to a more rigid routine, particularly at night. These pressures included comments written in her Plunket Book by the local nurse, such as "still not in a routine".

The following week, Lauren's routine started to change again and one evening she slept for eight hours on end:

> She went to bed at half past six, after a nice warm bath (and I actually think that is what did it) and at eleven o'clock she did a little grizzle and that woke me up. So I thought, "Right, that must be her time for a feed". I got out of bed, put my dressing gown on and was about to turn on the light, when I thought to myself, "There is no noise coming from the cot!" She had gone back to sleep. And I thought "Right, I will do the same even if it is only for another half hour", and low and behold at half past two she had another grizzle and at that stage I thought that she would go back to sleep. But I don't like this, eight hours is too long!
>
> (week seven)

Anna's reaction was to wake Lauren and feed her.

Anna's mixture of anxiety and excitement over Lauren's extended period of sleep, triggered memories of similar incidents with my own babies. I recognised in Anna (and Rachael, as described in the following pages) the jubilation at the prospect of an end in sight to broken and disrupted nights and the accompanying weariness endured during this period of motherhood. I also shared with Anna the feeling of anxiety she felt when she woke and realised that her baby was still asleep. I recognised that this realisation was tinged with an underlying fear that perhaps something was wrong and recalled the occasions that I had deliberately woken my babies to ensure they were still breathing. Moreover, I knew that accompanying these emotions was always the physical discomfort associated with overfull breasts from the missed feed and the almost desperate desire to feed your baby to gain relief.

From this point onwards, Lauren became increasingly more settled at night, and when I visited Anna the following week she greeted me with obvious pride and excitement:

> This week has been an exciting week, three nights in a row she has slept for six hours! That was Saturday night, Sunday night and Monday night. Oh I was so thrilled, I couldn't believe it. Especially because I thought right through "That's great, at last she

> is starting to extend the time." The next night I couldn't believe it and I thought "Now it is not going to happen again another night", but it did. Oh yes I was so thrilled.
> (week eight)

Lauren's nightly schedule gradually involved more extended periods of sleep, and by ten weeks of age she was sleeping for ten to twelve hours at night. At this point I noticed subtle changes in Anna; she was more relaxed from unbroken nights and, more significantly, appeared to have gained confidence as a successful mother. This observation prompted me to ask Anna if she indeed felt as if she had 'graduated' or 'made it' as a mother. She responded with an unequivocal "Yes".

Despite more settled nights, Lauren continued to have intermittent problems with wind, during which she was generally unsettled. Although Anna was not always certain why Lauren was "scratchy", she sometimes put it down to possible teething or a current cold. At eleven weeks of age, Lauren went through another period of upset behaviour during and after feeding:

> I am not sure what's going on, whether she has actually caught some...tummy bug or what. But she seems to have the first half of her feed, and in the process of being burped she gets very upset and cries as if she has got a lot of pain. So I try and settle her down and just as I think she is settled down and I go to put her on the other breast, she starts to cry loudly again. So I am not really quite sure [what's going on]...this morning I burped her for about fifteen minutes, so I thought she had no air in her stomach, so I lay her down and she started to cry again. But I knew that she was hungry because just before she started to cry she was about to latch on. It was as though she thought if she had another drink then that would mean that she would get all that tummy pain again because of wind or whatever.
> (week eleven)

On this occasion Anna resolved the problem by holding Lauren closely while rocking her backwards and forward until she was calm and ready to feed again.

Like Maria, Anna associated certain foods with colicky babies and therefore avoided eating anything she perceived as falling into this category. When I asked her which foods were likely to cause wind, she replied: "Definitely onions, and cabbage, raw or boiled". I then asked her if she had tried cabbage and she admitted that she hadn't eaten it since being in hospital, but had noticed that Lauren was grizzly after she had eaten onions. When pressed a little further, Anna declared:

> I have been a bit conservative about what I have eaten though. I like to stick to beans and have actually had peas which they say can cause wind. But that doesn't seem to be too bad, peas with mixed vegetables and things.

At this stage (Lauren was five weeks old), Anna was also avoiding cauliflower, tomatoes and lettuce and mentioned that she hadn't been "allowed" things like *milo*, chocolate or chocolate biscuits. Apparently Dave felt these items were not good for his daughter. Anna laughed as she described a recent incident:

> The day we took her to the clinic, I whizzed around the supermarket and grabbed a *Moro* bar each and hopped into the van chomping at the *Moro* bar. Dave grabbed it off me and said, "You are not having that, it is not good for Lauren!"
>
> (week seven)

Rachael

Rachael found that Toni tended to feed three to four hourly for the first month or so, and was often unsettled in the evenings making it difficult to get her down for the night. Rachael first experienced this difficulty while still in hospital, when one evening Toni "played up" from eight to eleven o'clock. Eventually one of the midwives took her to the nursery to settle her. During my first visit following Toni's birth, Rachael mentioned that for the last two nights Toni had been very unsettled:

> She won't settle for an hour or two. The first two nights she played up. In the end I'd go to bed and I would just lie her on my stomach or on my chest and she would be happy with that and would fall asleep. And my husband (he stays up late) he would...wake me up when he came to bed and then I would transfer her to the cot. But we didn't want her to get into the habit of doing that; they very quickly get into habits you see.
>
> (week two)

Rachael was very concerned to avoid practices that would develop into bad habits, even though the measures taken appeared to settle Toni very quickly. In an effort to avoid what she perceived as negative practices, Rachael tried something different:

> We woke her up after three hours and sort of played with her. You know she is quite happy just to look around and play. And then after an hour I fed her and then she stayed up for another hour and I put her to bed. For half an hour or so she grizzled a little bit. Just crying and then she'd stop to listen to hear if you were coming and doing anything, I think...And then she started grizzling a little bit more. That was about three hours [since the last feed] and then I just gave her a top-up of about ten minutes and she went off [to sleep].
>
> (week two)

However, Toni continued to have unsettled evenings and often ended up in bed with Rachael for a short while, this being the only way she would settle. Rachael was often feeling very tired in the evenings and found it difficult when Toni wanted to be wide awake or feeding at short intervals. By five weeks of age, Toni had started to sleep for longer periods at night, but was still proving difficult to settle in the evenings. In contrast with the other mothers in this study, Rachael decided to resolve the problem by complementing breastfeeding with formula on those nights when Toni was difficult to get down.

> I have actually started giving [her] a little bit of formula at night, because [it seems]... like I am trying to feed her almost every hour. She just won't settle down and she always wants to suck....it just seems to top her up and she is happy.
>
> (week five)

Rachael found other advantages associated with complementing Toni with formula:

> She is quite happy for her Dad to feed her that bottle and I can either have a break and sort of stretch out and relax, or get up and go and do things.
>
> (week five)

Rachael mentioned that because she was feeling so tired some evenings she felt that she just didn't have enough breastmilk to feed Toni. There were nights, however, when Toni appeared more settled and satisfied and there was no need to top her up with a bottle at all.

By seven weeks of age, Toni was much more settled and sleeping for longer periods. At about eight weeks, Toni suddenly extended her night's sleep, and Rachael (like Anna) was a little startled by the sudden turn of events:

> Last Friday night she slept seven hours, eight hours on Saturday night and it was about ten hours on Sunday night. I was a bit worried and rang up the Plunket nurse and asked her if it was alright, and she said "Fine, go for it". And ever since it has sort of been six, seven or eight hours, she sleeps at night.
>
> (week eight)

By this stage Toni was also much more settled during the evenings and only occasionally required a bottle. Rachael was now satisfied with her baby's routine:

> Yes, a better routine. More acceptable to Mum and Dad, especially this longer sleeping and easier to put down. That is the main thing. She is easier...You know she will cry but within half an hour she is asleep and in her own bed. It's none of this crying for two hours and then having to give in and put her into bed with us. She is happy to go to bed in her room and go to sleep in her own bed within half an hour. Even her cry is different!
>
> (week eight)

Rachael was now satisfied that Toni had always been a 'windy' baby and that this condition explained some of her more unsettled episodes. Underlying this conclusion was Rachael's observation that when unsettled, Toni could generally be calmed by being walked around, held over Andrew's shoulder. As with the other mothers, Rachael associated some of Toni's bouts of wind with her own diet. For example, when Toni was about four weeks old, she had a series of unsettled evenings, which Rachael 'explained' as follows:

> We are still suffering from my naughty dessert I had the other day. I had tamarillos with an orange sauce. I made it very nicely but it didn't agree with her.
>
> (week four)

At a later interview, she also admitted:

> I can't eat too much yoghurt, it just sort of comes out of this end. I notice she [was]...almost bordering on colic when I made cole slaw and was eating the cabbage.
>
> (week nine)

Popular perceptions of links between what a mother eats and its effect on her baby via breastmilk involves a combination of common sense, scientific knowledge and folk tales. Bottorff and Morse (1990:16), in their study on Canadian mothers, report that:

> ...if their babies were upset, mothers often blamed themselves. It was thought that eating excessive amounts of any particular food, especially 'gassy foods' could 'bother' a baby through breastmilk.

Foods and other products classified as likely to cause wind or colic included coconut, cabbage and onions, green peppers, hot and spicy foods, and chocolate as well as caffeine products.

What is immediately apparent is that the notions of the Canadian women, are very similar to those held by the women in this study. Investigation of the reasons behind

such beliefs is outside the scope of this thesis, but provides an interesting area for future research. What is relevant here is the perceived link between a woman's behaviour (through food consumption) and its effects on her infant. Clearly such beliefs cannot be dismissed as invalid as occasionally evidence of a cause/effect relationship is identifiable and even in the absence of such 'evidence' these beliefs do provide mothers with some sense of control over their infant's behaviour. That such a link is commonly accepted, however, provides fertile ground for guilt and obsessive avoidance of a range of foods, a point noted by Bottorff and Morse(1990:16). Although guilt and excessive avoidance did not appear to be a problem for the women in this study, the point remains that commonly held beliefs about the effect of certain foods on a mother's milk create yet another struggle between the physical functioning of the body and the social construction of this process.

CONCLUSION

The women in this study placed particular emphasis on the physical (and largely negative) aspects of the process of producing milk and suckling their babies. Their focus on the physical process of lactation can be understood through consideration of three factors. The first concerns the *unanticipated* severity and duration of many of the difficulties and discomforts associated with nursing a baby (particularly cracked nipples, overfull, uncomfortable and leaking breasts). A significant example of this phenomenon was evident in Kathy's experience with uncomfortable breasts. This aspect has been noted by Maclean (1990:35), who reports that:

> The physical discomforts of breastfeeding came as a surprise to a lot of women. Their image of a mother nursing peacefully in a rocking chair bore little resemblance to some of the physical sensations and discomforts they experienced during the early weeks of breast feeding. Although comfort alone did not deter women from continuation with breast feeding, it was a significant part of many women's experience.

The second factor that may account for the mothers' highlighting the negative physical aspects of breastfeeding concerns my own background as a breastfeeding counsellor, and in particular the difficulty associated with overcoming unconscious action while conducting research. That is, this emphasis could reflect the observer effect - the fact that informants may structure their responses to meet perceived needs of the interview

situation. As a counsellor my focus was on the physical 'how to' of breastfeeding, drawing on knowledge which is firmly grounded in biomedical notions of physiological functioning. Although La Leche training[7] places considerable emphasis on the social aspects of breastfeeding, problems nevertheless tend to be conceived firstly as physiological and secondly as social in origin. The point here is that my comments and questions during the course of interviewing may have (unintentionally) biased the mothers' responses in the direction of the more problematic aspects of breastfeeding because I was accustomed to trying to identify difficulties associated with nursing a baby.

The third factor concerns the relationship between the body and culture. Breastfeeding as a 'natural' body function is subject to cultural mediation, the social body constraining perception of the physical body (Douglas,1973:93). The biomedical construction of the female body and its reproductive processes has resulted in the medicalisation of childbirth and infant feeding. That is, infant feeding has become redefined as a process requiring the professional guidance and expertise of the medical profession. Van Esterik (1989:121-122) claims the medicalisation of breastfeeding is characterised by the use of medical jargon which:

> ...establishes professional legitimacy and theoretically educates patients about biomedical definition, standards, and understanding of infant feeding. Terms such as "colostrum", "engorgement", and the "insufficient milk syndrome", which are derived from biomedical models, influence the way mothers think about infant feeding.

The result is a new discourse on breastfeeding and the transference of responsibility from mother to health professional. Accompanying this transference is a shift in the perception of breastfeeding to that of a mechanistic process, liable to malfunction and breakdown. Biomedical thinking tends to emphasise expectation of the latter together with the notion of expert intervention, rather than perceiving the range of physical

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[7] La Leche leaders are required to endorse a set of concepts relating to parenting and breastfeeding. These concepts include acknowledgement of the importance and superiority of breastmilk and the relationship between mother and baby; ideals relating to perceptions of the baby's and family needs, nutrition, discipline etc. The point is that although leaders provide mother-to-mother support and information for women seeking assistance, there is an emphasis on a holistic approach to breastfeeding.

sensations and difficulties experienced while breastfeeding as part of the normal spectrum of events. The impact of biomedical dominance (hegemony) was clearly apparent in each mother's separation of the pleasurable, sensory aspects of breastfeeding (such as close skin contact with their babies), from the physiological process of producing milk and suckling their infants.

This chapter also demonstrates that all four mothers had specific expectations regarding the feeding schedules and sleeping routines of their babies. One of the major difficulties associated with these expectations appears to involve the tension created by the gap between anticipated and actual experience. Of the four mothers, Maria's experiences during the early weeks of her baby's life conformed most closely to her actual expectations, but even she commented on the fact that she could no longer "get things done". She undoubtedly perceived that more than just caring for her baby was expected of her.

In addition to the discrepancy between expectation and reality, each mother was subject to contradictions generated from positions occupied within the social field. As women, mothers and breastfeeding mothers they were subjected to a conflict of expectation: a woman in the home is expected to engage in the numerous domestic tasks that require attention; a mother is expected to devote her attention to the needs of her infant and other family members; a breastfeeding mother's production of an adequate milk supply requires frequent suckling of her infant and the absence of marked stress; and the body of a breastfeeding mother is commonly perceived as incompatible with prevailing Western notions of women as sex objects, and so on. The latter contradiction is ably articulated in Parker's (1992:5) comment that:

> ...in our society, breasts are considered quintessentially sexual all year long, but never when a baby's mouth is attached.

The emphasis placed by all the mothers on the importance of attending to other household duties, can be understood as a desire to appear 'productive', efficient and in control. These are values associated with traditional Protestant, Western perceptions of a model housewife and more latterly 'superwoman'. Implicit in the importance

attached to housework is the notion that feeding a baby is not 'real' work. Because breastfeeding generally involves sitting in a comfortable chair, 'cuddling' a baby, it somehow equates with laziness and 'doing nothing'. Such a view reflects predominant Western notions about the productivity and efficient use of time. It projects a cultural construction of the role of housewife and motherhood that conflicts with the physical process of producing milk for an infant. Palmer(1988:86) notes that ethnographic studies have contributed to an awareness that strictly scheduled feeding is a peculiarly Western phenomenon. Citing the example of the !Kung, where mothers and infants are always together, allowing the baby to "help herself at will", Palmer notes that it is not unusual for a !Kung woman to feed her infant for up to forty eight times in twenty four hours, as compared to the average Scottish and American mother's infant feeding frequency of six to eight times per day.

Kathy found the demands of frequent feeding the most difficult to adjust to and this caused her guilt and stress, exacerbating her experience of breast discomfort. However, similar perceptions of guilt and frustration manifested themselves in the comments of the other mothers, these emotions periodically detracting from their enjoyment of the breastfeeding experience and the close contact it provided them with their babies.

Finally, the problem of infant colic, and its perceived association with a mother's diet, created another source of tension for three of the four women. Colic was a condition clearly distressing for the baby, upsetting behaviour and feeding routine, while for the mother it generated feelings of frustration, impotence and guilt. Beliefs linking foods with infant behaviour, although restrictive on the mother's practices, can be understood as providing a limited means of control, via food avoidance strategies. If successful, food avoidance reduces the tension experienced from having an unhappy, unsettled infant.

To conclude, the physical processes involved in breastfeeding a baby must be recognised as converting the mother's body into a site where diverse discourses converge. In other words, the process of breastfeeding involves a struggle between the

demands of physical processes, and the social constructions of this event. The intensity of this struggle varies from woman to woman according to their social positioning.

CHAPTER FIVE
RELATIONSHIPS WITH OTHERS

> ...discussion and encouragement of breast feeding by individuals such as the woman's partner, mother, best friend, family doctor and Plunket nurse are...very important if they serve to allay fears, reduce embarrassment and enhance motivation.
>
> Trlin and Perry (1982:576-577)

A persistent theme during interviews with the four mothers in this study, concerned their relationships with other people. In common with the majority of new mothers, these women were exposed to numerous and varying opinions, advice, folklore and pressures relating to breastfeeding and general baby care. In some situations such advice was timely, supportive and appreciated. However, on a number of occasions these influences proved negative and confusing, undermining the mother's confidence and causing stress, uncertainty and self-doubt. Linked with the theme of relationships with others is the issue of breastfeeding a baby in the company of others - either in a public place or in the company of family and close friends within the home setting. Inevitably such behaviour confronts prevailing social attitudes, values and beliefs, and is associated with personal perceptions relating to what is and is not acceptable embodied practice, the latter varying in accordance with the social experience, lifestyle and immediate circumstances of each mother.

These two closely related themes are the subject of the current chapter, which will attempt to identify and understand meaning generated from each mother's contact with significant others. Accordingly attention will be directed in the following pages to three topic areas. The first concerns each mother's relationship with those individuals (parents, husband, close friends, etc.) perceived as most significant to herself. The second section focuses on the mother's interaction with hospital nurses and especially her local Plunket nurse, an authoritative expert who typically exemplifies biomedical discourse. Finally, the third area of interest is the issue of breastfeeding in public or in the company of significant others.

RELATIONSHIPS WITH RELATIVES AND CLOSE FRIENDS

Kathy

Kathy openly admitted that she was vulnerable to the opinions of others and that these opinions impacted on her own decisions and activities. She frequently experienced tension or stress when she perceived her own practices as incompatible with what others were saying and doing. Fortunately, Kathy enjoyed encouragement and support for her efforts to breastfeed Ben from her husband, midwife and doctor. Her relationship with her parents, particularly her mother, was close, positive and very important to her, intensifying as her parents displayed obvious pride in her ability to nurture Ben. However, these affirming relationships were offset by the unsettling and often negative impact of Kathy's contact with various friends.

As discussed in the previous chapter, a significant aspect of Kathy's breastfeeding experience concerned Ben's tendency to nurse for prolonged periods throughout the day. One of the consequences of Ben's feeding schedule was Kathy's difficulty in coming to terms with what she perceived as "sitting doing nothing all day". Indeed, during my first visit following Ben's birth, Kathy appeared anxious for confirmation that it was "all right that I am sitting here hour after hour?". I suspected that underlying her apparent lack of confidence was a concern about the opinions of others, a suspicion she subsequently verified:

> I just have this thing in the back of my head, that I can hear people saying, "she hasn't got any milk in her breasts for *that* long. You have got to stop feeding so that the breast can make more!"
>
> (week one)

Perceptive and self aware, Kathy acknowledged that she was emotionally vulnerable at this particular stage:

> ...what people are saying seems to matter more, it affects me more...normally I could brush things off and carry on. Maybe [it is] because I am doing something I have never done before, that I am a bit more unsure.
>
> (week one)

About this time Kathy's mother expressed doubts about the time Ben spent at the breast, suggesting that perhaps she was overfeeding her baby. Kathy reassured her

mother that this was not the case, but she subsequently admitted to me that these comments had sown a seed of doubt in her mind: "I wondered myself. I did wonder!" The impact of her mother's remarks were compounded by a further comment that bottle feeding was much easier, because the baby could be propped up with a bottle leaving her free to resume other activities. While Kathy interpreted this remark as indicating a mother's concern for her daughter, it nevertheless reflected her mother's lack of understanding of the importance she placed on being able to breastfeed:

> I am probably a bit hard on Mum. I think that she knows that breastfeeding is best and that's what I am going to do. I am going to breastfeed! But she doesn't understand breastfeeding...that you feed more frequently. I think that she thinks that it's like a bottle feed. Because earlier in the week I had been talking to her and Ben just wanted to suck, suck, suck and I said to her, "Sometimes he sucks so much and so long that I think that is what is making my breasts so sore." You know, I think she thought I shouldn't!
> (week three)

With the exception of these early dissenting remarks, Kathy's mother was generally very supportive and encouraging of her daughter's efforts. For example, after Kathy spent a few days with her parents (when Ben was five weeks old) she recalled:

> She's changed I feel. We really didn't discuss this, [but] I feel that she is changing because I am still getting a lot of discomfort with my breasts, and at one stage I said to her, "Oh I am just quite miserable with these breasts." And she said, "I know you are quite miserable but you know that breastfeeding really is a wonderful thing darling. If you can keep going it really is the best way to go."
> (week six)

Kathy acknowledged that her mother's approval was very important to her and that this remark made her feel really good, about herself and about breastfeeding Ben. She was really encouraged, particularly as she had feared that her mother's attitude towards breastfeeding may have been a critical one.

Kathy's relationship with her mother was in many respects similar to the one I shared with my own mother. Like Kathy, my oldest child was the first grandchild. My mother also came to stay when the baby was born and she had not successfully breastfed either myself or my two sisters. Kathy's experiences triggered a recollection of my intense feelings of desire for my mother's approval of the way I was feeding and caring for my baby. Moreover, these emotions were confused by a recognition that not only had ideas on infant feeding changed since I was a baby, but that my mother was unfamiliar with the 'how to' of breastfeeding. Like Kathy, I too was concerned that my mother wouldn't really understand why I felt breastfeeding to be important. I clearly

remembered the devastating impact that unintended, negatively interpreted remarks had on me, and the confidence and 'glow' I experienced from positive or praising comments. Moreover, I have frequently observed a similar need for maternal approval and support in the first-time mothers I have been involved with as a breastfeeding counsellor. I have often encountered a young mother struggling to breastfeed amidst opposition from her mother, sister, mother-in-law or other close relative or friend and have seen the devastating impact of such a situation.

Dana Raphael, an American anthropologist and one of the first social scientists to write on the social aspects of breastfeeding, has identified the role of a 'doula' as significant in ensuring breastfeeding success. Drawing the term from the ancient Greek, which in Aristotle's time meant slave, Raphael (1976:24) notes that it has evolved to describe:

> ...a woman who goes into the home and assists with the other children, holding the baby and so forth. She might be a neighbor, a relative, or a friend, and she performs her task voluntarily and on a temporary basis.

The significance of a doula is that she is someone who is available to 'mother' the mother, so that the mother is free to focus on her baby. Indeed, Raphael (1976:147) argues that:

> Women need support in order to lactate. In fact if they get such help even failures can be reversed. I doubt that breastfeeding can proceed in our bottle feeding culture without a doula. It would be a rare woman indeed who could manage such a feat, particularly with her first child.

Raphael's point may be a little extreme, although it must be acknowledged that both attitudes towards and the incidence of breastfeeding have changed markedly in the Western world since the mid 1970s. However, it is clear from my own experiences with other mothers, and the women in this study, that the presence of a sympathetic 'other' for support and encouragement is a very important aspect of breastfeeding outcome and success. Raphael argues that for most women the ideal doula is their own mother, believing that for many the mother/daughter relationship is a close and loving association between two people who are significant in each other's lives. In Kathy's case it seems that her mother was indeed fulfilling the role of a doula:

> She is a wonderful mother...You know when Ben cried she said to me, "I think he is hungry". So she makes me sit down and gets me a pillow and you know fluffs over me.

> She's really been more supportive than I thought she was going to be, and not critical at all about how much I feed.
>
> (week six)

Her mother's attitude contrasted sharply with that displayed by some of Kathy's friends and acquaintances. Within a few days of Ben's birth, Kathy faced a constant stream of visitors to her home. She found this tiring and at times awkward, especially if Ben needed feeding. Indeed, Ben's feeding sometimes provoked tactless and unhelpful comments which made Kathy uneasy and upset. For example, when Ben was two weeks old, close friends from another city came to stay for what proved to be a hectic weekend with people calling to see the new baby:

> On Saturday when I had everyone here, another girl I know called in. I felt uncomfortable because I felt I was doing nothing but breastfeeding. I was really conscious of them thinking, "What are you doing, that kid's just eating all weekend!" And Emma [the visiting friend] said at one stage, "Oh he is not still feeding is he?" Ben had only been on the breast for ten minutes at that stage.
>
> (week three)

Kathy admitted that this friend was not the only one to make negative remarks, and that she felt pressured by others who strongly advocated getting their babies into rigid routines quickly from the first weeks of life. These 'superwomen' made Kathy feel totally inadequate, particularly in light of Ben's early day-time feeding pattern. When I asked Kathy to describe the type of routine these women were advocating, she replied:

> Well one of them got her baby into a routine on day one. She's a runner and she has got to have time for [herself] and that's it. She gets up in the morning, goes for a run and feeds the baby when she gets home. Goes to the gym, comes home at lunch time and feeds the baby, and then she has got the afternoon. Another one of them is breastfeeding, and she manages to go out to morning teas!
>
> (week three)

These women, however, were not first time mothers; in fact, Kathy's runner friend was feeding her third baby. The following week, Kathy was still feeling unsettled by the number of visitors and the comments they were passing:

> I hate all these visitors coming with babies. One has...got a seven week old and she said, "Well I get my babies in a routine as soon as I go home." And I thought, "That's nice!" Her babies are fed for four minutes on the breast and that's that, because that's all the baby wants. I couldn't tell her that I can feed for hours!
>
> (week four)

Kathy acknowledged that comments such as those quoted above were undermining her confidence in the way she was breastfeeding and causing her to question if she was doing something wrong. She reiterated that she was always affected by what others thought, and was having to remind herself that as a Practice nurse she had constantly cautioned new mothers to disregard the opinions of others. Although she recognised what was happening, she nevertheless felt unable to avoid being affected, "just like any other normal person", despite her professional background. Moreover, Kathy was aware that her background as a Practice nurse was a significant element in her reactions to the opinions of others:

> ...I want people to see that I am doing well because I know what I am doing. You know like I should know what I am doing. All these best friends of mine that do have these wonderful perfect babies, I don't want them to see me like this.
>
> (week four)

Yet again Kathy was alluding to the experience of tension arising from: expectations based on her knowledge and expertise as a Practice nurse; the reality of events experienced as a breastfeeding mother; and the presumptions of others constructed through diverse discourse shaped practices. Kathy's strategy of allowing Ben to dictate the daily feeding schedule clearly deviated from and placed her at variance with the expectations, practices and lifestyle of many of her friends.

The tension Kathy experienced from Ben's 'unconventional' feeding pattern was compounded by her 'failure' to conform to a number of conventions specified for a housewife, mother, daughter and friend within the social space she normally occupied. A clear example was evident during my third visit when a friend telephoned and invited Kathy and Robert to a dinner party the following weekend. Kathy accepted the invitation but afterwards confided she was worried that she might end up sitting at the table feeding Ben all night. Although Kathy felt her friend and hostess would be understanding (her friend had been "completely out of society" for three years meeting her own children's needs), she was also aware that others present at the dinner party would not be so tolerant. The point here is that Kathy was simultaneously attempting to conform to two overlapping but conflicting discourses; the first, defining her role as a woman, friend and housewife; and the second, her venture into an alternative strategy

of infant care and feeding. The result was uncertainty, anxiety and a need for positive affirmation that Ben's feeding pattern was indeed 'normal'.

Maria

Maria's most significant relationships with other people involved her immediate family and her friend Margaret. Her parents were very supportive and encouraging, particularly during the first few weeks of having a new baby in the household. For example, Maria mentioned that after Rose's early morning feed her parents would often take the baby into bed with them for an hour or so, allowing her some extra sleep. On other occasions, if Rose was unsettled after her early morning feed, Maria's father would get up and take his granddaughter out to the kitchen. He was really helpful in caring for Rose, and when home for lunch would pick her up, talk to her, and play with her. He would also change her nappy if necessary. I was impressed by his gentleness and pride, and noted a similar attitude in Maria's mother who was very patient, confident and caring in her relationship with both her daughter and granddaughter. It was obvious that Maria's home situation provided her with reassurance and help in caring for, and breastfeeding her baby.

Maria primarily depended on her mother for help and advice when Rose was upset or distressed with colic, or when she herself was feeling tired or unsure about some aspect of caring for her baby. Like Kathy, it was important to Maria that her mother displayed obvious pride over the way she was coping. For example, her mother frequently remarked to myself and others how well her daughter was doing, stating she had always been confident things would work out that way. Maria was aware of and appreciated such comments.

That said, Maria was also aware there were certain baby rearing practices her mother disapproved of and which occasionally caused some minor tensions. The most significant of these points of difference was her mother's belief that taking a baby into your own bed at night would develop into a habit difficult to break. Maria enjoyed having Rose sleep with her, particularly when she was unsettled, as it allowed her to doze off while feeding her baby. She disagreed with her mother's reasoning, believing

that babies were unable to know right from wrong and it was, therefore, impossible to spoil a baby. In the event, Maria sometimes took Rose to bed with her, usually when all other attempts to settle her had failed. Clearly Maria was influenced by her mother's opinion and anxious not to upset or spoil their close, relaxed relationship; at times this placed a constraint on her practices.

Maria's friend Margaret, the other significant person in her life at this time, was also a single mother whom she met while attending hospital antenatal classes for single women. Margaret's baby was a month older than Rose and was breastfed for only four weeks. Margaret found being a mother stressful, difficult and demanding. Her daughter Nina was a very unsettled, wakeful baby that cried during the day, was having problems tolerating infant formula, and tended to be frail, sickly and slow to thrive. Maria's visibly relaxed personality and obvious enjoyment of her placid, plump and bonny baby presented a marked contrast with her friend's circumstances.

Maria frequently expressed concern for Nina, commenting on deficiencies in Margaret's mothering practices, which she constantly compared with her own. She believed that she was much more patient than her friend with both babies, noting:

> Nina is such a difficult child...[but] the thing is that I have got much more patience with her. It doesn't worry me. I can spend ages with her and I do when I go to Margaret's.
> (week seven)

Maria was also concerned that Nina, unlike Rose, did not get enough stimulation:

> The thing is that Nina is nearly four months old and Margaret always tries to put her back to bed! She never puts her on the floor [to kick]. Well I tell her but she says, "Oh no she is tired. Look how pale she is"....she will have her up but she won't put her on the floor...no stimulation! But she doesn't listen.
> (week ten)

The difference between her healthy thriving daughter and Margaret's much frailer infant was largely attributed by Maria to the fact that she was breastfeeding Rose. She firmly believed that breastfeeding ensured a beneficial closer physical contact with her baby and immunity from many illnesses. Illustrating her view with reference to Nina's less robust constitution, Maria commented that when Rose caught a cold from Nina:

> It was nowhere near as bad [as Nina's]...she has got better immunity because she is breastfed. But Nina just picks up anything and she is so little!
>
> (week eight)

Moreover, Maria recognised that as a single mother, dependent on a benefit, breast-feeding provided a much cheaper alternative to formula feeding, particularly as Nina's intolerance to formula called for much more expensive soya milk.

The significance of Maria's friendship with Margaret was twofold, involving: first, her recognition of common experience arising from their social positioning as young, single mothers; and second, her awareness of the differences between herself and Margaret as new mothers. The latter, marked by comparison of the physical progress of the two babies, provided Maria with a means of positive self assessment as a breastfeeding mother. It affirmed her sense of success in her ability to nurture and care for Rose, and reinforced her belief that breastfeeding was indeed providing Rose with the 'best' start in life. Maria's friendship with Margaret accordingly reinforced her self-confidence and self-perception as a successful breastfeeding mother, both important aspects of her breastfeeding experience (without any apparent negative effect on Margaret).

Anna

Anna appeared the most self-reliant of all the mothers in this study. Although she had a wide circle of friends, she did not seem to require close or frequent contact with a particular friend or group, preferring to seek support and help from her husband (Dave) and immediate family.

Dave took leave from work to help Anna during her first two weeks at home after Lauren's birth. Throughout this period, Dave recognised that much of Anna's time was taken up with feeding and attending to the new baby and was anxious to help in any possible way. He was encouraging of Anna's efforts to breastfeed Lauren, recognising that this was important to his wife.

During Lauren's very unsettled period at around six weeks, Anna mentioned that she felt pressured by Dave if she was unable to identify the reason underlying this unsettled

behaviour. She also recognised that Dave sometimes found the demands of a baby frustrating, even though Lauren's birth had had less impact on his lifestyle than her own:

> ...I think he has been able to more or less go back to his life as it was before. You know, he [can] go out and work on his motor bike in the shed if he wants to, and...just come back in if he wants to check that I don't need extra help or that she is not getting too upset.
>
> (week six)

Sometimes, quite unintentionally, Dave's concern and comments undermined Anna's self-confidence. Ultimately, however, she relied on her own judgement and instincts about how to manage her new baby. She appeared to handle this responsibility very well, being a calm, practical person who would not be pushed into hasty or rash decisions. But, on those occasions when Lauren really did get upset, such as the difficult afternoon she had at about four weeks of age (see previous chapter), it was Dave to whom Anna turned for support and practical help.

Unlike Kathy, Anna did not feel pressured by the opinions and advice of other people. When I asked how she coped in situations where someone was urging her to adopt a particular practice, she replied:

> I just say "Yes" at the time and I think about it. But I find that a lot of the time I go to a book and read up on what the book says on it...if it is reinforced in a book, then you know that it is worth trying.
>
> (week four)

Only a couple of weeks after this comment was made, Anna remarked that she had put all the books away because they were contributing to her confusion from conflicting advice she was receiving. At this stage she was feeling pressure from the Plunket nurse and various acquaintances about the fact that Lauren wasn't sleeping through the night and didn't have a rigid day-time routine. Furthermore, like Kathy and Maria, she was beginning to perceive that she "was not getting things done". She acknowledged also that:

> ...sometimes different pieces of advice have turned out to be not appropriate. Or perhaps it is not advice, it is just reassurance and support that I've needed more than anything else.
>
> (week six)

Anna's source of reassurance was her husband, and his brothers' wives, with whom she enjoyed fairly close contact. For example, when Lauren was very unsettled at around six weeks, Anna approached one of her sisters-in-law about the problem. Although this relative had not been through an identical situation, she found her sympathetic and supportive:

> I think she was actually impressed that I have carried on despite all the problems I was having!
>
> (week six)

The fact that she had relatives who lived close-by meant that Anna always had someone trustworthy to talk things over with, when she felt the need for advice and/or reassurance. She obviously found this contact encouraging but nevertheless relied mainly on her own resources when it came to decisions relating to breastfeeding Lauren.

Anna's self-reliance and the relative absence of pressure and conflicting advice from others can be interpreted as reflecting two distinct factors. The first factor, in relation to her self-reliance, was Anna's personality - calm, practical, and self-confident. My impression was that these qualities were developed and reinforced by her farming childhood, where such attributes were regarded as necessary aspects of the lifestyle. Indeed, Anna several times mentioned how her knowledge of farm animals tending their young had confirmed that her own reaction to a situation with Lauren was along the right lines. The second factor, in relation to the relative lack of pressure and conflicting advice, was the status of breastfeeding as the norm in Dave's family. This norm fostered understanding, consideration, encouragement and constructive advice rather than criticism when Anna needed help and support. Moreover, unlike Kathy's friends, Dave's relations appeared to lead lifestyles more compatible with the demands of a new baby and an irregular feeding schedule. The result was that Anna faced minimal conflict and tension from her interaction with family and friends, and the negative impact of others was therefore not as significant as it was for Kathy.

Rachael

The people who were most significant to Rachael while breastfeeding were her husband (Andrew), parents and antenatal support group. Like Dave, Andrew also took leave from work to be at home with his wife and baby for their first week at home.

Rachael enjoyed close and almost daily contact with her parents in Palmerston North. Her mother was very anxious to help and during Rachael's first weeks at home visited most days to allow her to rest, or help with the household chores. When it came to giving advice about baby rearing and feeding, however, Rachael was quick to explain that her mother felt out of touch with modern trends and was therefore hesitant to give advice. I asked Rachael if her mother encouraged her to breastfeed, and she replied:

> She is not pro-bottle, but she is just as happy to say to me, "Do whatever you feel comfortable with". She just leaves it up to me. I think she realises that...ideas have changed since [I was born].
>
> (week two)

On the other hand, Rachael's mother (like Maria's), did express concern over the practice of sleeping with a young baby, even if it was a successful way of calming Toni when she was unsettled during the early weeks:

> My Mum and other people [told me it was] a bad habit, I would just lie [Toni] on my stomach and she'd be happy with that and fall asleep. And my husband would wake me up when he came to bed and then I would transfer her to the cot.
>
> (week two)

This appeared to be one of the few occasions when Rachael's mother did express an opinion about her daughter's practices. Clearly this particular episode affected Rachael, who became anxious to avoid getting into what she now perceived as a "bad habit".

Rachael's relationship with her mother, like Kathy's and Maria's, involved the help and support associated with an individual fulfilling a doula role:

> ...she comes around every second day for an hour or two. She likes to know what is happening. She wants me to ring her everyday and let her know what I have done. So it is quite good.
>
> (week two)

In contrast to Kathy and Maria, however, Rachael did not appear to require her mother's complete approval for all her mothering practices. Underlying this difference was Rachael's perception of a distinct shift in the discourse on motherhood since her own mother's time of infant rearing. This belief created the space for Rachael to gain confidence in her own baby care ideas and practices, which were greatly influenced by those of her antenatal group. Rachael's construction of herself as a mother was thus shaped by confidence in the current and 'up-dated' knowledge she acquired through antenatal education and the baby care books she had access to, a field of discourse she perceived her mother to be out of touch with.

Rachael kept in contact with many friends and work colleagues. The most important of these were other first-time mothers in her antenatal support group. She really enjoyed the regular contact she had with this group of about ten women and tried not to miss their weekly meetings. These meetings took the form of informal gatherings, and provided the new mothers with an opportunity to discuss and compare their experiences and the progress and routines of their babies. I asked Rachael why the group was important to her:

> It is not supportive in terms of the breastfeeding, but it is in terms of the mothering and how you are all feeling. As a group we just chat.
>
> (week four)

Initially all the mothers in this group were breastfeeding their babies, but as time went by a couple of them began complementing with formula. Rachael's decision to 'top-up' Toni with a bottle on her more unsettled nights was therefore in keeping with the practices of some antenatal group mothers, and reinforced by the practice of a number of Andrew's friends:

> We know of two other people. They are actually topping up their babies at night. They found a similar thing; they wouldn't settle down, they were grizzly and it seemed that for ever they wanted more feed and Mum didn't have enough. It [formula 'top-up'] settles them down a lot quicker.
>
> (week five)

The influence of the antenatal group was again evident in Rachael's description of their Christmas barbecue:

> It was quite good because all the dads were outside cooking the tea and all us girls and babies were inside. When it was time to eat, all the babies were taken out to the dads so that all the mums could eat first. All the babies are still breastfeeding. A couple of the mothers are even starting to introduce solids every so often! I wasn't going to think about solids for at least another couple of months.
>
> (week fourteen)

Membership of the antenatal group was obviously an important source of friendship, support and information for Rachael. The group influenced and endorsed her practices as a first-time mother, and provided her with a comfortable, secure way to compare Toni's development. Rachael's location in this group of people sharing similar ideas and practices eliminated the possibility of tensions created by conflicting discourses and contributed to her confidence and enjoyment of motherhood. That this group presented a relaxed and flexible attitude towards breastfeeding, and focused on the developmental aspects of the baby's progress, was entirely commensurate with Rachael's outlook on breastfeeding and motherhood.

RELATIONSHIPS WITH HOSPITAL NURSES AND THE PLUNKET NURSE

An important aspect of relationships with others involved each mother's interaction with hospital nurses and/or regular contact with her Plunket nurse. The experience of the mother with these health professionals varied from very successful and supportive for Maria, to unsatisfactory and stress provoking for Kathy.

Kathy

Kathy's home birth effectively limited her interaction with health professionals to contacts with her midwife, doctor and especially her local Plunket nurse. Her relationship with the latter ultimately proved to be the most difficult of all her contacts with others while nursing Ben. Kathy recognised the Plunket nurse as a fellow professional, an adviser, an authority in her field, a person whose experience and judgement should be heeded. Unfortunately, the outcome of this contact was an undermining, rather than an enhancement of Kathy's self-confidence as a mother. The key to this situation was Kathy's informed questioning (as a Practice nurse and mother) of the Plunket nurse's professional knowledge and advice which at times she disregarded with an accompanying sense of guilt.

Kathy's contact with the Plunket nurse involved the usual home visits until Ben was about two months old. Although feeling that she had little need of the services of the Plunket nurse, because of her close links with the medical practice and her midwife, she nevertheless adhered to the New Zealand tradition of being under Plunket care. The most emphasised aspect of these visits was Ben's weight gain, a factor the nurse apparently perceived as the ultimate indicator of his progress.

Kathy first made reference to the Plunket visits when Ben was three weeks old:

> The Plunket nurse comes again this afternoon. She came last Monday and she weighed him and actually got less than Pat [Kathy's midwife] had got the week before! But that didn't worry me because I know that he has put weight on [some of his clothes no longer fit] and [they used] different scales. And Pat weighed him with his clothes on whereas the Plunket nurse weighed him with his clothes off. It will be interesting today because she is going to weigh him again.
>
> (week three)

As it turned out, the Plunket nurse seemed reasonably satisfied with Ben's progress until he reached eight weeks of age. At this point Ben was in a period of being rather unsettled, feeding frequently during the day, although he still slept for extended periods at night. I was visiting Kathy when the nurse called for Ben's check. On arrival, she complemented Kathy on her beautiful baby, remarking how bonny and healthy he appeared, and passed positive comments about his long periods of sleep at night. Once she had weighed Ben, however, her attitude towards his progress became negative and was accompanied by expressions of concern about his weight gain, which she perceived as being on "the low side". The nurse felt that Kathy was probably feeding Ben for periods that were too extended and therefore recommended that each feed be confined to a maximum of fifteen minutes followed by a top-up after a ten to fifteen minute break.

Underlying this recommended strategy was a concern about Kathy getting a proper let-down, which the nurse felt was more likely to occur when there was an interval between feeds. A let-down involves the release of the hormone oxytocin triggering a contraction of the milk producing cells in the breast. This releases 'hind-milk' which is higher in fat and protein content and therefore is more satisfying and nourishing to the infant than

the milk which has accumulated in the reservoir behind the nipple between feeds. 'Fore-milk' has a high carbohydrate but low fat and protein content. Consequently a baby getting only fore-milk does not thrive and gain weight as readily as the baby feeding regularly on hind-milk.

After the Plunket nurse left, Kathy admitted she was not unduly worried about the comments made, noting Ben was generally a happy, settled and growing baby. Yet it was clear that the nurse's comments had introduced an element of doubt into Kathy's mind causing her to feel anxious and slightly angry. The latter emotions were apparent in our subsequent conversation during which Kathy constantly sought reassurance that her baby was indeed healthy, well and growing. She also mentioned a course of medication she was taking, concerned that it might be affecting her milk:

> ...he was feeding so much the last two days. I wondered if he was hungry because of that [medication], even though I seemed to have lots of liquid there!
>
> (week eight)

For Kathy this Plunket visit signalled the beginning of a period of upheaval and self-doubt initiated by the nurse's focus on weight gain as the most significant indicator of a baby's progress. It should be noted here that the nurse's comments in Kathy's Plunket book gave little indication of a professional concern over the baby's weight gain.

While the nurse was visiting I asked her why she felt that weight gain was such a significant indicator of a baby's progress, when there were a number of other very tangible signs? Her response was to remind me that the research of (Auckland doctor) Shirley Tonkin had identified a link between low or slow weight gain and cot death. It appeared to me that this nurse perceived the link as a direct relationship, rather than as one of a number of correlates. She saw it as her role to eliminate, as far as possible, this risk factor.

My presence at this Plunket visit produced a sense of d'eja' vu as a mother and breastfeeding counsellor. As a breastfeeding mother, my first baby (Matthew) had a slow weight gain, progressing in a relatively steady but unspectacular manner. This pattern caused my Plunket nurse much concern and ultimately led me to wean him at three months of age - a change which had little impact on his weight as it continued to remain below the 'normal' line on the Plunket graph. I remembered well the feeling of self-doubt, a feeling mixed with skepticism and antagonism for a nurse who apparently failed to notice that my baby was happy and thriving in all other ways.

In my role as a La Leche Leader I frequently encountered similar situations with mothers who had confidently perceived their babies as happy, contented and thriving until a Plunket visit identified a weight gain falling below the 'average' line on the graph. The usual devastating outcome of such a visit and report on a new mother is self-doubt, confusion (everything appeared to be going so well), and a sense of anger and frustration, coupled with a feeling of guilt about what she was (unintentionally) doing to her baby.

The emphasis on weight gain graphs as tangible evidence of an infant's 'progress', exemplifies a hegemonic biomedical construction of the body and health. The narrow focus on a statistical norm overlooks a wide range of other signs perceived by mothers as equal indicators of their infant's progress. No longer is a mother's assessment of her baby's development considered valid. Instead, it is reconstructed as requiring 'expert' evaluation and transformed into lines on a chart. In other words, infant progress has become medicalised. Failure to conform to the predetermined norm then requires intervention in the form of advice and remedial strategies. Although many mothers may question the narrow focus on weight gain, to ignore it creates tension and conflict through their ingrained acceptance of the validity of biomedical knowledge. Failure to conform to this authoritative advice is perceived as possibly placing an infant at risk of a number of biomedically identified outcomes, including that of cot death.

My next meeting with Kathy, occurred before the Plunket nurse's return visit. I found her feeling confident and relaxed, not only about Ben's progress but also her own health. She now recognised that she had been much more concerned than she realised about the course of medication she was undergoing. She was sure that the medication had interfered with her milk supply and ability to let-down. As a measure of her concern, she had discussed her physical condition with a couple of very close friends, who had reassured her, providing an outlet for imagined fears. Consequently, Kathy felt less "up-tight" and more relaxed about the treatment programme. Not surprisingly, Ben was also more settled and although he had been feeding very frequently over the weekend, he was nevertheless happy and contented:

> ..that's just us now. He doesn't have feeds, he just grazes the whole time! Like when that Plunket nurse said can we fit in an extra feed, [well] you can't because he is just always feeding.
>
> (week nine)

Kathy's comments appeared to indicate that she was not following the Plunket nurse's idea of restricting a feed to fifteen minutes maximum, followed by a gap and then another feed if necessary, and I asked her if this was in fact the case. Kathy replied:

> I tried to do that at the beginning. Feed for ten minutes, but ten minutes isn't enough for him. After ten minutes I'd take him off and he was cross and wanted more, and I know now that is what he wants. He is hungry and wants more, so there is no point in taking him off!
>
> (week nine)

She also noted once again her breasts were leaking and aching, indicating that her supply was on the increase.

A few days later, Kathy was again visited by the Plunket nurse. She described this encounter as follows:

> Well she came and weighed him and I was *so* confident. I thought, "Silly woman has to come back if she wants to. It doesn't matter!" She weighed him and I said, "How much?", and she said, "Well, he hasn't really put on any significant amount." And I said, "Well how much exactly?" And he had put on 25 grammes, which is just under two ounces! I said, "Oh! How much is he meant to put on? Eight ounces?"

Kathy described the nurse's finding as "shattering"; she had been so confident that Ben was progressing well:

> I just couldn't believe that he hadn't put on much weight! And she seemed to think that it was quite serious. She was very good though...She didn't scare me...but she did say that what she wanted me to try and do this week was, to put on some more weight for Ben.

At this point Kathy told the nurse about her medication, explaining that it may have reduced her supply although it now appeared to be increasing again. The nurse agreed with her assessment, suggesting that over the next week Kathy feed Ben for a maximum of ten minutes each side, followed by a top-up of fifty mils of expressed breast milk or formula if breastmilk was unavailable. Kathy recalled that at the time she didn't perceive this suggestion as a problem. She was confident she could easily fulfil the nurse's request as she had a supply of frozen expressed milk and could resort to formula if all else failed.

Kathy's optimism was short-lived. Her supply of frozen breast milk ran out after a couple of days and her life developed into a continuous round of expressing milk and feeding Ben. The nurse's instructions were to express her milk an hour and a half after a feed. Kathy found that this proved impossible:

> I thought that sounds very good on paper but in actual fact what Ben has been doing is feeding every hour and a half! I just get to go and express the milk and he wants a feed and I'll feed him and then I [can't] express any more off because she told me to wait [for] an hour and a half!
>
> (week ten)

Where was the advantage of feeding Ben expressed milk, as opposed to him taking it direct from the breast? Kathy's response to my question conveyed her confusion and frustration:

> I don't know! I don't know! This is what I have been trying to work out. I didn't know if I could express [milk] after a feed, before a feed, when to do it. And then I couldn't express [any milk] anyway.
>
> On Sunday afternoon I was standing at the bench, because sometimes when I finally get something out of one breast the other drips. So I thought I'll catch that as well. I didn't have enough hands, and then I turned around and [having expressed forty mils] spilt it! I burst into tears, you know it was [literally] like crying over spilt milk!
>
> ...Ben was crying because he wanted a feed and I was busy up there expressing it to give to him! I kept thinking I must be doing something wrong.
>
> (week ten)

The following morning Kathy's friend Pat, the midwife, rang to see if Kathy wanted to go for a walk after she had fed Ben. Kathy would have loved to, but said she couldn't fit it in between feeding and expressing milk. Pat was puzzled, and asked for an explanation:

> ...I said that the Plunket nurse told me to feed him fifty mils. Pat said, "Oh shit! I'll be right round".
>
> (week ten)

Kathy admitted that by this stage she was so overwrought she couldn't think straight and had lost confidence in her own judgement. Pat advised her to ignore the Plunket nurse's advice, commenting that she herself couldn't see any advantage to be gained from it.

Despite Pat's reaction, Kathy decided to continue complementing Ben with her expressed milk until the nurse's next visit. Quite simply, Kathy was reluctant to ignore the nurse's advice out of fear of the consequences for Ben. As a first-time mother, she recognised the authority and knowledge of a Plunket nurse, even though she questioned this nurse's logic and judgement and was aware of her own professional expertise.

Reflecting back on the trauma of the previous few days, Kathy made three important observations. The first related to a question posed by her midwife. Pat asked Kathy what course of action she would have taken if the nurse hadn't called and offered the advice in the first place. Kathy indicated she would probably have carried on as before, because she felt everything was progressing very well. Her own judgement, in other words, was basically sound. The second observation involved her thoughts following the nurse's visit, particularly her new understanding of the behaviour of some mothers:

> ...I kept wondering, "Maybe I have got milk there but it is just like water! Maybe it is not good enough. Maybe he *needs* formula!" I was really having my doubts. I understand now why women think they haven't got enough milk and why they go out and buy formula!
>
> (week ten)

Finally, there came the realisation that she really wanted to continue breastfeeding:

> It was really interesting when it came down to the crunch! When [the Plunket nurse] suggested that I go out and buy some *Nurture* formula, it's amazing how I reacted. Suddenly, "Oh, no! Breastfeeding is *really* important". But then I said to Pat, "If he doesn't put on any weight, then I will go out and get some *Nurture*". But today I feel even more that I don't want to.
>
> (week ten)

In fact, Kathy had decided that she would continue to breastfeed Ben. She now realised that he was not going to have impressive weight gains, but she also knew that he was "doing marvelously well". Ben continued to thrive, albeit not according to the Plunket graph line, and was breastfed well into his second year of life. Kathy's resolution of the tension she experienced between her own assessment and the Plunket nurse's assessment of Ben's progress and strategy for improvement, is linked to the three observations detailed above. The significance of these observations is that they

indicate: that Kathy had worked through the conflict and determined the strategies she held as important; and that she was gaining confidence in her own judgement and assessment of Ben's progress.

Maria

Maria's relationship with health professionals, unlike Kathy's, were uneventful and unproblematic. Indeed, her experiences with both the hospital maternity staff and the Plunket nurse were positive and affirming. The hospital nurses were helpful and supportive, enabling her to establish with confidence the process of breastfeeding, while the Plunket nurse (whom Maria liked) proved to be a source of encouragement, information and support.

On the occasion of her first visit, the Plunket nurse (the same one who visited Kathy) expressed satisfaction over Rose's weight gain (which had exceeded her birth weight), noting in the record book that she was a "lovely babe, progressing well". Rose continued to make rapid weight gains and looked strong and robust, a combination of the very qualities that conformed to the nurse's criteria for a healthy, thriving infant. For Maria, therefore, the Plunket visits were an important endorsement of her success as a breastfeeding mother, and something she looked forward to.

Maria's positive experience with her Plunket nurse can be readily explained and understood. First, her baby (unlike Kathy's) conformed to the nurse's ideal of substantial, weekly weight gains as a sign of a thriving baby. Thus her relationship with the nurse was positive and affirming. Minchin(1985:214) noted a similar phenomenon among Australian mothers, where an infant's progress is checked by a clinic sister:

> ...many women found it utterly intimidating to subject themselves to the scrutiny of the clinic sister when things were not going well with the baby. If the baby was cheerful and thriving, her authority gave the mother an official stamp of approval, bolstering her confidence. If the baby was not thriving, her questions usually implied that the fault was the mother's.

A second factor was Maria's relative youth and inexperience (as compared with the other mothers) which may have contributed to her willing and often unquestioning

acceptance of the nurse as an authority on infant rearing. Finally, Maria was never in a situation of conflict over Rose's progress. For example, Maria was adamant in her personal opposition to the use of formula and fortunate that she never had to consider this option with Rose.

Anna

While in the maternity hospital, Anna was subjected to a situation of conflicting advice from various members of the nursing staff. As a result she become confused, unsure of what to do. A lack of communication between the various levels and types of nursing staff appeared to contribute to this problem:

> There were three different Charge nurses and Enrolled nurses. There were also Polytechnic nurses and their tutors floating around. So occasionally you would get two [sic] lots of advice from the Charge, Enrolled and the tutor ones.

Moreover, when her breasts were painfully overfull and she found it difficult to get Lauren attached, Anna experienced marked differences in the quality of assistance provided:

> ...there was one lady there, I think she may have been a tutor, and she was excellent. I felt that she explained things better. Whereas the others...I [often] felt that they probably weren't interested in watching the mother and the baby to see what was happening between the two of them. They would just say, "You need to do this," and they would take your breast and shove the baby's head on!

Dave, Anna's husband also commented on the situation in the hospital, remarking that because the staff were medical professionals both he and Anna felt obliged to heed their advice. Nevertheless Anna, though well aware of her inexperience and lack of knowledge, recognised the new mother's need to engage in a process of trial and error, a process that apparently led her to an important decision:

> ...because we were all novice mothers, we felt that what you were doing perhaps hadn't worked quite right. So you tried a new idea, to see if it worked better, with a view to perhaps going back to what you were doing before if it didn't work out. I came to the conclusion that they [some of the maternity nursing staff] were so dictatorial that I would do what they wanted until they went off their shift, and then I would go back to doing what I was [doing] before.

Anna's experience with the maternity hospital nurses can be understood in terms of her positioning within biomedical discourse as a new mother, woman and patient. Martin (1987:172) argues that dominant biomedical metaphors of the female body serve to fragment a woman's body from acts of femaleness (such as suckling an infant), and alienate the conscious self from the physical realm of body experience. Anna's comments regarding the way the nursing staff handled her breasts and the baby's head while attempting to attach Lauren at her breast, together with her perception of some nurses as dictatorial and not particularly interested in watching what the mothers were doing, highlight the dualistic nature of biomedical thought. As the dominant actors within the immediate situation, the maternity staff had defined Anna as a new mother - that is, one who lacked sufficient knowledge and experience on how to breastfeed her baby. Such a definition, of course, positions the nursing staff as the 'experts', possessing specialised knowledge which empowers them to dictate practice.

Anna's positioning during her hospital experience resulted in a situation where her own practices and desired strategies (defined by the dominant discourse as 'novice') were constrained by, and at times incompatible with, the knowledge of the 'experts'. Anna's comment that she adhered to recommended practices only while the individual concerned remained on duty, signals her reluctance to accept this construction of self. That is, Anna demonstrated that although her practices were *constrained* by the dominant discourse they were not *determined* by it. By resorting to strategies she perceived as most compatible with her perception of the situation, Anna was able to retain a sense of independence and autonomy.

Contact with the local Plunket nurse (not the same as the one visiting Kathy and Maria) was more complex than Maria's experience. During her first few weeks, baby Lauren progressed well and the nurse's visits served to confirm and endorse her progress. When, at about six weeks of age, Lauren went through a very unsettled period, the nurse suggested complementing breastfeeding with formula, a suggestion that Anna was very unhappy with and didn't heed. Anna also expressed dissatisfaction over the nurse confusing her name and Lauren's progress on two separate occasions. These

slip-ups seemed to indicate a certain lack of interest from a person who, in addition to her professional role, was also a distant relative.

The Plunket nurse's advice on coping with Lauren's wind problem was very helpful:

> The hints the Plunket nurse has given me I have used. Such as using the wind mixture. That helped because she gave bigger burps and soon afterwards. She recommended an elixir saying if she was extra windy...you [could] give it to her before a feed.
> (week four)

However, Anna did experience subtle pressure from the nurse regarding Lauren's feeding routine and duration of sleep at night. For example, when Lauren was unsettled and reverted to a two hourly feeding routine at around five or six weeks, Anna thought it was a 'growth spurt'.[1] Although the nurse had cautioned Anna to the possibility of Lauren going through a growth spurt around this time, on this occasion she attributed Lauren's feeding change to "snacking" instead of feeding properly. The nurse's interpretation was that Lauren was hungry, and she suggested a formula complement.

Anna expressed real dissatisfaction with the nurse's assessment, arguing that she had failed to consider three important factors. First, that she had an obviously abundant milk supply; "I told the nurse that it is squirting out between feeds". Second, Lauren had marked weight gains. Third, the nurse's solution of getting Lauren to drink more was something Anna had been unsuccessfully attempting to do. In other words, at the time when Anna was finding the change in Lauren's daily routine particularly demanding and tiring, the nurse's assessment added to the tensions already being experienced. Moreover, the nurse's comments reinforced Anna's perception that she was unable to "get anything done", therefore adding to a subtle pressure to establish Lauren in a firm feeding and sleeping routine.

Anna's recognition of the authority of the Plunket nurse was evident during her first visit to the Plunket rooms (the nurse was no longer home visiting):

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[1] Growth or frequency spurts occur in most breastfed babies at around six and twelve weeks of age. At these times the growing infant's needs outstrip the mother's supply. The result is a dramatic increase in the number of feeds over a two to three day period, the extra sucking stimulation ensuring that the supply of milk increases.

> I was so thrilled about [Lauren] sleeping through the night that I raced in and that was the first thing I said to her. She thought that was really good [and also] that I [had] got her on a four hour [feeding] schedule. She [thought that was] a good schedule to keep to. She said to me just before I left, "Oh I think that you can cope for a fortnight, so we will see you in a fortnight".
>
> (week nine)

On reflection, Anna felt that Lauren had crossed the line from being a newborn to being a "settled" baby. She clearly perceived the nurse's comments as "very supportive" and as bestowing 'official' approval on her success as a breastfeeding mother.

A few weeks later (when Lauren was twelve weeks old), Anna reported that during her most recent Plunket visit she had been presented with information on the introduction of solids and weaning. A little taken aback by this development, Anna said she hadn't even considered such a move or given thought as to how long she intended to breastfeed Lauren. The nurse alerted her to signs that could indicate Lauren was indeed ready for solid food. In the absence of any of these signs, Anna was reassured that Lauren was not yet at this stage.

To sum up, there seem to be two general points concerning Anna's relationship with the Plunket nurse. First, on some occasions the nurse's advice served to support and affirm success as a breastfeeding mother, while on others it conflicted with Anna's assessment of the situation. Second, the nurse was certainly an important source of information regarding management of Lauren's colic problem (and perhaps the issue of introducing solids and weaning) but she also contributed to Anna's frustration and tension over Lauren's feeding and sleeping routine. On balance, therefore, Anna's experience with health professionals (hospital staff and Plunket nurse) places her approximately midway between the extremes of Kathy and Maria.

Rachael

Rachael's maternity hospital experience was generally a positive one, although like Anna she experienced some confusion from conflicting and/or inconsistent advice. She had difficulty getting Toni attached to an inverted nipple and found that some of the hospital staff (and one nurse in particular) were more effective than others in helping

her to overcome this problem. According to Rachael, an important element underlying the variation in the consistency and effectiveness of advice was the intrusion of personal opinion. This aspect aside, the hospital environment was one in which she was able to master the breastfeeding technique before returning home:

> I wanted to stay [in hospital] until I got the feeding worked out...Monday night I got the feeding worked out fine. I was happy with it. She fed well that day and night and the next day and night, so I thought I was happy with that.

Rachael's relationship with her Plunket nurse was similar to Maria's. Perceiving the nurse as primarily a resource person, whose role was to advise, inform and record her baby's progress, Rachael found her helpful and supportive. From this perspective the Plunket nurse was not an authority figure whose approval was either sought or required to affirm Rachael's success as a breastfeeding mother.

This divergent perception of the Plunket nurse as a resource person, as opposed to an assessor, was evident on a number of occasions. For example, when I asked Rachael if she found the nurse helpful she responded: "Yes. She suggests creams, oils and lotions". On another occasion, when about eight weeks old, Toni unexpectedly slept for a ten hour stretch one night. Concerned over this development, Rachael sought advice:

> I rang the Plunket rooms to ask them. [The nurse wasn't there]. The lady seemed to think that it was a bit too long, and that I should have perhaps woken her.
>
> (week eight)

The nurse eventually contacted Rachael and was able to reassure her that Toni's long sleep was a normal development. A few weeks later the nurse identified a minimal weight gain over the four pervious weeks. Like Kathy, Rachael had been confident of Toni's progress and was taken by surprise. The nurse arranged to weigh Toni a week later, and a similar result was obtained. However, the nurse appeared unconcerned and reassured Rachael:

> She said that there was certainly nothing wrong with her. She [was] certainly a content baby, and not to worry about the [weight gain] graph.
>
> (week thirteen)

Rachael found it difficult to accept the weight gain result and wondered if the latest reading was inaccurate or perhaps being compared with an earlier one recorded just after Toni had been fed:

> ...sometimes I could have just finished feeding her. They say that you can put on anywhere up to almost two hundred grammes...
>
> (week thirteen)

Rachael's husband (Andrew) also expressed concern, noting that he was unhappy with both the weighing procedures and the expectation of conformity to an 'average' weight gain graph:

> It's not that I don't like the Plunket book...[it's just that] it leaves you all worried when you first see the decline on it. You look at something like that and you think, "Well that doesn't line up with what you actually see". You know it actually creates a doubt!
>
> (week thirteen)

In fact, Andrew appeared more concerned than Rachael about Toni's 'slow' weight gain. Rachael accepted the reassurance on her baby's progress, comforted also by the fact that the nurse scheduled her next visit for a date four weeks ahead.

BREASTFEEDING IN PUBLIC

Apart from Kathy, the mothers were fairly relaxed about the prospect of breastfeeding in front of others, although there was some feeling that in certain situations it was inappropriate behaviour. 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 needs.

Kathy

From the beginning of her pregnancy, Kathy felt anxious about the prospect of breastfeeding her baby in front of others. Kathy's inhibitions stemmed from a lack of confidence in her ability to breastfeed correctly, and an awareness that others might be critical of her techniques.

When Ben was two weeks old, she had her first experience of feeding in front of others outside her own home. On this occasion, Kathy and her husband had joined a friend for Sunday morning tea. Although she felt comfortable feeding in front of this friend, a stranger was present:

> ...there was another woman there, that we didn't know. She had had two children and she had obviously breastfed hers, [so] I felt okay...but I would only feed from the left breast because I felt so much more comfortable with the left breast.
>
> (week two)

To understand this statement, it must be noted that Kathy was having trouble positioning Ben on the right breast and felt she looked too awkward to feed from this side in public. She also needed cushions to prop Ben up on her knee and was unable to see any immediately available:

> I was too embarrassed to ask Sarah for some cushions. I didn't want to say, "Sarah I'm new at this game. I need three thousand cushions!" I didn't want to make a big thing of it anyway.
>
> (week two)

Shortly after the above episode, Kathy and Robert were host to a couple from another city:

> ...even though these friends are very, very dear friends I still don't feel that great breastfeeding in front of them. Even though we have been on holiday together and all of us swim and sun bathe with no clothes on!
>
> (week three)

I asked Kathy why she made this distinction?

> ...because I think that I don't want to look like some other people I have seen breastfeeding, who flaunt it...also I still feel a bit fumbly sometimes when I go to put him on. I think I have got to get my confidence more.
>
> (week three)

Kathy's comments identify three concerns in relation to breastfeeding her baby in front of others. The first involved the opinions others held of her and her self-perception as a novice "fumbly" feeder. The second, linked with the first, concerned her perceived need for more experience (and hence confidence) if she was to feed in front of others. And the third reflected Kathy's culturally-formed perceptions of the female body. Her

concern that she would appear awkward and "fumbly" reveal her awareness of a redefined self; that is, the former nurse/expert was now the mother/novice. Kathy (perhaps incorrectly) perceived an expectation from others that as a former 'expert' she would effortlessly transfer professionally acquired knowledge and skills to her new role as a breastfeeding mother. She felt pressured to perform perfectly and effortlessly without the need to practise and learn new skills. For Kathy, this was far removed from her actual experience and she was therefore embarrassed and self-conscious about the gap existing between her knowledge as a nurse/expert and its transformation into action as a mother/novice.

Kathy also distinguished between public practices acceptable as a woman, but not as a mother. As a woman, she perceived nudity to be acceptable within certain social contexts (sunbathing, swimming with close friends), whereas nudity resulting from breast exposure while feeding an infant she considered unacceptable. Indeed, she not only regarded the latter as unacceptable but labelled it as "flaunting" behaviour, a habitus generated, 'common sense' notion of propriety.

Kathy's perception of the female body parallels Parker's (1992:5) comment that:

> ...in our society, breasts are considered quintessentially sexual all year long...but never when a baby's mouth is attached.

The significance of the above differentiation can be understood in terms of Kathy's location within a culture that distinguishes between the roles of the female body as a sex object, and as the generator and nurturer of infants. This dual construction of Western femaleness illustrates the symbolic significance of the body through which individual experience of society is manifest, reflected and augmented (Douglas, 1973:16). The body, as the outward symbol of individual habitus, permits identification of an individual's location within a social field. Bodily expressions (individual practice/action) are therefore a means of communication. Kathy was fundamentally concerned that her awkward, "fumbly" practices as a novice breastfeeding mother would not clearly locate her within the discourse of maternal behaviour and could be misinterpreted as sexually provocative. As a breastfeeding mother, Kathy desired that

her embodied practice clearly express her immediate perception of being-in-the-world, but was concerned that this communication could be misinterpreted while she was learning to be expert and acceptably discreet.

Maria

At no stage did Maria express any hesitation about breastfeeding in front of others or in a public place. In contrast with Kathy, Maria wasn't at all concerned whether her breastfeeding was indiscreet, believing firmly that the function of her breasts was to suckle an infant. Accordingly, Maria was happy to nurse Rose whenever she needed a feed, regardless of the surrounding circumstances. In fact, Maria admitted to feeding Rose in various places and situations, including restaurants, coffee bars, public bars, the lawyer's office, the dentist's waiting room and in church.

Maria's relaxed attitude toward breastfeeding her baby in public reflected her perceptions of her body, her role as a mother, and her social location. In contrast with the other mothers, Maria was considerably younger, single and unskilled. Her close friends were predominantly people of a similar age and from similar social circumstances. Kathy, Anna and Rachael had professional or clerical skills, were married and orientated towards establishing the traditional New Zealand nuclear family, and associated with others who shared these characteristics. Maria's social location was an important factor underlying her different attitudes. As a single mother she was stationed outside the dominant discourse, and had little to lose by failing to conform socially, and therefore had greater choice and flexibility of practice which relieved her of much of the tension and conflict faced by the others (Kathy in particular).

Anna

In general, breastfeeding in public situations did not present a problem for Anna who tended to be pragmatic about meeting her baby's needs. She did mention, however, that for out-of-town mothers such as herself, there were few comfortable, sheltered places available to feed a baby while shopping in Palmerston North. Anna's point concerned not a reluctance to feed in a public place but the need for somewhere warm and comfortable to do so for a baby born in winter.

Anna's first experience of feeding in front of others occurred when she was still in the maternity hospital. The arrival of visitors often coincided with Lauren's feeds:

> ...I just carried on. I was embarrassed with a few people but most were relations [so] I didn't worry at all...there were a couple of people, more or less acquaintances, but I thought, "Well, the most important person is Lauren", so I just went ahead and did it!

She also recognised, of course, that in some situations it was not always appropriate behaviour. For example, the local bowling club, of which she was a very active member and president, was not always a suitable place to take Lauren, let alone breastfeed her:

> ...if I took her along to the bowling club dinner, I think it would be acceptable for me to breastfeed her. [But during an evening when bowls are played] probably not, because the majority of people are single minded...older, and a lot of the competitors are there for one reason only [to win]. I don't feel I would be comfortable on bowling night.
> (week four)

Anna found most people accommodating when Lauren needed a feed, often having a room made available to her for privacy. For example, when Lauren was about two months old, Anna visited her former office and while there Lauren wanted to feed. Anna admitted having imagined she might be uncomfortable in this situation:

> ...[it] wasn't the problem I thought it would be at first. Nobody minded at all! They all abandoned me in the tea room which was good.
> (week nine)

At another time, a family dinner gathering, Anna was offered the choice of feeding in a bedroom or sitting in the lounge. She chose the latter and was able to socialise as she fed.

A few weeks after the family dinner, Anna, Dave and Lauren travelled to Hawkes Bay to attend a family funeral. It was a long day and Lauren needed feeding a number of times, in their van at the cemetery while the graveside service was being held and also at an aunt's home where the extended family gathered after the service:

> I didn't worry about feeding her in front of the relations. I know some of them got a bit embarrassed. It was really my young cousin, he is about seventeen or eighteen, so you can expect that sort of thing from boys of that age. It is something they wouldn't encounter very often. I just carried on. I thought, "No Lauren needs to be fed". I just

> sat in the corner of the sitting room. It wasn't as if I was right in the middle of everything, they could have actually ignored me if they wanted to!
>
> (week twelve)

Any reluctance to breastfeed Lauren in front of others was firmly overruled by Anna's belief that her baby's needs were paramount. Thus breastfeeding in public was not an issue, although she did recognise that it sometimes caused problems for others, notably young males and the elderly. She attempted to minimise such problems by being discreet (at the family funeral) or leaving Lauren with Dave (on bowling club nights).

Rachael

Rachael's expectations about breastfeeding in public tended to focus on the reaction of other people. She was aware that some people would be embarrassed and was anxious not to offend anyone. Rachael's concern reflected her husband's attitude:

> ...even it if is discreet, he feels he is prying into somebody's private rituals. I'm a person who would go out of their way to look for a ladies' rest room or whatever.
>
> (pre-birth interview)

Like Anna, Rachael also mentioned the problem of finding a suitable place in Palmerston North, and generally called into her parent's home if she needed to feed Toni while visiting town.

Once Toni was born, Rachael found there were times when it was impossible to avoid feeding her baby in public, and normally didn't feel uncomfortable about it. As an example, she usually took Toni to her antenatal group and was naturally comfortable in this setting. Similarly, when Toni was about four weeks old, Rachael visited her former work place for afternoon tea in the staff room. While there, Toni needed a feed:

> ...when she was ready I just popped into the little room next door...anyone who wanted to continue talking to me just followed me through.
>
> (week four)

Rachael's strategy offered her former workmates a choice and avoided any possible embarrassment. She felt it would not have been comfortable to simply stay in the staff room with everyone around. As it happened, most of her friends (including a couple of

men) chose to follow her into the next room. Aside from these examples, Rachael made only one other reference to breastfeeding in public. When she did so, it was to state that she now felt very comfortable and relaxed feeding before others. My impression was that breastfeeding was becoming integrated into her general lifestyle, thanks to supportive relatives, friends and positive experiences.

CONCLUSION

This chapter has explored two broad themes concerning relationships with other people. These themes, as they emerged in regular interviews with the four mothers, concerned: the importance and influence of significant others (relatives, friends and health professionals) in relation to the practice of breastfeeding; and the question of breastfeeding in a public place or situation. The importance and influence of others was found to be far reaching and can be generally understood to reflect the social location, expectations and perceptions of self held by each mother.

Those individuals closest to the mother during her early weeks with a newborn are clearly in a position to make or break her breastfeeding success. Raphael's (1976) notion of a doula illustrates this point. In each case it was possible to identify a person who fulfilled the doula role and to witness the support and reassurance their presence offered. For Kathy, Maria and Rachael it was their mothers who provided immediate support and reassurance. Individual circumstances and choice appear to be relevant here. For example, Maria, a single mother living with her parents had less choice than Anna who maintained a relatively distant contact with her mother and preferred to draw support from other sources. Thus in Anna's case it was her husband Dave who initially fulfilled the doula role. Raphael (1976:151) makes the point that:

> The baby's father is an excellent doula if he is available and if he is aware of what is needed.

Certainly Dave was caring, supportive and understanding of his wife's needs and wishes, though his remarks sometimes caused a certain tension while Anna was engaged in establishing and managing a breastfeeding routine. The key point, of

course, is that a doula can minimise or diffuse some of the tensions and conflicts faced by newly breastfeeding mothers.

Close friends can perform a function similar to that of a doula, albeit less frequent and immediate. Obvious examples include Anna's sisters-in-law and Rachael's antenatal group or Kathy's friend Pat, the midwife. Each of these examples has in common the element of positive support and encouragement available to the new breastfeeding mother. Maria's friend Margaret was somewhat different, but the outcome of the relationship was Maria's sense of doing well in comparison with an infant whose mother had opted for formula feeding. On the other hand, it must also be recognised that close friends may have a negative impact. This situation was amply demonstrated in Kathy's account, where thoughtless and unhelpful remarks seeded feelings of self doubt, embarrassment and stress.

Health professionals because of their perceived expert knowledge and authority on matters of infant health and development, form a special group of significant others for the breastfeeding mother. As demonstrated by the experience of the four mothers in this study, however, the influence or impact of health professionals isn't necessarily positive or consistent. For example, while Rachael and especially Maria found their hospital maternity staff supportive and helpful, this was not the case for Anna. Conflicting advice from members of the nursing staff caused Anna to feel confused, while the detached, clinical and dictatorial manner of some nurses left her feeling that they were basically disinterested in her progress. Reluctant to accept what she perceived as a subordinate, uninformed novice identity, Anna resorted to a strategy of selective compliance with respect to practices recommended by hospital staff and thereby retained a sense of independence and autonomy.

In terms of her influence and impact upon their breastfeeding experience, the most important health professional for each of the four mothers was undoubtly the Plunket nurse. A medical 'expert' trained in infant care and development, the Plunket nurse was variously perceived as a fellow professional, an authority figure or as a resource person. Her position of influence and power was such that she could empower a woman by

being supportive and reassuring or she could equally well undermine a woman's confidence and breastfeeding practice by emphasising a biomedical perception of 'normal' infant progress. These outcome alternatives were well illustrated by the experience of the mothers in this study.

Kathy identified her Plunket nurse as a fellow professional, possessing a similar role and knowledge within biomedical discourse. As a mother, however, Kathy's positioning had shifted, effectively dispossessing her of 'expert' knowledge. Kathy appeared to accept this redefinition of self when she decided to continue with the nurse's suggestions, despite finding them illogical, extremely difficult to adhere to and a considerable source of tension and self-doubt. Once Kathy began to trust her own knowledge and judgement, the tension and conflict she was experiencing diminished. Though not as extreme as Kathy's experience, Anna also experienced doubt, frustration and tension when the Plunket nurse's advice conflicted with her own assessment of a particular situation. On balance, the benefits outweighed the drawbacks for Anna because of the positive support received along with effective information for the management of Lauren's colic problem.

Unlike Kathy, from the outset Maria recognised the Plunket nurse as an authority figure capable of endorsing and affirming her success as a mother. The two factors crucial to Maria's experience were a thriving baby (gaining weight in accord with the nurse's biomedical norm), and her youthful inexperience which seemed to facilitate an unquestioning acceptance of the nurse's authority. Maria's relationship with the Plunket nurse exemplifies Minchin's (1985:214) statement that when the baby is obviously thriving the nurse's authority places an official stamp of approval on the mother. Conversely, Minchin's linking of an infant's failure to thrive (or more specifically to gain weight) with inadequacy on the part of the mother, was manifest in the advice given to Kathy and Anna to complement their breastfeeding with formula. In contrast to Maria, Rachael's recognition of the Plunket nurse as a resource person constrained their relationship. Rachael was content to accept the nurse's expert knowledge only on those occasions when she deemed her own knowledge and judgement to be inadequate.

Finally, this chapter has briefly touched on the matter of breastfeeding in public. As the experiences of each mother indicate, their perceptions of the acceptability of feeding in front of others varied in accordance with their self-perception (notably in Kathy's case), expectations of others (particularly supportive relatives and friends) and particular social contexts (e.g. the bowling club and workplace staff room as compared with more private, domestic settings). Social perceptions of the female body, significantly contradictory in nature as indicated by Parker (1992), transform a breastfeeding mother's body into a site of conflict between opposing discourses. The result is tension, inhibition and embarrassment, and even derogatory labelling of a mother who fails to discreetly conform to socially defined acceptable practice.

To sum up, it may be concluded that underlying each breastfeeding mother's relationships with others are social constructions of the body and personhood. The breastfeeding mother is perceived (biomedically) as a biological organism, functioning to produce milk for her infant. As such she may be judged according to the expected progress of her infant. She is expected also to conform to social definitions of appropriate strategies and actions defined by her various locations (woman, wife, mother, daughter, friend, etc.) within the social field. The convergence of discourses constructing these various locations transforms her body into the 'body politic'; that is, into a site of varying conflict and struggle. Fundamental to each woman's relationship with others is, therefore, the disjunction of physical processes and social forces.

CHAPTER SIX

A LITTLE GEM? PERCEPTIONS AND REFLECTIONS

> I began to see breastfeeding as many Third World women saw it - perhaps pleasurable but certainly quite ordinary. In the Western world many of us turn to breastfeeding as a little gem: as a divine opening up of emotional contact, as something important we can do with our bodies and not be ashamed, as a way of validating our womanliness. And furthermore, finally in the 1980s, especially in the United States, everybody makes a fuss of approval over the mother who does breastfeed.
>
> Raphael (1985:21)

> The rewards of breast feeding centered around the emotional satisfaction of doing something that was good for the baby and around the unique intimacy that developed between mother and baby over the course of breast feeding. Many enjoyed breast feeding simply because they found it easy and convenient but the more fundamental satisfaction came from the emotional nurturing and closeness.
>
> Maclean (1990:95)

Central to a woman's experience of breastfeeding is the tension between the physical process of lactation and the social process of breastfeeding. As shown in the two previous chapters, the effect of the convergence of these two processes was unique to each mother, reflecting her social positioning, relationships with others, and expectations. It can be argued that the material presented thus far serves to contextualise each mother's perceptions and reflections which are examined in this chapter with the aim of providing further insight into the experience of breastfeeding.

KATHY

Kathy anticipated that breastfeeding would (initially at least) be a painful, unpleasant experience, endurable only because she was determined to give her baby the best possible start in life. Underlying these convictions, was Kathy's professional training and experience as a nurse. Her association of breastfeeding with unpleasantness and pain was forged by events during her years as a student nurse:

> ...I can remember them pushing me into a room to go and help new mothers breastfeed their newborn babies, which I hated because I did not know what I was doing. "Latch it on", that was the thing they said, "Latch it on". And I used to hate that because I had never had anything to do with babies. I hadn't been taught to breastfeed. [But I found myself confronted with] having this baby's head in the one hand and the woman's breast in the other and the baby screaming and the woman hurting. I didn't really know what to do. We just sort of fumbled through it together. I know that they were not good experiences for the patients.
>
> (week two)

When I interviewed Kathy before Ben's birth she was very apprehensive, anxious she would not like the 'feel' of breastfeeding. Against this background, Kathy's first attempt at feeding Ben (about an hour after he was born) was a pleasant surprise; everything went very smoothly. Kathy remarked that she experienced no discomfort and that Ben latched on well:

> I was relieved. It didn't hurt like I thought it was going to. I felt quite clever! I thought, "Oh we can do this", you know, it wasn't a big deal. I thought I was lucky because he sucked straight away.
>
> (week two)

Despite her realisation that breastfeeding need not be an unpleasant or painful experience, Kathy continued to perceive it in terms of benefits for Ben, rather than as a pleasurable experience for herself. For example, when Ben was three weeks old Kathy mentioned that she was "sick of breasts and things":

> I'm not getting any of the rewards from it yet. Sometimes when he wants to suck and suck and suck and I get sore, I get the feeling of "Oh God, not again. I don't have to put him to the breast again do I?"
>
> (week three)

Nevertheless, over the next three months of interviews she continued to anticipate that her experience of breastfeeding would get better. She also remained determined to continue breastfeeding:

> ....no, I still don't want to give it away. It's because I really know that it is important to breastfeed. I don't want to stop breastfeeding but I just...feel like it's still got to get better...
>
> (week four)

At this stage Kathy was experiencing frequent day-time feeding, sore breasts, and tension provoked by the comments and opinions of her friends regarding Ben's feeding pattern. Moreover, she had not anticipated that Ben's initial pattern of frequent feeding at irregular intervals, would continue beyond the first weeks. This combination of factors was proving difficult to endure:

> I can now understand why some women give up breastfeeding at three weeks, and I have known some women to stop at about two weeks because they don't like it. But I want to persevere.
>
> (week three)

When Ben was six weeks old, I remarked how interesting it was that although she was not enjoying breastfeeding she was not prepared to give it up. Kathy responded:

> Yes, it is funny isn't it! I think I know in the back of my head that it will get better, and I am just holding out because already I have had the odd day [when] it is not too bad. This morning I was feeling quite good, and I thought "You can do it".
>
> (week six)

Kathy continued to struggle with very sore, aching breasts in the belief that this phenomenon would soon settle down.

Throughout my period of contact with Kathy, I continued to ask how she was finding breastfeeding and observed a gradual change in her perceptions. For example, after Kathy and Robert travelled north for an extended weekend, she remarked:

> I am really enjoying the convenience of [breastfeeding], especially over this weekend.
>
> (week seven)

Kathy was referring to the fact that their return journey had taken ten hours, with Robert stopping for business meetings in several towns. Kathy recalled a few hours at Ohakune, where it became very cold with sleet and snow:

> I was starting to feel a bit guilty about having Ben out at all...I kept thinking, "Thank God I'm breastfeeding". You know, because I didn't [have to worry that I would] run out of bottles because it was a longer day than I expected. I had this milk just there for him. I just carried on feeding him until we reached home.
>
> (week seven)

The following week, Kathy commented that she was feeling much more relaxed about breastfeeding and I asked her if, on reflection, breastfeeding had been a difficult experience:

> No, not really. It hasn't been as bad as I thought it was going to be. I wasn't expecting the breasts would be so sore, but looking back on it I think that it was not that bad. Having the baby in the house hasn't been half as awful as I thought it was going to be. But I keep thinking that is because he is such a good baby.
>
> (week eight)

I asked her why she had expected things to be so awful. Kathy's answer pinpointed the influence of others:

> ...just because everyone kept telling us that once you get a baby your life's never your own.
>
> (week eight)

She also realised that her practice of putting Ben to the breast when he cried, prevented him from becoming more distressed. Describing this practice as "clever", because it ensured a relaxed peaceful atmosphere in the household, Kathy added:

> I don't see why he should have to cry when all he wants to do is suck.
>
> (week eight)

Although Kathy was feeling quite positive during the eighth week, it is important to understand that her perceptions varied somewhat according to the smoothness of progress or problems encountered. For example, when Ben was nine weeks old and things had settled down, Kathy's comments reflected her relaxed confidence and success:

> ...I can't understand the argument that people say that they have to be convinced that breastfeeding is better. I don't know why people ever invented formula! It is stupid. You have a baby and you have food there for it. Why are we spending time trying to convince people that breastfeeding is better? I mean, it should just be the obvious choice.
>
> (week nine)

The following week, however, she was stressed and frustrated, trying to conform to what she perceived as the Plunket's nurse's *requirement* that Ben have complements of expressed breast milk. Typically her confidence plummeted and things became worse. She referred to previous remarks:

> Do you remember me saying to you last week, "I wondered why they had invented formula?" Well I have been thinking, "Oh thank God they invented formula".
>
> (week ten)

Gradually, however, as the duration of beastfeeding increased, Kathy realised that the bad periods did end:

> ...[if] I am having a bad day, or a day when he is sucking all the time, then I'll think to myself that this isn't going to be like this every day. You know, it is not going to be like this for ever. Tomorrow won't be the same.
>
> (week eleven)

Kathy, in fact, was beginning to recognise some advantages for herself from breastfeeding Ben. It was convenient (particularly while travelling) and a ready means of settling or pacifying Ben. However, these advantages were offset by the time spent "just sitting feeding", and the bouts of sore breasts that she periodically endured. Kathy also noted that, having never formula fed a baby, her perception of the advantages of breastfeeding was based on limited experience ("the only way I know"). She wondered if this may have distorted her perception.

By way of example, Kathy mentioned Pat (her midwife friend) who had elected to bottle feed. In the face of pressures to breastfeed, Pat firmly maintained that formula feeding was more convenient, less demanding of the mother and allowed time away from the baby. Although Kathy did not share these views, she admitted that she recognised in Pat's defence of formula feeding a reaction to the pressures in favour of breastfeeding that they both experienced as health professionals:

> I felt for her, because I understand that she doesn't want to breastfeed, because I felt a bit like that too. I felt sad that she [was] feeling the social pressure [to breastfeed].
> (week nine)

With these comments, Kathy in effect reiterated that her decision to breastfeed Ben was primarily a response to her biomedical knowledge *and the expectations of her professional colleagues.* Indeed, Kathy declared: "I couldn't have stood having to justify why I was bottle feeding".

Understanding Kathy's experience

Kathy's decision to breast rather than bottle feed was closely linked with her self-perception. A dominant aspect of this self-perception was her career as a nurse, demanding an ability to appear 'professional', confident and competent. Breastfeeding was best for Ben and expected of her. Her ability to successfully breastfeed was an assumed extension of her professional competence; a tangible measure of her knowledge, skills, training and credibility. For Kathy these professional qualities were dominant, while her desires as a woman and mother were of secondary importance. Little wonder, therefore, that Kathy did not want friends to see her struggling with sore breasts and constant feeding (a trained nurse should be able to avoid such hassles),

and that she was surprised to find herself vulnerable to the opinions of others, "just like everyone else!" (a trained professional, aware of such pressures, should be able to rise above them).

The pain, discomfort and trauma that Kathy observed as a student nurse, deeply influenced her expectations of breastfeeding and gave rise to an altruistic conception of this activity. Her biomedically constructed expectations interfered with her ability to recognise benefits for herself, particularly as medical discourse confines its focus to the realm of the physiological. Thus Kathy's perception of breastfeeding initially focused on benefits to her baby's health. Personal advantages of enjoyment, convenience, a settled infant with consequent household harmony and closeness with her baby, (beyond the scope of biomedical discourse) Kathy initially found illusory, generally unrealised and outside her personal construction of herself as a breastfeeding mother.

Subsequently, despite the advantages of convenience and a contented baby, she remained ambivalent about her experience. She had hoped it would prove pleasurable as well as convenient:

> ...I still am [ambivalent], I am still not enjoying it. I am still not getting that wonderful thing. People say, "Well breastfeeding is lovely...[or] I loved breastfeeding my children". I may feel like that one day, I don't know. I may look back on it and think breastfeeding was wonderful. [For now, however] I'm really pleased that I can do it.
>
> (week nine)

Although, as I later learned, Kathy was delighted to be able to breastfeed Ben until well into his second year, and gained considerable satisfaction from his obvious progress, breastfeeding never attained the status of "that wonderful thing", "a little gem". For Kathy, the rewards of breastfeeding and the motivation to continue were dependent on the benefits for Ben. Namely, immunological protection, the decreased risk of asthma, cot death and general infection. Robert constantly reminded her that "breast was best" and urged her to continue when she became discouraged.

I observed a number of occasions when Kathy appeared very calm and serene while feeding Ben - a placid baby, and tranquil feeder who rarely got impatient while nursing.

As a breastfeeding couple they seemed increasingly content. Unless she was experiencing obvious pain, my impression was that breastfeeding generally provided Kathy with opportunities to enjoy close, quiet contact with her baby, though she herself did not appear to recognise this aspect of her experience.

Like Kathy, I too had been ambivalent about breastfeeding my first baby, although I was not pressured to do so. Unlike Kathy, however, I found I enjoyed breastfeeding, especially the intimacy it established between myself and each baby, and the unique and intense relationship involving feelings of inseparability and mutual dependence. I have been in contact with many other mothers who have similarly observed that the closeness with their baby was one of the most rewarding aspects of this process. Conversely, I have also encountered women who saw breastfeeding as restricting, 'tying' them down, and who therefore resented the demands that it imposed.

The divergence between women's perceptions of breastfeeding as a process facilitating closeness with their babies, as opposed to one which restricts and limits personal freedom, reflects individual social positioning. Kathy, for example, was prepared to be 'tied down', initially at least, but experienced considerable pressure from others to regulate Ben's feeding schedule so that she could quickly resume her former lifestyle. The result was tension, confusion and guilt which interfered with her ability to relax and enjoy her contact with Ben.

In such situations the mother is 'caught' between the requirements of a physical process (adequate milk supply is dependent on the baby sucking frequently) and the social forces which define and construct her role (as a career woman 'doing her own thing', as a housewife/hostess etc.). The resulting tension and distress, unless resolved, constrains a woman's perception so that breastfeeding becomes or is confirmed as a process that is too demanding, ties one down, and so on. For those perceiving breastfeeding this way it is or becomes an altruistic act requiring great personal sacrifice. For some the outcome is unexpectedly pleasant and enjoyable, thereby dissipating much of the tension and conflict experienced. For others, socially formed preconceptions maintain negative feelings and place the pleasurable side of breastfeeding beyond their reach. Significantly, the predominant biomedical literature on breastfeeding confines 'success' to duration and infant progress. Excluded is a woman's perception of this event, particularly the satisfactions and associated rewards.

Bottorff (1990:205) argues that suckling an infant involves the exchange of a gift:

> The gift of breastmilk, unlike many other gifts, is something that cannot be bought or acquired through an act of will. It is a gift that can only be given by giving oneself. The contented child returns a gift that continues the exchange. The child's eyes sparkle with delight, a smile comes to her lips. An exchange has taken place.

Bottorff's point with regard to this exchange is that the rewards are subtle and often elude the mother who then struggles to breastfeed in our individualistic society which tends to perceive it as a 'tie' and a burden. Bottorff (1990:206) also points out that the commitment of breastfeeding offers the possibility of a deeper, enriching life, where:

> ...a mother and infant become one. It is with this feeling of companionship and closeness with the infant that a mother finds it easy to breastfeed and easy to continue. It almost becomes 'effortless'.

However, the "effortless" quality can only be achieved if there is a shift in a woman's perception of being-in-the-world. A mother's self-perception needs to extend to accommodate her infant, so that she responds to the environment in relation to her infant as well as herself (Bottorff,1990:202). When this change occurs, the tension between the physical process and social forces slips away, leaving the mother free to enjoy her experience of breastfeeding.

To sum up, Kathy's perception of her experience needs to be recognised as complex and variable, comprehensible only within the context of her previous experiences and location within the wider social field (as a nurse, wife and friend). She had anticipated that having a baby in the house would be demanding and require much adjustment because her lifestyle had involved frequent contact and socialising with friends. Many of these friends advocated strict routines for their babies so as to minimise disruption to their lifestyles. Feeling pressured (as a nurse) to breastfeed, Kathy (as a woman, wife, friend) was well aware that such an action would be time consuming and personally restrictive.

As the reality of the commitment to successfully breastfeed became apparent, a reality involving tensions and conflicts not always foreseen and/or of a greater intensity and duration, Kathy experienced further tension and conflict as her responses and strategies

to maintain successful breastfeeding frequently overstepped the boundaries of discourses shared with some close friends and acquaintances. Indeed, Kathy's situation can be understood as one of social marginalisation; her breastfeeding practice and strategy, by failing to conform to the social expectations of many friends, relocated her in mutually unfamiliar territory. Furthermore this social repositioning was accompanied by a lack of experience to determine exact meaning from her new situation.

It is not surprising, therefore, that Kathy's perception of breastfeeding failed to conform to her expectations, that she professed an inability to register enjoyable aspects of this experience, or to realise "that wonderful thing" (week nine). In contrast, as time passed I observed Kathy more relaxed and apparently enjoying breastfeeding as she gazed tenderly at the baby in her arms. Kathy's constant statements that she was not enjoying breastfeeding were concomitant with her socially formed expectations, but contradicted my observations of her manifold expressions of this experience.

MARIA

In contrast with Kathy, Maria saw breastfeeding as the natural way of nourishing a baby and eagerly anticipated the close body contact that would be part of her experience. Although Maria realised that having a new baby would be time consuming and demanding, her situation as a single mother living with her parents removed many of the stresses and obligations experienced by Kathy as a wife, friend and household manager. Whereas Kathy perceived Ben's arrival as an event requiring some lifestyle adjustment, Maria anticipated a completely new lifestyle, one within which her activities would be baby-led (in the short term at least). As a consequence Maria did not experience the conflict endured by Kathy and this in turn may have reduced the risk of exposure to a variety of breastfeeding difficulties.

From the beginning it was apparent that Maria was very happy to sit, cuddle and suckle her baby for much of the day. Rose was born at the beginning of winter and it was not uncommon to find Maria sitting in her preferred armchair by the fire with Rose in her arms. Maria always appeared contented, free of anxiety and frustration, and clearly

enjoyed constant close physical contact with her baby. She was generally very stoical, so breast and nipple discomfort were not emphasised as significant problems. Of course, these problems were relatively minor and short-lived, largely confined to overfull breasts and cracked nipples for a few days following Rose's birth.

For Maria the best aspects of breastfeeding were:

> Convenience and being close to [Rose]...not having to get up at night and get the bottle out of the fridge while she is screaming.
>
> (week thirteen)

Like Kathy, Maria firmly believed that breastfeeding offered the best possible start in life, providing the 'perfect' food for her baby. However, this was perceived as an additional benefit, rather than as a reason for continuing breastfeeding. When asked why she was so strongly convinced of the advantages of breastfeeding, her response reflected the example provided by her friend Margaret:

> ...look at the difference between Rose and Nina [Margaret's baby]. Nina is bottle fed and she gets sick so easily and Rose has had two colds and that's it! Anyway, why would you be making milk if it wasn't the best for your baby?
>
> (week thirteen)

Maria felt that her close relationship with Rose was also due to breastfeeding:

> ...you have got skin. The skin with breastfeeding, whereas with the bottle it is just a hard bottle.
>
> (week thirteen)

The sense of closeness through skin contact was a very significant aspect of Maria's breastfeeding experience. Kathy, on the other hand, did not regard closeness as a benefit of breastfeeding.

As early as the second week, breastfeeding proved to be even better than Maria had expected:

> I think I probably expected to get worse cracked nipples....I think I expected her not to be a cuddly baby. [I like] just being close to her, because she is so cuddly.
>
> (week two)

She continued to perceive breastfeeding as enjoyable, commenting, when Rose was eight weeks old, that it was "perfect!" This assessment was confirmed by Rose's very settled, placid behaviour, in contrast with Nina (Margaret's baby). Maria attributed much of the difference between the two babies, to the fact that Rose was breastfed, believing that the physical closeness associated with nursing provided an effective means of calming Rose if she become upset.

Maria was amazed at the progress of her baby, particularly when she considered that it was solely due to her breastmilk. She displayed obvious pride in her ability and often referred to this when discussing her friendship with Margaret. For example, on one occasion when they were planning to go out for a day, Margaret had suggested that Rose be fed formula so that she could be left behind. Maria described her reaction as, "No way! She is *exclusively* breastfed!" and felt extreme pride in being able to make that statement.

It should be noted at this point that Maria was much less reflexive than Kathy about her experiences (possibly because of her relative youth and optimism). Identification of the most meaningful aspects and perceptions of her breastfeeding experience was therefore dependent on my observation of her embodied expressions. In other words, Maria's breastfeeding experiences were primarily expressed through body language and behaviour in the company of others.

Observations recorded in my fieldnotes endorse a number of Maria's stated perceptions about breastfeeding Rose. For example, I had noted how very relaxed she appeared, how uninhibited she was feeding in the presence of others (week three), her tranquility when handling Rose and her obviously happy, unselfconscious enjoyment of motherhood (week five). When I attended a La Leche League meeting with Maria, I observed her among a group of breastfeeding mothers most of whom were older and married. I was aware that young single mothers were a rarity at such gatherings and therefore often conspicuous when present among the group. What struck me about Maria was the way she quietly and confidently blended in, contributing to the discussion

with Rose asleep on her lap for much of the time. Rose stirred twice during the meeting, and was immediately nursed by Maria in a calm, confident manner.

I noted on a number of other occasions that Rose was a happy, settled baby who smiled often and liked to be cuddled. These characteristics appeared to me to reflect the relationship she enjoyed with her mother. My overriding impression was that Maria found motherhood and breastfeeding enjoyable and somehow instinctively knew how to cope with Rose's needs when she was unhappy or unsettled.

During my final interview with Maria, I asked her to reflect back on her experience of the last three months. Her response was immediate, concise and enthusiastic: "Amazing! I think I was meant to be a mother" (week thirteen). When the subject of motherhood was raised a few weeks earlier, Maria admitted that she was enjoying the role and had always wanted to have a family, although it had happened a bit earlier than expected. Her immediate aspirations focused on the hope that she would meet someone and get married. She had enjoyed her experience of pregnancy, motherhood and breastfeeding and wanted to " have another [baby] right now", if somebody would marry her. Maria's positive view stemmed, at least in part, from her belief that she had learnt sufficient from her first experience to avoid any difficulties or problems already encountered.

Understanding Maria's experience

Maria recognised the important aspects of her breastfeeding experience as the contact and closeness it promoted with her baby. She also felt it was a natural and superior way to feed her baby. Nevertheless, as a young, single mother, Maria could have faced a multitude of potentially negative social and economic problems with adverse effects on her breastfeeding experience.

The relationship between stress and breastfeeding failure is well documented, originally identified by Jelliffe (1978) as involving physiological dysfunction, triggered by social and emotional factors. Working among the poor of South America, Jelliffe demonstrated that maternal stress inhibited release of the hormone oxytocin, and therefore interfered with

the let-down reflex. The results of an inhibited let-down reflex are less satisfying milk for the infant (see Chapter Five) and eventual loss of supply. Jelliffe (1986:61) concluded that successful breastfeeding requires a supportive and relatively stress-free social environment for the mother, noting:

> The commonest cause of inadequate lactation in most parts of the world is due to emotional interference with the let-down reflex - so called 'anxiety-nursing failure syndrome'.

Jelliffe's findings can be recognised as biomedical confirmation of Raphael's (1976) point that all breastfeeding mother's need a doula. The doula's role is one of support and encouragement which, by implication, deflects tension and stress away from the new mother. Jelliffe's identification of "anxiety-nursing failure syndrome" recognises the dialectical relationship between physical processes and social forces, linking socially induced conflict, stress and tension with a mother's physical inability to adequately nourish her baby with breastmilk.

Maria's position as a young, single mother placed her at potential risk from "anxiety-nursing failure syndrome". Fortunately this risk was minimised by the support and encouragement she received from her family. Unlike the other mothers in this study, Maria was able to focus almost all of her attention on caring for Rose. She did not have to juggle the complex, demanding responsibilities of running a home with the care of a new baby, nor (in the absence of a partner) did she have to face the numerous interaction adjustments required by a transition from dyad to triad.

Maria's relationship with others must be recognised as a very significant aspect of her breastfeeding experience, cushioning her from emotional stress and providing encouragement, support and affirmation of her success as a breastfeeding mother. Maria's family provided the support necessary to care for Rose in the way she believed was right. Her firm self-perception that she was a "born mother" was endorsed through interaction with her mother, Plunket nurse and friend Margaret. Contact with La Leche League, although brief, provided further confirmation of her success as did Rose's obvious progress and behaviour.

Maria's contact with others affirmed her social repositioning as a mother. For example, she clearly viewed herself as more patient, perceptive and understanding of Nina than Margaret. She believed that she had a much closer relationship with Rose than Margaret did with Nina, noting that she was prepared to have Rose up and awake and to spend time playing with her, unlike Margaret. Although these qualities were valued as significant aspects of successful motherhood, it was breastfeeding that she regarded as central to this role. Breastfeeding was perceived as a process facilitating an *enhanced* relationship between mother and baby, as well as being the ideal method of infant feeding.

ANNA

Anna, like Maria, also looked forward to breastfeeding as the most natural and convenient way of feeding a baby and as an enjoyable means of getting very close to her infant. Although prepared for a few hitches and some initial discomfort, she did not anticipate any major problems or a radical change in her lifestyle. Anna expected to arrange her daily pattern of activities around feeding times. Underlying this expectation was a belief in the importance of getting a baby into a routine. A routine would allow her to predict the timing of feeds and thus the times when she would be free to get on with other things.

During my first visit after Lauren's birth (Anna had been home for almost a week), both Anna and Dave admitted that having a new baby in the household actually required a much bigger adjustment than either of them had anticipated. Lauren was feeding every two to three hours and was proving difficult and time consuming to 'wind'. Dave remarked that this pattern cut down on the available time to do other things during the evenings and weekends. Having expected that life would continue more or less as normal once the baby arrived, Anna and Dave were quite surprised at the extent of the change to their lifestyle.

A few weeks later, Anna again reflected on the impact that Lauren had made on their lives. There was more to breastfeeding than she had imagined and it was "not just a matter of getting milk out and getting it into her [baby's] mouth" (week five). She

mentioned, as an example of Lauren's impact, how she had always made a point of having the evening meal at a predetermined time, being "a person of habit" who liked to be organised with a routine. Since Lauren's arrival, however, Anna had found it increasingly difficult to have the evening meal at a set time and laughingly admitted that now if she couldn't get tea on the table at 6.30pm, it didn't worry her at all!

> Yesterday I thought with the schedule that she was keeping I would start tea early. I had specific things in mind that I wanted to do, so I started them early. But she woke up after two hours sleep instead of three hours and, of course, I was in the middle of things! ...ordinarily I would have got annoyed about it, but I just turned everything off, [and] came and did what I had to do for her. I just said to myself, "You know that Lauren has to be attended to and once she is actually attended to and asleep, then that will be our time". So things just flowed and I felt...[that] here I could have been stewing and annoyed...[but] here I was just sort of cruising on through!
>
> (week four)

Lauren's daily feeding pattern was unpredictable for much of my period of contact, and on a number of occasions she also experienced bouts of being particularly unsettled or distressed, events which Anna found trying and upsetting. Discussing this aspect of Lauren's behaviour, Anna admitted that she sometimes reacted by becoming very annoyed when Lauren wouldn't settle. For example, the first time Lauren became really distressed and took a number of hours to calm down, Anna described her reaction as follows:

> I felt annoyed at her and then I felt terrible at myself for feeling annoyed at her, because I knew that there was nothing malicious about it on her part. The thing that really upset me the most was that she came off the breast crying.
>
> (week four)

Part of Anna's annoyance sprang from her confusion and inability to identify the cause of Lauren's distress. When Lauren behaved in a similar fashion a couple of nights later, Anna again found herself feeling cross and had to make a conscious effort to remain calm and relaxed. Anna now realised that:

> ...when she is feeding, if I feel that I am not relaxed, I relax myself and then I notice that she relaxes too.
>
> (week four)

A couple of weeks later, when Lauren was going through a period of very frequent feeding, Anna again experienced phases of anger with the situation. I asked her to explain exactly what she experienced:

> I wasn't upset at her [Lauren], just at what was happening. I couldn't seem to pick up on what was wrong and be able to deal with it properly. ...I think that she has been such a placid baby and perhaps easy to read. Yet when she is upset, she really is upset!
>
> (week six)

Clearly Anna was frustrated by her inability to detect the reasons behind her baby's behaviour. She also found Lauren's pattern of frequent feeding very disruptive of both her daily routine and ability to get a good night's sleep.

In fact, Lauren's unsettled behaviour was beginning to undermine Anna's confidence and prompted doubts concerning her ability to produce milk of sufficient quality and quantity, particularly as Dave suggested that Lauren might be hungry. Moreover, it will be recalled (Chapter Five) that at this stage the Plunket nurse was recommending that Lauren be offered a formula complement, thereby reinforcing the notion that Anna's milk supply was in someway inadequate. Anna's doubts, however, were offset by Lauren's constant, satisfactory weight gains and the evidence of an over-abundant milk supply. As a person disinclined to reach hasty conclusions, Anna characteristically adopted a 'wait and see' approach before taking any action.

The situation when Anna began to wonder if the fault lay with either the quality or quantity of her breast milk, was one that I had encountered on many occasions with other breastfeeding mothers. Generally, the quality and quantity of a mother's milk supply are the first things queried when infant feeding and behaviour are not going well. A common folk belief among many women (particularly those in older age groups) and some health professionals is the idea that the breast milk may be too 'watery' for the baby and therefore in need of 'testing' to ensure that it is 'good enough'. Such a belief can be very damaging to the confidence of the breastfeeding mother, particularly when she realises that her milk is 'blue' and 'watery' in appearance (the normal appearance of breastmilk) and inappropriately compares it with the opaque whiteness of cow's milk.

As time passed, Anna grew to accept Lauren's unsettled periods, realising that even if she could not identify their cause, she could 'ride them through' by rocking and cuddling Lauren until she was calm enough to feed. She coped with these incidents by

telling herself: "This will soon finish. Don't worry, it will soon finish". By accepting that these occasions required patience and a relaxed attitude, Anna found that they actually became easier to deal with and receded as a problem. In essence, Anna had transformed each of Lauren's bouts of distress from being a problem to being a normal event, her change in perspective dissipating the tension and stress that accompanied such bouts.

The difficulties of adjusting to the needs of a new baby, notably variations in Lauren's feeding schedule, and her bouts of distress were the most negative aspects of Anna's breastfeeding experience. On a more positive note, from very early on, Anna found breastfeeding to be as enjoyable as she had initially anticipated. For example, when Lauren was only four weeks old, Anna observed that breastfeeding was the most satisfying aspect of being pregnant and giving birth. This perception arose from recognition of her baby's obvious good health and steady weight gains as tangible benefits of being breastfed. Sitting feeding her baby was also very relaxing and helped put things into a new perspective:

> I sit there when I am feeding her and all sort of thoughts come into my mind. It is relaxing, it is very relaxing. It makes you think of things differently. Some things that might have been important before are not necessarily important to you anymore.
>
> (week four)

Anna continued to enjoy breastfeeding, finding it more rewarding as Lauren became older and more responsive and as her own perceptions changed. She believed that had she bottle fed Lauren she would have been tempted to hand her to others, and this would have interfered with the close contact she so much enjoyed:

> ...I am finding now that with the second half of the feed she just lies there and talks to me. And that's quite neat really because it is the kind of talking where I know that she will talk back to me. It is almost as if she is trying to use her mouth to form the words and it is really gorgeous the way she is trying to articulate all of that and perhaps copy what you are saying.
>
> (week thirteen)

At this point I remarked that they appeared to be a very harmonious nursing couple, with a discernable bond between them. Anna agreed, confident that she could now 'read' Lauren's various signals and that she was becoming a settled baby. These

comments regarding her feelings of closeness and harmony, corroborated a remark made a few weeks before in relation to the sensation experienced when going to the supermarket without Lauren:

> ...every time a little baby went past I was peering in the trolley. I felt 'light', as if I should be carrying, or looking out for something. Or that the pram was behind me and I would just turn around and pull it along with me.
>
> (week seven)

Anna's reaction at the supermarket was one that I too was very familiar with, having experienced feelings of 'being out of place' without my baby present. Anna's description of it as feeling "light" was one I immediately identified with. I had also heard other mothers comment on similar experiences and how, when they actually came to have time away from their baby, they felt uncomfortable and restless. I had always understood these feelings as being associated with the bond developed through the intimate contact involved in breastfeeding. My own experience was that while breastfeeding, the baby becomes an extension of yourself. She is always there, totally dependent on you. And yet there is also a dimension of mutual dependence, both emotionally and physically. Very full breasts can be extremely uncomfortable, even painful and mothers are often heard to remark, "I need to nurse!"

Understanding Anna's experience

Anna's progression from a situation of tension resulting from unreal expectations, to one of acceptance and enjoyment is linked with a change in her self-perception. Her former social location as a woman, career woman, and wife, demanded particular actions relating to her role(s), time restraints and social obligations. With the exception of her career, Anna assumed that she would be able to schedule her baby around these roles and responsibilities so that life would continue more or less as before. However, Anna overlooked the fact that once her baby arrived, her social position would need to accommodate new roles of fulltime housewife and mother. The transition to motherhood was accompanied by major changes, involving new experience, roles and perceptions of reality. Physically, Anna also experienced hitherto unknowable sensations which generated a new way of seeing herself and her relationship with the world, forcing her to revise and reform previous perceptions and assimilate new ones. Her perception of breastfeeding changed from 'oppressive' to 'rewarding' when she accepted that attending to Lauren was a commitment that required patience, time and dedication - qualities that relieved anger and frustration, resulting in personal relaxation and enjoyment.

Bottorff (1990:202,206) notes that the breastfeeding commitment links a mother with her infant in a special, continuous way, which is reflected in her everyday experiences. Anna's experience at the supermarket supports this view, demonstrating that her perception of being-in-the-world had shifted to accommodate Lauren. In other words, Anna was "responding to her environment in relation to her infant" (Bottorff,1990:202).

Finally, one other matter that warrants consideration concerns perceptions of the adequacy of Anna's milk supply. Despite the demonstrable quantity of her supply the quality was called into question by Lauren's behaviour, Dave's comments, and the Plunket nurse's recommendation to complement with formula. The notion of inadequate or 'watery' milk can be linked to Sir Truby King, founder of the Plunket organisation in New Zealand. Wickes (1953:499) notes:

> The nurses were taught to encourage breast feeding, to guard against overfeeding at all costs, to learn how to collect representative samples of breast milk and to estimate the fat content, in addition to all other aspects of mother craft.

Wickes(1953:499) also notes that King's interest in breastfeeding originated from his studies of plant and animal life, becoming "particularly interested in the scientific feeding of calves and the reduction of scouring among them". Wickes's point is that King's theories on 'scientific' infant rearing were founded on the best methods of producing healthy calves. Assuming human and cow's milk to be comparable, King overlooked differences in the growth and development of the respective offspring.

Scientific research has since established considerable variation between the composition of breast and cow's milk, identifying all mammalian milk as species specific. Moreover, it is now known that the composition of breastmilk varies within and between feeds. Thus 'testing' breastmilk to determine whether 'it is good enough' is a procedure open to a number of searching questions, not the least being: When should a sample be taken (at the beginning, middle or end of a feed), and by what criteria should such a sample be judged?

The belief that a mother's milk may 'not be good enough' or 'watery' exemplifies not only outmoded scientific thinking, but also the hegemonic influence of biomedical

thought. That is, it demonstrates a popular perception that breastmilk (as a product of physiological functioning) can be measured and analysed by trained experts to determine whether or not it is fit for the mother's infant. The implication is that some mothers are unable to satisfactorily nourish their infants and are, therefore, directly responsible for an unsettled baby or one failing to thrive. Such problems are perceived as requiring intervention and monitoring by trained experts, such as Plunket nurses. Against this background the apparent doubts of Anna, Dave and the Plunket nurse (when faced by Lauren's unsettled behaviour) become understandable, as does the nurse's recommendation for a formula complement.

RACHAEL

Rachael had always taken it for granted that she would breastfeed, a process she perceived as a convenient, inexpensive, and 'natural' source of nourishment which would help her bond with her baby. Her decision to breastfeed did not involve any firm belief about the advantages of breast milk for her infant. She hoped it would prove an enjoyable event, having heard other women describe it as a 'wonderful' experience. However, as a very easy going person who was, on the whole, happy to "take things as they come", Rachael didn't build up her hopes too much. Indeed, of the four mothers in this study, she appeared to be the most open-minded about what her experience of breastfeeding would involve, and could be described as embarking with very few expectations or preconceptions.

Like Kathy, Rachael's attitude to her breastfeeding experience proved to be somewhat ambivalent. During the early weeks she recognised that she was learning a new skill and while quite prepared to do this nevertheless acknowledged that:

> ...[while breastfeeding is] alright...I wouldn't say its like one of life's wonderful [moments]. But I am not saying I am disliking it, I am just doing it.
>
> (week two)

Throughout most of the interviewing period she continued to perceive breastfeeding as just something that had to be done, neither a chore nor particularly enjoyable. When Toni was ten weeks old, Rachael confirmed that she was still feeling ambivalent about breastfeeding. I asked her how she thought she would feel if she was forced to give

up immediately and put Toni on formula. Rachael's response indicated only the possibility of being a little disappointed at such a decision:

> ...I have got this supply available to her and it's a pity if she can't have it. But you know, I would not be really upset, like the end of the world or anything, if she had to go on a bottle.
>
> (week ten)

The convenience would also be missed, the 'instant source' being very helpful when out and about with Toni, even though she sometimes found breastfeeding a tie. For example, Rachael had always liked dancing and was keen to rejoin a regular group one evening a week, but breastfeeding restricted this activity. With a touch of pragmatism, she eventually resolved this problem by leaving a bottle of expressed milk with the baby sitter. Overall, her perception of the advantages and disadvantages of breastfeeding was consistent with her ambivalence:

> ...it has got its benefits but then it has got its disadvantages, so it works out at about fifty-fifty.
>
> (week ten)

Rachael did not link breastfeeding with the close relationship she enjoyed with her baby. Breastfeeding and closeness, in her eyes, belonged to two quite separate realms. Indeed, she clearly regarded breastfeeding as simply:

> ...a way of feeding Toni. [For example] sometimes at night when she wants feeding every two hours or something, I am sort of just a straight milking machine! That's what it is, just a comfort thing.
>
> (week ten)

In general, I observed that Rachael while breastfeeding, did not look intently at her baby as I had seen numerous other mothers do, with the result that feeding time was not typically a period of interaction between them. Rachael admitted that she preferred to do other things while feeding, such as read a magazine or watch television. I had also noticed, however, that whenever Toni needed to be attended to in other ways, particularly bathing and changing, Rachael became very communicative with her baby and would talk, play and sing to her in a way that expressed obvious enjoyment and pleasure.

My fieldnotes and photographs support this observation, particularly my notes on Rachael bathing Toni when she was eleven weeks old. These notes detail the interaction that occurred between them, describing how Rachael initiated certain actions (blowing, coughing) for Toni to imitate. I wrote:

> How lovely they are together, Rachael is clearly enjoying Toni very much...Toni liked lying on her stomach in the bath with Rachael's hand underneath her head. Rachael...squeezed water on [Toni's] face with the flannel "to get her used to water on her face". This interaction contrasts with breastfeeding which tends to be strictly a means of nourishment.
>
> (week eleven)

After the bath, while Rachael fed Toni, I commented on how much more passive their relationship was while breastfeeding. Rachael confirmed my observation, declaring she much preferred to interact with Toni while doing other things.

Understanding Rachael's experience

It was never clear why Rachael regarded breastfeeding as just a form of sustenance for her baby. Consistent with this view she attributed Toni's pattern of short interval feeding to "comfort sucking" even though Toni was reluctant to accept a dummy or to be comforted by Andrew. My interpretation was that Toni desired the closeness to her mother that breastfeeding facilitates, but Rachael did not accept this suggestion, preferring to separate closeness and interaction from feeding.

Rachael's perceptions of her breastfeeding experience share some similarities with Kathy's. Both Kathy and Rachael were ambivalent about the personal benefits, neither of them perceiving it as particularly pleasurable, enjoyable or attaining the status of "a wonderful thing". But unlike Kathy, Rachael was not subject to conflict generated from her social positioning, nor did she embark on breastfeeding with firm beliefs and expectations one way or another. The result was that she was free to evaluate this experience unhindered by preconceptions.

Rachael's image of herself as an "easy going", "take it as it comes" type of person allowed her to cope with daily difficulties in a very relaxed manner, but also meant that (from my view point) she was disinclined to be introspective or reflective about what was

happening in her life. I interpreted Rachael's ambivalence about breastfeeding and her passivity while nursing Toni, as signifying a relaxed and pragmatic attitude. For Rachael, the most significant elements of motherhood appeared to lie outside the realm of breastfeeding.

To sum up, Rachael's experience may be understood as one where breastfeeding was an unimportant, partial aspect of caring for her baby, "something that had to be done", a means to an end. It was not an activity to be particularly enjoyed or reflected on. Although Rachael recognised that adequate nourishment was important for her baby, she had no strong beliefs about the superiority of breastmilk. Nor did she have a holistic conception of breastfeeding. Instead, Rachael preferred to regard breastfeeding (quite dispassionately) as a process and function falling within the range of general baby care and feeding options.

CONCLUSION

Rachael's experiences (along with Kathy's) raise the question of why some women perceive nursing a baby as a satisfying, rewarding and holistic experience, facilitating 'total mothering' of their infant (Maria and Anna), while others 'endure' but do not enjoy it? Some insight into these differences of perception has been obtained through investigating the nature and congruence of expectations and actual experience, and their relationship to an individual's positioning within the social field. The presence of conflict and tension generated by conflicting discourses is of particular significance.

Kathy's ambivalence, inability to relax and enjoy her experience of breastfeeding, and her failure to recognise its role in enhancing her relationship with Ben, are all features which reflect the impact of pressure from others, her background as a nurse and the physical difficulties she encountered. In contrast, Rachael's ambivalence towards breastfeeding involved a detached pragmatism, a lack of precise expectations and firm convictions, and a focus on other aspects of her mothering experience. Rachael was not exposed to conflict between her practices and those of her friends, her perceptions generally conforming to those held by the antenatal group to which she belonged.

Maria and Anna on the other hand were very positive about their experience of breastfeeding. In Maria's case a relative absence of physical problems and a healthy, placid baby contributed to a stress-free and enjoyable experience. More importantly, Maria identified motherhood as a long-time aspiration and clearly regarded her ability to breastfeed successfully as central to this status. The impact of others, in verifying her successful transition from young woman to breastfeeding mother, was a significant aspect of her experience, encouraging her to continue and endorsing her belief that breastfeeding was of great benefit to both herself and Rose.

Anna, like Maria, also regarded breastfeeding as a rewarding and enjoyable experience, although she acknowledged that it required patience, perseverance and dedication. Anna's location within a pro-breastfeeding family was supportive and encouraging, contrasting with her chequered relationship with the Plunket nurse, the latter involving both helpful and unconstructive advice and assessment. Anna's experience of breastfeeding contributed to an altered and extended sense of self. This shift and development in her self-perception enhanced Anna's sense of satisfaction and encouraged her to continue breastfeeding.

It is clear that each mother's perceptions of her breastfeeding experience predominantly reflected her position within the social field and her relationship with other people. Negative perceptions derived from her social position and relationships with others made the experience much more difficult and inhibited the realisation of enjoyment and satisfaction. Positive perceptions, on the other hand, enhanced her enjoyment of breastfeeding but more importantly reduced tensions and conflict generated by the disjunction of physical processes and social forces.

CONCLUSION

> Contextual factors play an important role in breast feeding. These include the structural realities that are manifested in concrete barriers to breast feeding and the more subtle socialization processes that influence a woman's response to her own experience. All concerned individuals must work together to press for changes in our socio-cultural environment so it will be easier for women and men to nurture societies' children.
> Maclean (1990:211)

This thesis has argued that cultural studies on breastfeeding are dominated by a biomedical construction which separates mind from body, resulting in a focus on physiological functioning at the expense of the social, cultural and experiential aspects of breastfeeding as well as other areas of human life. In effect, biomedical understanding of the process of breastfeeding presents a simplistic, reductionist approach to the topic. Accordingly, alternative perspectives are needed if a more holistic understanding of breastfeeding is to be obtained.

The objective of the present study has been to present an alternative understanding of the process of breastfeeding, one which focuses on the mother's experience of this event. I have argued that the process of breastfeeding reflects the relationship between physical processes and social and cultural forces. Central to the theoretical focus of this alternative perspective is the politics of the body. The body is construed as the site where physical processes confront social forces and where often contending discourses converge. As a site of tension, struggle and conflict, the body encompasses the social at the heart of the individual, the impersonal beneath the intimate and the universal buried deep within the particular.

The datum for this thesis were drawn from three separate sources. The first, the literature review, revealed the dominance of biomedical discourse in cultural research on breastfeeding. It acted as an indicator of the dominant understanding of breastfeeding as well as signalling the need for alternative approaches to the topic. The second source was my own experience as a breastfeeding mother and La Leche League counsellor. It was this experience that gave rise to my dissatisfaction with the nature of the biomedical perspective on the process of breastfeeding. It also provided

the basis for comparison with and shared understanding of the experiences of others. The third and final source of data was the accounts of the breastfeeding experiences of four first-time mothers.

The predominant view of breastfeeding as a 'natural' body function, a biological process, was clearly evident in each mother's attitudes and expectations concerning breast and nipple discomfort and dysfunction, feeding schedules and the routines of her baby. A hegemonic biomedical influence was manifest in each mother's use of language describing physical aspects of breastfeeding (for example, the let-down reflex), her perceptions of physical dysfunction (inverted nipple, cracked nipple), and attitudes concerning appropriate practices and strategies of intervention (use of ultra-sound treatment and lotions for nipples, etc.).

A clear example of perceived need for professional guidance and knowledge was evident during the hospital stay of Anna and Rachael. Both mothers experienced a degree of difficulty or discomfort with the establishment of breastfeeding and, although the problems were common and possibly 'normal' for newly delivered mothers, they accepted the need for technical intervention. However, while Anna and Rachael had personal queries about the professional advice and apparent inconsistency of opinion among nursing staff, both women, as patients and 'novice' mothers, were reluctant to challenge or completely disregard the advice of the maternity staff, even when (as in Anna's case) it was at odds with one's assessment of the situation. The experience of these two mothers, Anna in particular, can be recognised as consistent with the process of medicalisation; that is, recognition of trained professionals as the custodians of specialised knowledge concerning diagnosis, prevention and treatment of individual health 'problems' and a devaluation of 'lay' or 'folk' experience and opinion. Their acceptance that as patients they must comply (or appear to comply in Anna's case) with the instructions of those possessing power through 'expert' knowledge is, of course, further evidence of hegemonic biomedical influence (Van Esterik,1989:114-115).

The relationship between the physical process of breastfeeding and social expectations regarding infant care practices was manifested in the conflict most of the mothers

experienced between the demands of breastfeeding and their perceived roles as women, mothers, wives and so on. The demands of frequent nursing, necessary for the maintenance of an adequate milk supply, often interfered with perceived domestic and social obligations, and fell short of expectations of 'life as normal' after the birth of the baby. Disjunctions between expectation and actual experience were apparent in anxieties and tensions over a baby's inability to conform to a timetabled sleeping routine and feeding schedule. All the babies fed more regularly than the mothers anticipated, and during the early weeks at least, failed to sleep for extended periods at night. An inability to predict and regulate an infant's sleeping and feeding patterns was perceived as being more or less problematic by each of the mothers because it interfered with desires to conform to the social construction of their role(s) as a mother, housewife, etc. The fact that the social construction of each role was often incompatible with a mother's needs, the needs of her infant and the physiological requirements of maintaining an adequate milk supply, generated feelings of inadequacy and tension. Caught between the demands of physical functioning and social requirements, the mother's body was the site of this struggle and conflict.

I have identified the positive and negative aspects of each mother's contact with other people. In particular, the importance of a doula was identified, an individual capable of supporting and assisting the new mother, cushioning her from the daily demands of her normal lifestyle and the expectations of others. As a person of support, reassurance and practical help, the presence of a doula (usually a respondent's mother or spouse) was instrumental in diminishing conflict and tensions faced by the newly breastfeeding mother.

The impact of spouses, relatives, friends and acquaintances varied from mother to mother. Generally, spouses provided significant support, reassurance and practical help for their wives, and in at least one instance ably fulfilled the doula role. In contrast, the contribution of other relatives and friends was mixed. Anna, for example, found her husband's family very helpful and supportive, and was happy to seek their assistance whenever she felt the need. In contrast, the demands and remarks of some of Kathy's

friends and acquaintances caused her to question her practices, undermined her confidence and thereby generated pressure and stress.

Significant to each mother was the scrutiny of the local Plunket nurse. For two of the mothers (Maria and Rachael), this professional was positively perceived as a helpful resource person or as an expert in the area of infant care and feeding who endorsed the success of a breastfeeding mother. However, for the other two mothers, the Plunket nurse represented a source of conflict and tension. These negative outcomes arose from the Plunket nurse's constructions of 'normal' infant behaviour and development, particularly in the areas of sleeping, feeding and weight gain. As an acknowledged authority on infant rearing, the nurse's comments have the potential to endorse or undermine a mother's confidence and practices. While the baby conforms to the nurse's construction of 'normal' progress there is little need to question a mother's practices. But when the baby's progress falls outside this construction of 'normal', the concern expressed and intervention strategies recommended by the nurse may in fact compound or even worsen the situation.

Another aspect of relationships with others concerned the issue of breastfeeding in public. Once again differences in the attitudes, socially formed expectations and experiences of each mother were identified. Only Maria was totally uninhibited as to when and where she would breastfeed her baby. The other mothers perceived certain situations as inappropriate or uncomfortable and reported efforts made to avoid personal embarrassment or behaviour possibly disagreeable to others. Moreover, the issue of breastfeeding in public situations revealed an awareness of social contradictions regarding the female breast, defined as both a sex object and as a symbol of maternity. The conflict between these views of one part of the female body at times created a tension between the baby's need to be fed and the social demand for discretion to be exercised by the mother or even her voluntary removal from the public situation.

Each mother's perceptions and reflections on her breastfeeding experience varied from very positive to ambivalent. The reasons underlying these variations are complex, reflecting individual desires, self-perception, social positioning and the link between

expectations and actual experience. Fundamental to each mother's perceptions was the presence (or absence) of tension and conflict generated by conflicting discourses, the struggle between the physical process of breastfeeding and its social construction, and the demands made on her as a women, wife, mother, friend, patient and so on.

It is not surprising, therefore, that the mother with the most positive perception of breastfeeding was Maria. As a young, single mother, Maria was apparently less affected than the others by pressures to conform socially. Moreover, the help and support received from her parents contributed to a situation where she was able to organise her daily life around the needs of her baby. Maria's exposure to conflicting social demands was therefore minimised. In addition, Maria was fortunate in having a placid baby whose progress was consistent with Plunket ideals. As a result her experience of breastfeeding was enjoyable, rewarding, self-affirming and exceeded her expectations.

A woman's initial expectations are undoubtedly significant in terms of their affect upon her view of the actual experience of breastfeeding. For example, Kathy's inability to recognise breastfeeding as a "wonderful thing", and statements about her ignorance of the extent or intensity and duration of discomfort associated with breastfeeding, serve to indicate a substantial measure of difference between her expectations and actual reality. The gap between expectation and experience in Kathy's case manifested itself in her ambivalence towards breastfeeding. Rachael, although also ambivalent, did not appear to hold firm expectations of breastfeeding one way or the other. Her ambivalence may perhaps be understood to indicate that her experience of breastfeeding was disappointing as compared with other aspects of caring for her daughter.

Rachael's experience provided a valuable lesson in research. Her ambivalence towards breastfeeding initially puzzled me. I had expected that because everything was progressing relatively smoothly for her that she would 'naturally' enjoy the interaction it facilitated with her baby. Rachael, however, perceived breastfeeding as just something she "had to do", a means of nourishment for Toni and nothing more. This

observation thoroughly shook my own set of experience-biased, preconceived ideas. I needed to revise and broaden my assumptions about breastfeeding and mother-baby interaction before I was able to recognise how Rachael felt and to realise that it was during other aspects of baby care that she gained the greatest satisfaction from her interaction with Toni.

DIRECTIONS FOR FUTURE RESEARCH

At various points throughout this thesis, the discussion has touched on issues beyond the scope of the present investigation. Perhaps the most obvious of these issues concerns the relationship between breastfeeding and women's sexuality. For example, Van Esterik (1989), discussing infant feeding and the empowerment of women, draws attention to sex object perceptions of the female breast which appear to underlie conservative feminist perspectives. Classifying the La Leche League as a conservative group, Van Esterik (1989:92-94) argues that the organisation's literature and programmes:

> ...[promote] the need for modesty by keeping the breasts covered while breastfeeding; ... give assurances that breastfeeding will not endanger the sexual appeal of the breasts by making them sag...[and] make reference to the fact that men may be even more attracted to the enlarged breasts of a lactating mother...

At the more general level of Western culture and society, Gunther(1976:147) observes that:

> ...a young woman in Britain cannot be unaware of the unending seaside-postcard form of joke presented in all sorts of guises in the media and elsewhere. There has been a considerable increase in the exaggeration of the ideas of the male-attracting function [of female breasts] and almost an obliteration of the association with mothering.

More specifically, from the viewpoint of first-time mothers (such as Kathy, Anna and Rachael), Parker's (1992:5) point that "..breasts are considered quintessentially sexual all year long...but never when a baby's mouth is attached", neatly identifies the confusion caused by conflicting constructions of the female body, and highlights the need for investigation of the link between perceptions of female sexuality and breastfeeding.

Another topic worthy of careful research concerns the role and impact of the Plunket nurse, identified in Chapter Five as both positive and negative. The results presented in this study therefore pose an important question. Is the Plunket nurse only really effective when a baby is progressing normally and well, allowing the mother's confidence and ability to be approved and affirmed? Although it cannot be claimed that the case studies presented in this thesis are representative of all relationships between mothers and Plunket nurses, the experiences detailed in this thesis nevertheless raise questions about the role of the Plunket nurse and her relationship with first-time mothers.

Perhaps even more significant are the issues raised by the Plunket organisation's construction of infant progress and the fact that graphs indicating 'normal' height/weight ranges proved unsettling, and even upsetting, to Kathy (herself a health professional) and both Rachael and her husband. Why is it that graphic representation of an infant's progress assumes such importance to both parent and nurse, especially when only two (height and weight) factors are being considered out of a range of indicators capable of contributing to assessments of an infant's progress? Why is not more emphasis placed on alternative subjective assessments of the baby's progress (e.g. complexion, disposition, behaviour)? No doubt the answers to these questions can be found within the hegemonic nature of biomedical discourse. Clearly there is a need for research on the impact of biomedical assessments upon the mothers of infants (e.g. stress, loss of confidence, impaired ability to breastfeed, etc.) and for investigation into the potential benefits of alternative assessment criteria and strategies.

A further issue not pursued in this thesis concerns the place of the La Leche League in the discourse on breastfeeding. Van Esterik (1989:94) makes the interesting observation that:

> The La Leche League and various movements that support more natural childbirth and mothering can become oppressive as they develop ideals and standards against which mothers judge themselves and are judged.

A computer assisted search of the literature revealed a surprising lack of detailed social research focusing on the nature, role and impact of this organisation, either in New

Zealand or elsewhere.[1] Founded in the United States in 1956, the continued existence and expansion of this organisation raises a number of questions. How significant has the La Leche League been in contributing to the upsurge in breastfeeding occurring since the mid 1960s? What is the philosophy and underlying ideology of this organisation and does it relate to social, economic and cultural issues in the 1990s? Are there differences in membership and outlook between the La Leche League in New Zealand, the United States, Canada and elsewhere? What is its impact on the childrearing attitudes, behaviour and general lifestyle of the mothers who become members, and is this influence threatening or negative for those women who fail or struggle to breastfeed as Van Esterik's comments suggest? Have the La Leche League ideas and knowledge of breastfeeding had any affect on the attitudes and practices of medical professionals? Clearly there are a number of interesting issues waiting to be investigated concerning the La Leche League, its members and its influence both within New Zealand and further afield.

Finally, it should be noted that with the possible exception of Maria, the women in this study shared very similar social and cultural characteristics. It must therefore be stressed that the experiences detailed in this study and the conclusions reached, while identifying patterns that occur and recur in diverse sets of social relations, are not necessarily representative of *all* breastfeeding mothers. There is a need for broader investigation into the topic that allows inclusion of not only pakeha New Zealand women from different social backgrounds, but also those from other cultural or ethnic groups. Of particular interest would be an examination of alternative cultural constructions of the process and practice of breastfeeding within New Zealand, and how these contradict or complement the biomedical construction of this event.

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[1] One of the few studies specifically focusing on La Leche League mothers is a study by Cable and Rothenberger(1984). There are, of course, a number of studies which make passing reference to the organisation (see Maclean,1990:195-198; Van Esterik,1989:93-94,102,104) or which give limited attention to its impact (see Trlin and Perry, 1982: 575-576).

IMPLICATIONS FOR PRACTICE

Finally, in the context of a research exercise investigating the politics of the body, it is fitting that comment be made on the relevance of some conclusions for practicing health professionals. Of paramount significance is a need for a more general recognition that the experience of bodily function and processes is individually unique and variable. In other words, the biomedical assumption of commonality of bodily experience is both erroneous and misleading. Assumptions of this kind were not always helpful for the women in this study, contributing to an undermining of confidence when they perceived their experience as different from their own expectations and those of others.

Linked with the above is the need for recognition that breastfeeding occurs not in isolation but within the context of complex social forces. As a significant aspect of a mother's perception of breastfeeding, tension and conflict generated by social pressures have the potential to affect her ability to produce sufficient milk. Moreover, the social environment is clearly influential in enhancing or undermining the confidence of each mother in her ability to successfully breastfeed her baby. Thus health professionals need to recognise and take into account a mother's location within a particular social and cultural context when offering advice and strategies of intervention.

Relationships with others emerged as an important aspect of the breastfeeding experience. There are several implications arising from this conclusion. First, other people are a crucial source of support or conflict. Thus it is important that the breastfeeding mother has access to those who will support and encourage her efforts and that she is shielded from those who don't. It would be desirable, for example, if health professionals were aware of (and promoted) the advantage of someone to fulfil the doula role for new breastfeeding mothers. Second, as a health professional, the Plunket nurse clearly plays a key role on a number of levels. As a support and resource person her knowledge and expertise is valued and respected. As a 'baby expert' her advice and support carries the weight of authority. Thus the nurse needs to be aware that she is in a power relationship and must carefully consider the impact of her comments and advice on the confidence and practice of each mother. Third, maternity hospital staff also emerged as possessing power and control over the actions

of the women in this study. At a time when a mother is unsure and vulnerable, conflicting and inconsistent advice is unhelpful and confusing. Maternity hospitals need to ensure that staff have adequate training and offer consistent advice, especially to those attempting to breastfeed for the first time.

POSTSCRIPT

This thesis, structured according to the logic of discovery, needs to be recognised as an integral part of a personal process of constant reappraisal of ideas, knowledge and understanding. Completion of this project has stimulated a reassessment of my ideas and interpretations, tempering any sense of accomplishment with dissatisfaction and ongoing curiosity. Accordingly, I view this research project as essentially incomplete, something which serves to mark a stage in a process of discovery of further insight, understanding and knowledge of human action, thought and experience.

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APPENDIX

CONSENT FORM

1) I agree to participate in this study but understand that I have the right to withdraw at any time.

2) I understand that confidentiality of information is guaranteed, and that any information I provide or observations of my practices will be used for research purposes only, Annette's MA thesis and possible academic publications. Thesis photographs will have facial features obscured and anything published directly from a transcript will first be checked by me.

3) I agree to Annette recording any interviews and/or observations photographically, on tape and in writing.

----------------- Signed

----------------- Witness

----------------- Researcher