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Responding to the Call to Care:

Women's Experience of Breastfeeding in New Zealand

A thesis presented in fulfilment of the requirements

for the degree of

Doctor of Philosophy in Nursing

at Massey University, Wellington, New Zealand.

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Abstract

New Zealand breastfeeding experts have long contended that New Zealand does not have a breastfeeding culture, as demonstrated by anecdotal evidence suggesting that women find breastfeeding difficult to initiate and sustain. A review of the literature indicates that, in New Zealand, breastfeeding knowledge falls within the domain of health care professionals, which marginalises women's own experiential knowledge about breastfeeding. Therefore, this study explores the experience of breastfeeding for women in New Zealand. A reflective lifeworld research methodology underpins this study, allowing the participants' narratives to be explored without the use of pre-existing theoretical frameworks that may close down on aspects of the interpretive analysis. Nineteen women were interviewed for this study, all of whom were New Zealanders who were either breastfeeding at the time of the interviews, or had breastfed within the last two years. Many of the participants had breastfed more than one child.

What emerges as the central thesis of this study is that breastfeeding is *a priori* to unique embodied experiences. A number of sub-themes, which further explicate this central thesis, include: the silencing of the reality of breastfeeding within the public domain, the pervasive influence of society, or 'the they', through the accepted frameworks by which breastfeeding women interpret their individual breastfeeding experiences, and breastfeeding as a means of facilitating close relationships between women and their infants. The findings of this study will assist health care professionals working alongside breastfeeding women, as it offers fresh understandings of what it is to be a breastfeeding woman. It is important that health care professionals lay aside their previously-held perceptions about breastfeeding, and pay careful attention to individual women's experiences prior to planning interventions. If health care professionals value women's embodied breastfeeding narratives, women will be supported to articulate their breastfeeding experiences, thereby increasing women's confidence in their embodied breastfeeding knowledge and capabilities.

Acknowledgements

I am so grateful for the wisdom, experience and courage of the women who shared their life stories. They have touched my life, which is forever changed because they were open to talking about their lives. It is important that they know that, because of all they taught me, I was able to breastfeed my son.

My wonderful husband, Norm, has astounded me with all the ways he has managed to support me whilst I spent hours locked away with my computer, not the least of which was editing my final draft. I am grateful that he, a devout physicists, was open-minded enough to accept my phenomenological turning.

Matthew, my little gift, has taught me an incredible amount over the last 16 months. He has extended my horizon, and there is no going back.

I also need to acknowledge my family's contribution to this project. They have offered me endless encouragement, and bolstered my confidence during challenging periods. My mother always told me I should never settle for anything other than my best – I hope I have lived up to her expectations. I am so grateful for the family that my Mum and Dad built, which has provided me with such amazing and unceasing support.

I now appreciate the immensity of the commitment that Associate Professor Gill White and Associate Professor Cheryl Benn made when they agreed to supervise this process. I am grateful for the wise counsel they have both provided, which has shaped my thinking and writing.

The Journey

As a child thoughts bigger than words sought me
Criticised: My time, my place prevented thoughts from finding me
Fidelity's acceptance of my openness, my turning
Illuminates the breath that will lift me
My soul echoes with the voice of excitement
For the language that my body has always longed to speak is at last –
Coming to me

Karen McBride-Henry
16 June 1999

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Chapter One

Introduction and Background to the Study

1.1 Introduction

The health benefits of breastfeeding for both mother and infant have been widely recognised, with research demonstrating that breastfeeding offers infants and young children the optimal source of nutrition, paving the way for a healthy start to life, while at the same time contributing to the mother's health (American Academy of Pediatrics, 1997; Australian College of Paediatrics, 1998; Riordan & Auerbach, 1993). Furthermore, research into the economic benefits of breastfeeding has highlighted the financial contribution breastfeeding women make to society through lower health care costs (Galtry, 1997; Waring, 2000). Despite all of these benefits, statistics indicate that the majority of New Zealand women wean their infants before six months of age (Ministry of Health, 2002); therefore, an investigation into what women in New Zealand experience when they breastfeed is warranted.

This chapter offers an introduction to this study into women's experience of breastfeeding in New Zealand. It outlines the biomedical literature that demonstrates the health benefits of breastfeeding, and locates alongside this the research that has examined women's experience of breastfeeding. To contextualise the researcher's personal journey, an account of how breastfeeding emerged as significant is presented. This chapter also provides a brief introduction to the methodology of reflective lifeworld research, which has facilitated this study. The chapter concludes with an overview of the research project.

1.2 The Focus of this Study

Scientific research has created a particular type of knowledge around breastfeeding; however, this knowledge often contradicts women's experience

of breastfeeding (Britton, 1997). It has been argued that women's experiences of breastfeeding within New Zealand have been silenced, and there has been a call to examine these experiences to facilitate a change in this society's perceptions of breastfeeding (Beasley & Trlin, 1998; Dignam, 2001; Watson, 2001). Furthermore, Dignam calls for research that explores the "psychological, emotional and interpersonal dynamics of breastfeeding" (MacLennan, 2001, p. 13).

Research indicates that women are well versed in the biomedical significance of breastfeeding for their infants, and are also aware of the economic benefits of breastfeeding (Earle, 2002; Galtry, 1997; Kessler, Gielen, Diener-West, & Paign, 1995; Meyer & de Oliveira, 2003; Wagner, Hulsey, Southgate, & Annibale, 2002; Waring, 2000). However, this knowledge appears to have limited influence on whether an individual woman will continue breastfeeding beyond the first few months. This is reflected in the national breastfeeding rates: forty nine percent of women wean their infants before three months of age (Ministry of Health, 2002), despite global (World Health Organisation & UNICEF, 1990; World Health Organization, 2002; World Health Organisation & UNICEF, 1989) and national policies (Ministry of Health, 1997; Ministry of Health, 1999a; Ministry of Health, 1999b; Ministry of Health, 2001; Ministry of Health, 2002) aimed at protecting, promoting and supporting breastfeeding.

Global and national initiatives often fail to take into account the lived experience of breastfeeding, essentially ignoring the cultural environment in which women breastfeed. Examining the meaning that breastfeeding has for women will allow the emergence of fresh understandings, thereby enabling health care workers to promote breastfeeding in a manner that takes into account the world in which women find themselves. Therefore, this research project asks the question: *what is women's experience of breastfeeding in New Zealand?*

1.3 The Health Benefits of Breastfeeding

Research has demonstrated that breastfeeding offers both women and their infants significant and long-term health benefits (Australian College of Paediatrics, 1997). There is strong evidence that, in developed nations, breastfed infants are less likely to suffer from a number of acute and chronic

illnesses; if they do, their illnesses are frequently less severe than for non-breastfed infants. These include diarrhoea (Bhandari et al., 2003), otitis media (Duncan, Holberg, Wright, Martinez, & Taussig, 1993), lower respiratory infections (Bachrach, Schwarz, & Bachrach, 2003; Chulada, Arbes, Dunson, & Zeldin, 2003), urinary tract infections (Hanson et al., 2002), *Haemophilus influenzae* type B (Silfverdal et al., 2002), and bacteraemia (American Academy of Pediatrics, 1997; Heikkila & Saris, 2003). Breastfed infants are less likely to suffer from sudden infant death syndrome (Alm et al., 2002), and there is evidence that breastfeeding may provide protection from chronic illness such as insulin-dependent diabetes mellitus (Ravelli, van der Meulen, Osmond, Barker, & Bleker, 2000; Young et al., 2002), lymphoma (Davis, 1998), leukaemia (Infante-Rivard, Fortier, & Olsen, 2000), asthma (Chulada et al., 2003; Sears et al., 2002), atopic-related reactions (Kull, Wickman, Lilja, Nordvall, & Pershagen, 2002; van Odijk et al., 2003), Crohn's disease (Corrao et al., 1998; Silfverdal et al., 2002), high blood cholesterol levels (Plancoulaine et al., 2000; Ravelli et al., 2000), obesity (Gillman, 2002; Toschke et al., 2002), celiac disease (Ivarsson, Hernell, Stenlund, & Ake Persson, 2002), and ulcerative colitis (Corrao et al., 1998). Breastfeeding has also been linked to enhanced cognitive development (Dewey, Cohen, Brown, & Landa Rivera, 2001; Mortensen, Michaelsen, Sanders, & Reinisch, 2002).

Research also indicates a number of benefits for women who breastfeed. In the initial postpartum period, breastfeeding results in the increased secretion of oxytocin, decreasing the risk of haemorrhage (Riordan & Auerbach, 1993). Women are also more likely to return to their pre-pregnancy weight if they breastfeed (Dewey et al., 2001). Lactational amenorrhoea and delayed ovulation mean that women are less likely to become pregnant and they also lose less menstrual blood in the months following birth (Simondon, Delaunay, Diallo, Elguero, & Simondon, 2003). The long-term benefits of breastfeeding for women are also significant, and include enhanced bone re-mineralization (Paton et al., 2003; Polatti, Capuzzo, Viazzo, Colleoni, & Klersy, 1999), reduced risk of suffering hip fractures in older age (Cumming & Klinebergm, 1993), and reduced risk of developing breast and ovarian cancer (Collaborative Group on Hormonal Factors in Breast Cancer, 2002; Rosenblatt & Thomas, 1993).

In light of these health benefits, breastfeeding offers significant consequences for public health. As a result, organisations such as the United Nations

International Children's Fund (UNICEF) and the World Health Organisation (WHO) actively promote strategies that encourage breastfeeding. However, as the previously-mentioned statistics demonstrate, many New Zealand women do not breastfeed their infants beyond the first few months. The reasons for this trend begin to emerge through examining the research that explores the experience of breastfeeding in New Zealand.

1.4 Women's Experience of Breastfeeding

Research demonstrates that women gain knowledge about breastfeeding from their culture (Beasley & Trlin, 1998; Ryan & Grace, 2001). Examination of historical accounts of infant feeding in New Zealand also indicates that the past plays a major role in how breastfeeding is currently understood (Kedgley, 1996; Ryan, 1999a). This culturally-mediated awareness provides women with understandings of breasts and breastfeeding, dictating acceptable breastfeeding practices and influencing decisions about infant feeding.

Women's decisions to breastfeed are typically made during pregnancy (Aldridge & Stevenson, 2000; Arora, McJunkin, Wehrer, & Kuhn, 2000; Earle, 2000; Heath, Reeves Tuutle, Simons, Cleghorn, & Parnell, 2002), and are significantly influenced by the knowledge that breastfeeding provides infants with optimum nutrition, whilst also attending to their emotional wellbeing. These beliefs mean that women express a strong desire to breastfeed prior to giving birth.

However, women report that it can be more difficult to establish breastfeeding than they anticipated (Benn, Budge, Anderson, & Wright, 2002; Benson, 2000; Mozingo, Davis, Droppleman, & Merideth, 2000). They cite a lack of support from health care professionals and inconsistent advice as factors that contribute to negative breastfeeding experiences in the initial postpartum period (Benn et al., 2002; Cronin, 2003). The technical skill needed to effectively latch an infant on to the breast is reported to contribute to women's stress in the beginning phases of breastfeeding (Cronin, 2003). Perceptions of insufficient milk and unsettled infants also act as strong deterrents to breastfeeding (Beasley, 1996a; Beasley et al., 1998; Heath et al., 2002; Hill, Humenick, & West, 1994; Vogel & Mitchell, 1998a). However, the greatest difficulty faced by women who are establishing breastfeeding is pain, which is frequently attributable to sore and

cracked nipples (Benson, 2000; Mozingo et al., 2000; Page, Lockwood, & Guest, 2003; Schmied & Barclay, 1999; Schmied & Lupton, 2001), and may continue for months (Schmied & Barclay, 1999).

It is clear that many women wean their infants before they had intended to (Blyth et al., 2002; Mozingo et al., 2000; Vogel & Mitchell, 1998b), and it would appear that the major reason is a perception of insufficient milk (Blyth et al., 2002; Hill, 1992; Hill et al., 1994; Mozingo et al., 2000; Vogel & Mitchell, 1998b). Researchers have indicated that women often question their ability to produce enough milk to sustain their infants, especially if they are unsettled (Blyth et al., 2002; Heath et al., 2002). Other reasons cited for premature weaning include painful breastfeeding, unrealistic expectations, infant behaviours, a lack of knowledge, and the obligations of paid employment (Maclean, 1990; McLeod, Pullon, & Basire, 1998; Vogel & Mitchell, 1998b).

If a woman has confidence that she is capable of breastfeeding she is more likely to successfully establish breastfeeding (Blyth et al., 2002; Dennis, 1999; Ozturk Ertem, Kaynak, Kaynak, Ulukol, & Baskan Gulnar, 2001). As the length of time a woman breastfeeds increases, her confidence in her ability continues to grow (Blyth et al., 2002). Researchers often employ the term 'successful breastfeeding' to describe women who breastfeed for relatively long periods (Henderson, Stamp, & Pincombe, 2001; Inch & Fisher, 2000; Jones, 2001; Labbok, 2000). Women who are more likely to be successful at breastfeeding are well educated, older, and of European descent (Ford & Labbok, 1990; Heath et al., 2002; Ruowei & Grummer-Strawn, 2002). Women are also more likely to breastfeed if they are either not in paid employment, or are employed in a professional position (Carlson Gielen, Faden, O'Campo, Brown, & Paige, 1991; Hills-Bonczyk, Avery, Savik, Potter, & Duckett, 1993; Ryan & Martinez, 1989).

Women who continue to breastfeed their infants describe how breastfeeding can facilitate an intimate and close relationship with their infants (Bottorff, 1990; Dignam, 2001; Schmied & Lupton, 2001). Breastfeeding means that women feel a connection with their infants, and as a result women experience satisfaction, which supports their resolve to continue breastfeeding (Dignam, 2001; Schmied & Lupton, 2001).

1.5 My Journey as the Researcher

I was in high school during the late 1980s when the discourse of 'women's right to choice' was highly valued. The philosophy of choice, I believed, was the 'birth rite' of all women. The freedom to choose one's life path was a message and philosophy that I embraced as a young woman in the middle of defining who I was as a person. This belief affected the way I viewed the issue of breastfeeding: I believed that women had a choice as to whether they breastfed or not, and I did not understand why women *chose* not to.

I completed my undergraduate degree and subsequently registered as a nurse in the early 1990s. My degree programme did not contain much information about the importance of breastfeeding, nor did it provide me with the skills to support women who were breastfeeding.

I was aware that most women in New Zealand initiated breastfeeding, but that many did not continue to breastfeed. Within my clinical practice as a Child and Family Health Nurse, I also observed a preference within the acute care system for quantifiable methods of measuring infant nutrition, which is difficult to achieve if an infant is breastfed. This preference on the part of practitioners meant that breastfeeding women were frequently offered bottles of artificial formula[1] to feed to sick infants, so their intake could be measured.

As a nurse who resolutely believes in health promotion, I struggled to resolve the discrepancies between information provided by the WHO (World Health Organisation & UNICEF, 1989; World Health Organisation & UNICEF, 1990) and the everyday practice of health care practitioners in the acute care setting. This, coupled with the awareness that I lacked the skills and knowledge to advocate for, and support, the breastfeeding mothers whom I worked alongside, left me in a vulnerable position. These concerns led me to seek opportunities to learn more about the issues surrounding breastfeeding.

While studying towards a Master of Nursing degree, I enrolled in an elective paper on breastfeeding, which focused primarily on the social consequences of breastfeeding. I learned that breastfeeding is a multi-factorial issue and that

[1] Throughout this document, the phrase "artificial formula" is used to describe any milk-based product routinely offered to infants that is intended to replace human milk.

historical, social, cultural and political discourses all influence the manner in which breasts and breastfeeding are interpreted.

During the course of my study I came to position myself as a feminist, in part because of feminist writings that significantly influenced my understanding of women's health issues. I came to understand that women's bodies are frequently problematised and considered faulty (Carter, 1995; Greer, 1999), which has influenced my interpretation of research addressing women's health.

Following the completion of the breastfeeding paper I commenced a research project that focused on breastfeeding women's perceptions of infant care routines (McBride, 1999). I had hoped to gain insight into why breastfeeding women chose to use routines to manage the care of their infants, and I suspected that the need to reconcile breastfeeding routines with lifestyle prompted women to choose not to breastfeed. Instead, I discovered that a woman's choice of whether or not to use a structured routine does not influence her breastfeeding decisions. This left me asking the question: why, in light of the benefits of breastfeeding for both women and infants, were some women choosing not to breastfeed?

This led me to challenge my previously-held understandings about breastfeeding and choice, and I realised that I had no understanding of the lived experience of breastfeeding. Furthermore, the insight I needed was not fully available in the literature that examined the issue of breastfeeding. This desire to know what breastfeeding was like for women led me to embark on this doctoral study.

To investigate the fundamental question posed in this study, a specific methodology that valued the meaning that lifeworld experience held was paramount; therefore, reflective lifeworld research was chosen as the methodology to guide this research. This methodology is primarily based on the philosophical works of Heidegger (1962), Gadamer (1989) and Merleau-Ponty (1981). Reflective lifeworld research focuses on describing and interpreting lived experiences. It is a methodology that enables a researcher to examine phenomena in their entirety, and does not require previously-designed theoretical frameworks to prescribe interpretive directions.

Four years into this study, following the analysis of the findings, I gave birth to my first child. My son was premature and, due to severe reflux, was a challenge to breastfeed. During this period I became increasingly aware of the gift the women who had participated in this study had given to me, a novice breastfeeder. The information I had gained from their stories fuelled my desire to persevere, and gave me confidence that I was capable of rising to the challenge of breastfeeding. I was prepared for the difficulties that the establishment of breastfeeding held, and willing to endure a great deal of pain for the relationship that can be born through breastfeeding. Supported by the shared knowledge of the women who participated in this study, I am still breastfeeding my son a year later.

Another personal insight emerged when I was preparing the literature review nine months after the birth of my son. At that time I returned to Bottorff's (1990) article on persisting with breastfeeding. I marvelled at the wisdom and insight that emerged through her study, finding my own breastfeeding story mirrored in the narratives of the women who participated. Persisting with breastfeeding means adjusting to the unpredictable, the ever-changing ebb and flow of your infant's needs. It also necessitates giving birth to a new sense of self, which for me involved incorporating my baby as an integral part of me, a concept that is also discussed by Beasley (1996a) in her book about breastfeeding for the first time. Had I not readjusted my sense of self I would have fought the constant demands my son placed on me. It was important that I gave myself the freedom to be what I was called to be, and fight societal forces that attempted to bridle my breastfeeding philosophy.

Ultimately, this research has had a tremendous effect on me, both professionally and personally. However, had I not been influenced by the context in which I found myself as a nurse, the issue of breastfeeding would not have risen to the fore and held significance for me. Heidegger (1962) calls us to conversation. He calls to us to interpret his philosophy by way of conversation with that which we encounter in the world in which we find ourselves. This leads to differing ways of understanding the lifeworld. This research is my attempt to converse with the philosophical developments of Heidegger (1962), Gadamer (1989) and Merleau-Ponty (1981), to facilitate an understanding of the lifeworld of a woman who breastfeeds. It is my hope that this conversation will call you to thinking; that it will call you to engage with the 'taken-for-granted' in

a way you might otherwise not have. This, as with any interpretation, is dynamic and never finished – your own interpretations, as a result of engaging in this interpretation, will hopefully extend your own lifeworld horizon, facilitating a different way of perceiving and understanding the lifeworld in which we exist.

1.6 Breastfeeding, *A Priori* to New Understandings

Some experiences result in transforming one's life perspective, causing one to extend their horizon, giving birth to new and exciting possibilities that would otherwise never have existed. This "establishment of a new dimension of experience is the setting forth of *a priori*" (Merleau-Ponty, 1962, p. 30). Becoming a breastfeeding woman is *a priori*, as it irrevocably alters a woman's perspective and facilitates the emergence of expanded horizons; thus, breastfeeding provides a portal for new ways to understand and interpret, altering a woman's fundamental way of 'being-in-the-world'.

Breastfeeding provides women with access to new experiential knowledge, and becomes *a priori* to understanding embodiment, close relationships and *'the they'*. The embodied understandings gained by the women in this study can only be birthed through experiencing breastfeeding. The role of experiential knowledge "opens up distinctly differentiated lifeworlds of perceptions, concerns and understandings" (Benner, 2000, p. 8). The experiential learning and emotions of breastfeeding women open up a differentiated lifeworld of awareness and concernful caring, concepts that are further explicated in the following pages.

1.7 Overview of the Chapters

Chapter Two of this study explores the history of infant feeding in New Zealand, outlining how women have historically interpreted breastfeeding in accordance with biomedical discourses. It also locates the role of both global and national policies to promote and support breastfeeding, due to its importance for public health.

In Chapter Three the literature that describes the experience of breastfeeding is examined. The literature review is not presented in a traditional manner, which might include a critical examination of methodologies and research locations; instead, this review takes an approach consistent with reflective lifeworld research and focuses on the meaning that the experience of breastfeeding has for women. This review demonstrates that health care professionals interpret breastfeeding as problematic, and that intervention is needed by professionals if breastfeeding is to be achievable. Researchers also paint a picture of women as incapable of knowing and articulating their breastfeeding experiences. An argument for re-examining the issue of breastfeeding, placing the emphasis on women's perspectives and knowledge of breastfeeding, is offered.

Chapter Four discusses the methodology of reflective lifeworld research, which offers the researcher the ability to re-examine the experience of breastfeeding afresh without any pre-conceived frameworks to limit their interpretations. As a part of this discussion, the reader is introduced to the principles that have guided the research process. Chapter Five then describes the process of reflective lifeworld research as it played itself out in the context of this study. The study's design, participant recruitment, and ethical considerations are also highlighted.

Chapters Six through Nine present the findings of this study. Particular emphasis is placed on the participants' narratives, as it is my contention that the language used by women to describe breastfeeding is often silenced, and as a result their knowledge is not visible in much of the research that has explored breastfeeding. Therefore, in these chapters I have focused on rendering the participants' narratives, deferring my interpretations of them until Chapter Ten.

The sixth chapter of the study begins by describing how women come to understand breasts and breastfeeding through dwelling with others. It also highlights that women interpret their breastfeeding experience in accordance with the socially-prescribed images of the perfect breastfeeding mother. Such images frequently confine women to a certain way of behaving, causing them to hide from public scrutiny if they do not mirror the perfect breastfeeder. Failure to measure up to externally-prescribed edicts means that breastfeeding women suffer in silence from emotions such as guilt.

Chapter Seven discusses how the participants came to understand breastfeeding through the inherited language of the body as object. The objectification of women's bodies means women have come to understand through language that their breasts are objects that need to be managed and tamed to be effective. The participants spoke about their breasts and breastfeeding by employing medical terms, and these accounts are explored using Heidegger's (1962) concepts of objects. However, it became apparent that a different language was required if women's experience of breastfeeding was to emerge in its entirety.

Chapter Eight demonstrates that a language that meaningfully describes breastfeeding emerged as the participants let the medicalised 'body-as-object' language fall away. What remained was a language that described breastfeeding as an embodied act, and the participants' narratives are discussed in light of Merleau-Ponty's (1981) writings on embodiment.

The last findings chapter, Chapter Nine, describes how women need to know their infants in a close way if breastfeeding is to be prolonged. The participants describe how over time they came to understand that breastfeeding offers the ultimate source of comfort for their infants. The closeness and exclusive nature of the relationship that breastfeeding offers was valued by those participants who continued to breastfeed. This chapter focuses primarily on how 'breastfeeding as a technical function' falls away and 'breastfeeding as relationship' emerges as significant for women who breastfeed over time.

Chapter Ten offers a discussion of the findings, describing how the reality of breastfeeding is silenced in New Zealand. Women who struggle to measure up to the perfect breastfeeding mother hide themselves from the public domain and reinforce unachievable ideals about breastfeeding. However, the emergence of a language that values embodied knowledge offers a path to illuminating breastfeeding in a meaningful manner. The implication of this knowledge for health care professionals is explored in the context of the findings. The limitations of this study are discussed, as is the need for future research projects.

1.8 Conclusion

When one gazes upon a mother breastfeeding her baby, one might surmise about the meaning breastfeeding has for that woman. It might mean providing her baby with needed nutritional requirements, or perhaps for her it means closeness. However, for that woman it may also symbolise a triumph over pain, or possibly physical weariness. "There is no way of understanding them [or the experience of breastfeeding] other than by looking at them, but to the beholder they say what they mean" (Merleau-Ponty, 1962, p. 321). This study attends to the multifaceted meanings that breastfeeding holds for women who breastfeed their infants, and seeks to understand what it is to breastfeed a baby in New Zealand. It begins with an examination of how the history of infant feeding in New Zealand has affected current understandings of breastfeeding.

Chapter Two

The New Zealand Context

2.1 Introduction

In this chapter, the history of infant feeding practices in New Zealand is explored through periods ranging from pre-1900 to the present, to place this study in a historical context. Prior to European colonisation in the nineteenth century, Maori history was primarily passed on through spoken word, and little has been written about the infant feeding practices of New Zealand's indigenous people. Therefore, this chapter focuses on the period from the late nineteenth century to the beginning of the twenty-first century, for which written history is available.

2.2 Breastfeeding Practices in New Zealand Pre-1900

Life in New Zealand prior to 1900 was pre-industrial. There were no mass-produced commercial goods, and although artificial infant formula had been produced in Europe since the 1840s, it did not become available in Australia until the 1880s, and not in New Zealand until the 1900s (Apple, 1994). English immigrants tried to establish lifestyles similar to those they had previously led. At that time in England, mothers were encouraged to follow the example of Queen Victoria and breastfeed their children, shouldering the responsibility of caring for them; mothers who chose not to breastfeed were viewed as selfish (Yalom, 1997). These Victorian values informed the manner in which New Zealand immigrants viewed breastfeeding.

After birthing, women of European decent were typically encouraged to 'lie-in' to assist in the establishment of breastfeeding. Often a neighbour or midwife would assist the new mother by living-in with her for a few weeks, and it is reported that Maori women commonly assisted in teaching immigrants to become lay midwives (Kedgley, 1996). There was a clear sense of community

responsibility for the nurturing of infants, and women's sphere of knowledge and expertise incorporated infant feeding (Kedgley, 1996).

Unfortunately, another defining characteristic of the lives of women in pre-1900 New Zealand was a relatively high infant mortality rate. In 1898, 19,000 infants of European descent were born in New Zealand, with the death rate being 79 per 1000 live births prior to one year of age (Davidson, 1984). Although this rate was approximately half that of England, infant deaths would certainly have been very common by today's standards. Maori birth and mortality rates were not documented reliably until 1930 (Davidson, 1984), although it has been estimated that the death rate was one in five infants before the age of one year prior to European colonisation (Pool, 1991; Pool & Bedford, 1996). Most deaths, of both European and Maori infants, have been attributed to infectious diseases, in particular gastroenteritis resulting from inadequate sanitation (Davidson, 1984).

Towards the end of the nineteenth century the medical profession had taken the first steps towards medicalising infant health and feeding, in effect taking over part of the responsibility for overseeing the physical growth and nutrition of infants (Apple, 1994; Baumslag & Michels, 1995; Davidson, 1984). It was believed by many physicians that specialised knowledge of infants and infant feeding was required if the infant mortality rate was to be reduced (Apple, 1994; Baumslag & Michels, 1995; Ryan & Grace, 2001). This trend was illustrated with the publication of the first book addressing infant feeding, by Dr Saunders in 1892 (Davidson, 1984). Saunders strongly advocated for breastfeeding, but suggested a recipe for artificial formula to be used in the event that a mother was unable to breastfeed (Davidson, 1984).

In England and the United States the medical fraternity and commercial manufacturers joined forces in the production and marketing of artificial formula (Baumslag & Michels, 1995). According to Baumslag (1995), their partnership was portrayed as intelligent men finally stepping in and helping comparatively uneducated women to raise healthy infants. This value system began having an effect on New Zealand culture around the beginning of the twentieth century (Apple, 1994; Davidson, 1984).

2.3 1900-1920

During the early twentieth century, New Zealand's infant mortality rate continued to concern government officials, which in part led to the founding of the Department of Health. The estimated mortality rate for European infants was between 62 and 100 per 1000 live births during the first decade of the twentieth century (Davidson, 1984; Dow, 1999). During the same period, it has been suggested that approximately half of all Maori infants died within their first year of life, which represents a substantial increase over the estimated pre-colonisation mortality rate (Dow, 1999). At that time, it was noted that infants fed on artificial formula were more likely to succumb to illness than breastfed infants; therefore, doctors advocated once again for breastfeeding, while ardently debating the best formula for producing an artificial milk (Beckman, 1977; Davidson, 1984). Doctors began monitoring infants through regular surveillance in their medical clinics, prescribing particular infant care regimes including advice on formula mixtures (Davidson, 1984).

During this period Dr Truby King was the medical superintendent of Seacliff Mental Hospital, where he studied science-based farming methods. The application of scientific methods to animal farming produced impressive results, and Dr King took a particular interest in dairy farming and milk production. This work profoundly influenced his views of infant health and feeding, and he began a publicity campaign that focused on educating parents about infant health. To prove his claims, he cared for sickly infants in his own home, demonstrating that unwell children could survive on 'humanised' cows milk (Davidson, 1984; Kedgley, 1996).

In 1907, King founded The Royal New Zealand Society for the Health of Women and Children, now commonly known as the Plunket Society after the Society's patroness, Lady Plunket. The organisation opened hospitals dedicated to caring for sick and premature infants, and training mothers in childcare. The Plunket Society also commissioned nurses to visit the homes of new mothers to monitor infant growth and development. Plunket nurses provided instruction on mother-craft, which attended to infant nutrition and regimens for both breastfed and formula-fed infants. For example, infants were to be fed at four-hourly intervals with no more than five feeds per day, and overnight feeding was expressly prohibited, a protocol that stemmed from King's research into dairy

farming. These rules remained in place for 40 years, mirroring King's belief in a standardised, scientific approach to infant feeding (Apple, 1994; Davidson, 1984; Kedgley, 1996).

Women's initial breastfeeding practices were also influenced by the formal registration of midwives in New Zealand in 1904, which coincided with the opening of the country's first maternity hospitals. The first of the St Helens Hospitals opened in Dunedin in 1905, and had a significant influence on the training of midwives (Mein Smith, 1986). Registered midwives commonly advised new mothers on breastfeeding during the initial postpartum period, encouraging women to demand-feed their infants and suggesting special diets intended to increase milk supply (Kedgley, 1996). However, after this initial period, Plunket nurses assumed the task of advising women on issues such as infant feeding.

Plunket nurses based their infant feeding advice on a perceived need for strict scheduling of infant care. This approach was difficult for breastfeeding mothers to follow, and often resulted in weaning to artificial formula to adhere to the required schedule. Despite the negative effect on breastfeeding, the mortality rate for infants of European descent did drop significantly following the Plunket Society's formation: the death rate fell from 73 deaths per 1000 live births in 1907 to 48 deaths per 1000 live births in 1917 (Apple, 1994; Davidson, 1984). However, it has been suggested that this was due primarily to improvements in sanitation and the end of the influenza epidemic in 1907 (Kedgley, 1996).

Because they lived primarily in rural areas, Maori infants fell outside the Plunket Society's sphere of influence, which was essentially urban (Davidson, 1984). No Maori births or deaths were registered until after 1920, which effectively made the plight of Maori infants invisible (Pool, 1991). However, it has been estimated that, prior to 1920, approximately half of the Maori population was wiped out, and that approximately half of all Maori children died before the age of four (Davidson, 1984; Pool, 1991). The majority of the deaths have been attributed to infectious diseases such as tuberculosis, malnutrition, and birthing difficulties (Dow, 1999; Durie, 2001; Pool, 1991; Ramsden, 2001). However, it was widely held among European settlers that the high infant mortality rate amongst Maori was the result of parental ignorance and incompetence (Dow, 1999).

When the Department of Public Health was established in 1901, a Maori Medical Officer, Dr Maui Pomare, was appointed to oversee the development of public health care for Maori. Dr Pomare attended the American Missionary College in Chicago, graduating from medical school in 1899 (Cody, 1953). He was reportedly a strong leader who worked closely with Maori elders to address issues affecting Maori health (Durie, 1998; Durie, 2001). He also focused on issues that indirectly influenced health status amongst Maori such as cultural values, housing and economics (Durie, 2001).

Although Pomare was a strong advocate for Maori children and believed a complete change was needed in the way that health care was provided for Maori (Davidson, 1984), at that time there was little support from people of European descent for re-orienting health services for Maori, some believing instead that the race should be left to die out (Pool, 1991; Ramsden, 2001). Pomare spent eight years pleading with his colleagues in the Department of Health for the financing of proposed reforms, without much success, and finally resigned in 1909 to pursue a career in politics (Cody, 1953; Davidson, 1984; Dow, 1999; Durie, 2001). He was eventually appointed the Minister of Health and served in that position from 1923 to 1926 (Dow, 1999), during which time he improved access to education, quality housing and employment (Cody, 1953; Durie, 2001). Other significant advancements that were made through Pomare's efforts were the introduction of community health workers and the enhanced recruitment of Maori nurses. Both of these groups were strongly encouraged to work in collaboration with Maori communities to improve the health status of Maori (Dow, 1999; Durie, 1998; Durie, 2001).

As noted above, by 1917 the mortality rate for European infants had fallen to 48 per 1000 live births; in contrast, by the 1920s the mortality rate for Maori ranged between 107 and 160 per 1000 live births (Dow, 1999; Pool, 1991). Although these figures represent an improvement in the plight of Maori infants, they highlight the continuing disparity between the health of Maori infants and those of European descent.

The overarching message of the early 1900s was that success at raising and feeding healthy infants required specialty knowledge that was the domain of health care professionals, whether they were registered midwives, doctors or Plunket nurses. In effect, women had lost some of their control over childcare, as their knowledge was no longer valued in relation to either child rearing or

infant feeding (Beckman, 1977; Davidson, 1984; Kedgley, 1996; Ryan & Grace, 2001). However, with the emergence of the suffrage movement in the early part of the century, women had become politically active, lobbying not just for the right to vote but also to achieve autonomy as both citizens and women. This new-found sense of self-determination sufficiently influenced infant feeding practices that it became unfashionable for middle-class women to breastfeed; mothers who chose not to breastfeed were expressing their personal right to freedom (Kedgley, 1996).

2.4 1920-1950

The use of artificial formula became widely accepted during the 1920s and, although many women continued to breastfeed, formula feeding was increasingly common. The acceptance of artificial formula assisted the development of industry in New Zealand, and in 1927 the Karitane Products Society was formed. The organisation coined the term 'humanised milk' as an aid in marketing the formula developed by King (Davidson, 1984), which proved to be an effective means of portraying formula as an acceptable substitute for breastmilk. Proceeds from this company were used to support The Royal New Zealand Society for the Health of Women and Children (Davidson, 1984), and contributions are still made by Karitane Products Society to the Royal New Zealand Plunket Society.

During the 1920s a dramatic shift in birthing practices took place. The perceived need on the part of medical practitioners to remove contamination from childbirth, as a means of reducing mortality rates for both infants and mothers, led to a rapid increase in the number of births occurring in hospitals (Kedgley, 1996: Mein Smith, 1986). In 1927, 60 percent of births in New Zealand took place in a maternity hospital; by 1936, this rate had increased to over 80 percent (Apple, 1994). During a woman's fourteen-day stay in the maternity hospital, feeding regimes were highly structured, which significantly influenced breastfeeding initiation. Women were allowed only limited access to their infants, feeding times were restricted, night feeds were prohibited, and infants were weighed after feeds to assess the amount consumed (Apple, 1994; Kedgley, 1996).

The shift to birthing in maternity hospitals contributed to the normalisation of birthing, mother care, and infant feeding as medicalised practices (Ryan & Grace, 2001). Once a mother and child were discharged home, a Plunket nurse would take over the monitoring and instruction of the new mother, reinforcing the notion that women were incapable of caring for their infants without professional assistance (Kedgley, 1996). The re-conceptualisation of motherhood as a medicalised scientific practice was, therefore, solidified during this era.

The 1930s had also seen serious debate about the composition of artificial formula. A number of medical practitioners critiqued King's recommended formula, claiming it contributed to anaemia and other vitamin deficiencies (Davidson, 1984). However, by the 1940s the medical community had accepted that artificial formula was of equal nutritional value to breastmilk (Ryan & Grace, 2001). A number of justifications for the use of formula rather than breastmilk were suggested during this era, including inadequate nutritional status for breastmilk, having fair skin, flat nipples, or a chronic illness. Infants also came under scrutiny in relation to their ability to breastfeed. At that time it was recommended that infants that were either large or small, had jaundice, or had a physical defect should not be breastfed (Ryan & Grace, 2001). Meanwhile, pressure from health care professionals to adhere to strict routines for both bottle-fed and breastfed infants also continued (Dignam, 2001).

Events of the 1940s had a significant influence on the role of women within the community. During the Second World War many men left New Zealand to fight in Europe or the South Pacific, leaving women to carry on much of the essential work outside of the home. During the period from 1940 to 1945 no breastfeeding statistics were kept; however, it has been suggested that approximately 70% of women initiated breastfeeding, with 44% of infants still being breastfed at three months and 21% at six months (Deem, 1945-1946, as cited in Davidson, 1984).

The 1940s were characterised by women's compliance with the mandates of the scientific and medical communities in relation to infant feeding (Ryan & Grace, 2001). Ryan (1999b) describes how women embraced a 'not for me' stance in relation to breastfeeding; breastfeeding was perceived as untenable because of potential difficulties and breastmilk's questionable quality. The practices adhered to in maternity hospitals continued to undermine women's

ability to breastfeed. These practices included complementary feeds, extremely limited access to infants during the first three days, and continued adherence to four-hourly routines (Kedgley, 1996). It has also been documented that when women were attempting to initiate breastfeeding, both they and their infants were handled roughly by nursing staff, further discouraging women to breastfeed (Kedgley, 1996). Such practices continue to the present day (Benn et al., 2002; Vogel & Mitchell, 1998a). To solve the difficulties of breastfeeding, which were often caused by hospital policies, women were offered the benefits of technology in the form of artificial formula (Kedgley, 1996; Ryan, 1999b).

Ryan and Grace (2001) described the scientific, technological, and medical establishments' influence over infant feeding practices during this era in the following manner: "It is difficult to illustrate the dominance of this knowledge source because it is so taken-for-granted, all-pervasive, and incorporated into every day understandings and language" (p. 492). This ubiquitous ownership of infant feeding practices continued throughout the 1950s and into the 1960s (Apple, 1994; Davidson, 1984; Dignam, 2001; Kedgley, 1996; Ryan & Grace, 2001).

2.5 1950-1980

In 1952, a group of women concerned about their birthing experiences in hospitals formed the Parents' Centre to facilitate antenatal education for women. The women involved with Parents' Centre were politically active, lobbying for women's rights during childbirth and actively encouraging women's unrestricted access to their newborn infants (Kedgley, 1996). Parents' Centre became a place where women could meet and discuss their experiences with birthing and mothering. Women were encouraged to listen to their instincts when caring for their infants, and the use of strict routines was challenged as it prevented women from responding to their infant's psychological needs (Kedgley, 1996). The establishment of community networks such as the Parents' Centre foreshadowed a major change in the way that women valued their own knowledge, which ultimately led to the feminist movement of the 1960s. Women's ways of knowing became valued in this setting, and women began to question the hegemonic sway held by the medical fraternity. A shift in

the ideology of infant feeding was thus initiated by feminists and the associated feminist movement (Carter, 1995; Ryan & Grace, 2001; Vares, 1992).

Despite changing perceptions amongst women, only 47 percent of infants were breastfed by the end of the 1960s (Davidson, 1984). In contrast, approximately 87% of infants were breastfed during the 1920s (Royal New Zealand Plunket Society, 1995). The drop in breastfeeding rates has been attributed in part to the practices of health care professionals in relation to infant feeding (Kedgley, 1996), as discussed in the previous section. However, social pressure also played a role in reducing breastfeeding rates. During this era, Western societies viewed the breast as a sexual item, rather than a functional part of a woman (Carter, 1995; Yalom, 1997). As a result, women felt embarrassed to 'expose' their breasts whilst breastfeeding, effectively relegating breastfeeding to the private sphere. Breastfeeding was, therefore, viewed as a perverse, indecent practice. These socially-prescribed understandings effectively left women who chose to breastfeed their infants isolated from public places (Kedgley, 1996).

The breastfeeding support group La Leche League emerged during the mid-1960s, with the express purpose of supporting and valuing women's knowledge of breastfeeding and infant care (Gordon, 1998; Kedgley, 1996). La Leche League groups grew rapidly in New Zealand, especially during the 1970s. It has been interpreted as primarily a white middle-class organisation; however, it has been noted that the rise in the number of women choosing to breastfeed during the 1970s and 1980s mirrored the growth of the number of La Leche League groups (Gordon, 1998), suggesting their influence assisted a general change in attitude.

The women involved in La Leche League groups were vehement in their desire to re-position breastfeeding expertise within the realm of women's knowledge rather than that of health care professionals (Gordon, 1998). The La Leche League had radical ideas about breastfeeding at that time, and completely contradicted existing hospital practices of restricted access and regimented scheduling of infant feeding (Apple, 1994; Gordon, 1998; Kedgley, 1996). Its philosophy embraced a mother's right to actively participate in breastfeeding at birth, unlimited access to the infant whilst in hospital, breastmilk as the best source of nutrition during an infant's first six months of life, the provision of sensitive care oriented to the infant's needs, and that the timing of weaning be

directed by the infant (Gordon, 1998). La Leche League's success is reported to have stemmed from the organisation's foundational belief that women who are mothers are the experts in breastfeeding (Palmer, 1993). Because of the work of such organisations during the 1970s, women began to oppose the notion of strict infant routines, focusing instead on responsive mothering of infants (Ryan & Grace, 2001).

The resurgence of women-centred knowledge of breastfeeding freed women to make informed choices about whether or not to breastfeed their infants. During this decade, increasing numbers of women were initiating breastfeeding, and continuing to feed their infants for longer periods (Ford, Wild, Mitchell, & Tuohy, 1995; Msuya, Harding, Robinson, & McKenzie-Parnell, 1990; Royal New Zealand Plunket Society, 1995). It has been suggested that this was the result of the feminist movement as well as the work of organisations such as Parents' Centre and La Leche League (Carter, 1995; Kedgley, 1996; Palmer, 1993; Ryan & Grace, 2001).

Ryan and Grace (2001, p. 493) describe how, during this era, women created a language about breastfeeding that included scientific-sounding depictions of breastfeeding, such as 'infant-led feeding' and an infant being 'positioned at the breast'. This re-framing of breastfeeding assisted women to once again normalise breastfeeding. Health care professionals adopted this new breastfeeding language, incorporating it into research studies that supported what women had been asserting about the beneficial nature of breastfeeding (Ryan, 1999a). As a result, the catch phrase 'breast is best' became popular during the 1970s as research results supporting the superiority of breastmilk began to emerge (Anyon, 1976; Fergusson, Horwood, Shannon, & Taylor, 1978; Hood, Faed, Silva, & Buckfield, 1978; Kedgley, 1996; Kerr, 1981; Roberts, 1980; Ryan & Grace, 2001).

2.6 The 1980s

The research conducted during the 1970s clearly demonstrated the superiority of women's milk, and breastfeeding, over bottle feeding with artificial formula. These results, coupled with reports from health care professionals working in developing countries, raised wide-spread concern about the behaviour of

companies producing artificial formula (Baumslag & Michels, 1995). In an effort to increase sales, companies distributing formula in developing countries were employing tactics such as radio advertising and the employment of 'milk nurses' who would visit new mothers in hospitals. Women began to believe that formula was superior to breastmilk, with tragic consequences –infant morbidity and mortality rose dramatically (Baumslag & Michels, 1995), due primarily to the lack of clean water with which to make formula, an inability to sterilize used bottles or correctly make up the formula, and a lack of refrigeration. A number of individual groups from countries such as the United States, Australia, Canada, and New Zealand, banded together to form the International Baby Food Action Network (IBFAN), which actively publicised the plight of infants in developing countries. Their efforts led to a consumer boycott of Nestle products in 1981 (Baumslag & Michels, 1995; Van Esterik, 1989).

New Zealand breastfeeding rates continued to rise in the 1980s, with 78 percent of infants still being at least partially breastfed at three months of age (Ford et al., 1995; Royal New Zealand Plunket Society, 1995). This trend has been attributed to societal influences such as the positive portrayal of breastfeeding by the media, health care professionals ceasing to actively promote artificial formula, and the activities of breastfeeding support groups (Msuya et al., 1990). However, breastfeeding rates had plateaued by the end of the decade (Msuya et al., 1990).

During the 1980s, a number of New Zealand researchers addressed issues surrounding infant feeding (Davies, 1989; Flight & Adam, 1986; Ford, Schluter, & Wild, 1996; Gunn, 1984; Msuya et al., 1990; Perry & Trlin, 1985; Trlin & Perry, 1982), focusing primarily on the demographic trends of infant feeding. Their results highlighted many factors that influenced breastfeeding and bottle feeding rates, such as socio-demographic influences (Davies, 1989; Flight & Adam, 1986), ethnicity (Flight & Adam, 1986; Gunn, 1984; Perry & Trlin, 1985), health care professionals (Davies, 1989; Gunn, 1984; Trlin & Perry, 1982), insufficient milk due to complementary feeding practices (Davies, 1989; Gunn, 1984), and the availability of support for breastfeeding women (Flight & Adam, 1986; Gunn, 1984; Perry & Trlin, 1985; Trlin & Perry, 1982). It is interesting to note that the recommendations from the authors of these studies focused primarily on the role of the health care professional in increasing breastfeeding rates. However, a few studies acknowledge the role that social networks, including family

members and La Leche League, had on women's breastfeeding success (Davies, 1989; Trlin & Perry, 1982).

2.6.1 The International Code for the Marketing of Breast-milk Substitutes

The WHO and UNICEF responded to pressure from IBFAN and health care professionals to develop breastfeeding policies that would protect infants in developing countries. In 1979, WHO and UNICEF met to discuss the regulation of breastmilk substitutes (Baumslag, 1995; Van Esterik, 1995; Williams, 2000). In 1981, they jointly issued the *International Code for the Marketing of Breast-Milk Substitutes*, which called for a ban on the distribution of free artificial formula, a ban on advertising of breastmilk substitutes in health care centres, the removal of any idealisation of artificial formula, and the addition of labelling on formula tins clearly stating that breastmilk is the safest and best source of nutrition for infants (World Health Organisation & UNICEF, 1981). New Zealand was among the 118 countries who signed the Code (Baumslag & Michels, 1995; Galtry, 1998).

Lobbying groups objected that the Code had been developed in conjunction with the industry involved in the making and marketing of artificial formula (Baumslag & Michels, 1995; Van Esterik, 1989), interpreting it as a minimal effort to curtail the activities of the artificial formula industry (Van Esterik, 1989). These fears proved to be well-founded, as it soon became clear how difficult it would be to force companies to comply with the Code. Unless a country's government was willing to pass legislation to enforce the Code, individual companies were left to regulate their own activities in relation to the promotion of their products (Baumslag & Michels, 1995; Van Esterik, 1989; Williams, 2000).

In 1983, the Breast Milk Substitutes Monitoring committee was formed in New Zealand specifically to monitor compliance with the Code. Unfortunately, the committee had no authority, and was disbanded due to a lack of funding in 1990 (Dignam, 2001; New Zealand Breastfeeding Authority, 2000). By the end of the 1980s, there was growing global awareness that the Code was failing to deliver change in the promotion of breastfeeding, prompting the WHO and UNICEF to summon international policy makers to revisit the issue of breastfeeding

promotion (Baumslag & Michels, 1995). This eventually led to the development of the *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding.*

2.7 1990-2002

2.7.1 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding

This latest WHO/UNICEF initiative led to a meeting, titled "Breastfeeding in the 1990's: A global initiative", at the international assembly of August 1990, during which the *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding* was designed (World Health Organisation & UNICEF, 1990). The declaration states that breastfeeding provides infants with the ideal food needed for growth and development, reduces the incidence of infant morbidity and mortality, results in enhanced health for women, and is economically beneficial. It stipulates that the minimum age that all infants should be exclusively breastfed is four to six months, and that breastfeeding should continue for at least the first two years of age. The declaration also states that "all women should be enabled to practice exclusive breastfeeding" (World Health Organisation & UNICEF, 1990, p. 1).

The declaration also outlines targets for individual countries to achieve, including the appointment of a national breastfeeding coordinator, the establishment of a multi-sector national breastfeeding committee, ensuring hospitals support the 'Ten steps to successful breastfeeding', compliance with the Code, and legislation to protect breastfeeding women. It was hoped that the *Innocenti Declaration* would pressure governments to implement policies that would support women to breastfeed.

In 1990 the New Zealand Department of Health signalled their support for the *Innocenti Declaration.* Responding to pressure from professional groups such as The Lactation Consultants Association (Vogel & Mitchell, 1998c) and lay groups including La Leche League (Gordon, 1998), the Department of Health convened a meeting in 1991 to re-consider the Code's place within New

Zealand. In 1992, the department developed a 'breastfeeding kit' to educate health care professionals working for the Royal New Zealand Plunket Society, and within the hospital system, about the Code and the *Innocenti Declaration.* However, a national breastfeeding coordinator has never been appointed. Furthermore, legislative policy requiring companies to comply with the Code has not been developed and, to date, compliance with the Code remains voluntary. A committee to monitor the implementation of the Code was eventually established in 1998; however, as was the case with the 1983 Breast Milk Substitutes Monitoring committee, it lacks the authority to enforce the Code.

New Zealand has had only limited success with the *Innocenti Declaration,* which has been attributed to the lack of a co-ordinated effort on its behalf (Beasley & Trlin, 1998). It has also been suggested that there has been a lack of commitment to, and financial support for, implementation of the Code in New Zealand (Dignam, 2001).

However, it became evident early on that New Zealand was not the only country having difficulty ensuring that the Code and the *Innocenti Declaration* were adhered to. This prompted a group of 17 international organisations to form the World Alliance for Breastfeeding Action (WABA) in 1991 (Baumslag & Michels, 1995). WABA supports breastfeeding through World Breastfeeding Week, which is held each year and through collaboration with UNICEF. In 1992, the theme for World Breastfeeding Week was the Baby Friendly Hospital Initiative (BFHI). New Zealand took part in celebrating the 2002 World Breastfeeding Week, which assisted in raising the profile of both breastfeeding and the BFHI in this country (Heritage, 2003).

2.7.2 The Baby Friendly Hospital Initiative

The fact that most women give birth to their babies within a hospital setting led the WHO and UNICEF to develop guidelines for encouraging breastfeeding in maternity facilities, resulting in the *Ten steps to successful breastfeeding* (World Health Organisation & UNICEF, 1989). These steps outline how health care professionals should go about ensuring that breastfeeding is protected and promoted within the hospital setting. Each of the ten steps is supported by

research that highlights how it can support women to breastfeed[2]. It was hoped that the implementation of these steps would revolutionize practices, especially in maternity hospitals and associated facilities.

The guidelines form the basis of the Baby Friendly Hospital Initiative (BFHI), which was launched in 1991 by the WHO and UNICEF. The BFHI was established with the aim of empowering women throughout the world to breastfeed, and eliminating the provision of artificial formula within the hospital setting. The New Zealand College of Midwives included the *Ten steps to successful breastfeeding* in their publication *Protecting, promoting and supporting breastfeeding* (New Zealand College of Midwives, 1992). The *Ten steps to successful breastfeeding* was also adopted by the Royal New Zealand Plunket Society, which, in 1996, published their own breastfeeding policy, adapting the document to better fit the services offered by the community-based organisation.

By the mid-1990s, New Zealand government agencies were beginning to respond to pressure from lobby groups, and in 1994 the Ministry of Health convened a meeting of interested parties to discuss how the BFHI might be implemented. It was concluded that the BFHI should serve as a vehicle through which to increase breastfeeding rates in New Zealand (Vogel & Mitchell, 1998c). The Ministry oversaw the formation of the BFHI taskforce, which became known as the New Zealand Breastfeeding Initiative Taskforce (NZBIT), and reported to the Ministry as well as to the Public Health Commission.

That year the Public Health Commission acknowledged the importance of breastfeeding, and outlined targets for breastfeeding rates, which included increasing the number of exclusively breastfed infants at three months of age to 75% (Public Health Commission, 1994). In 1995, the Public Health Commission also specifically mentioned the BFHI in the publications *Food and nutrition*

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2 For further information about the research that formed the basis for the *Ten Steps to Successful Breastfeeding* please refer to the following authors: Step one (Ellis, 1992); Step two (Auerbach, 1988; Becker, 1992); Step three (Rentschler, 1991); Step four (Kuriniji & Shiono, 1991); Step five (Slavin & Harvey, 1981); Step six (Glover & Sandilands, 1990); Step seven (Keefe, 1986); Step eight (De Carvalho, Robertson, Friedman, & Klaus, 1983); Step nine (Newman, 1990); Step ten (Kyenkya-Isabirye & Malgalheas, 1990).

guidelines for healthy infants and toddlers (Public Health Commission, 1995a; 1995b), and *Food and nutrition guidelines for healthy breastfeeding women* (Public Health Commission, 1995a; 1995b). However, no funding was made available for the operation of the NZBIT (New Zealand Breastfeeding Authority, 2000; Vogel & Mitchell, 1998c). Following the 1997 New Zealand Lactation Consultants Association Conference, the Lactation Consultants' Association, La Leche League New Zealand, and the College of Midwives joined forces to submit a proposal to the Health Funding Authority to implement BFHI (Vogel & Mitchell, 1998c). Their proposal was not funded.

In 1998, the Ministry of Health published *Progress on Health Targets*, which noted that the goals set for breastfeeding rates had not been achieved (Ministry of Health, 1998). The report highlighted changes to global policy as implemented by the WHO (World Health Organisation & UNICEF, 1990), and offered an assessment of why the goals had not been met; however, this discussion was limited because of a lack of available research that explored the reasons why women were not breastfeeding, with only one study being cited by way of explanation (Basire, Pullon, & McLeod, 1997).

That same year saw the establishment of the New Zealand Breastfeeding Authority (NZBA), a coalition of 30 stakeholder organisations that included midwives, La Leche League representatives, medical practitioners, dieticians, and representatives from the Royal New Zealand Plunket Society. The NZBA was granted funding in 1999 by the Health Funding Authority to establish the BFHI within New Zealand. The funding contract provided for the establishment of structures to support the implementation of BFHI within New Zealand, and initiate training for BFHI assessors (New Zealand Breastfeeding Authority, 2000).

It became evident when assessing breastfeeding rates that there was a need to streamline the manner in which national health targets for breastfeeding were measured. Therefore, the Ministry of Health commissioned a document that reviewed, and provided recommendations for, national breastfeeding definitions (Coubrough, 1999). The report compiled research and expert opinion on how breastfeeding rates could be measured against precise definitions, for the purpose of accurately assessing New Zealand's success at meeting its targets.

The year 2000 saw the establishment of a NZBA Committee and an Implementation Advisory Group to oversee implementation of the BFHI in New Zealand. A national co-ordinator was appointed to manage the initiative and, by the end of the year, 17 trainers had completed the NZBA's BFHI training course (Stufkins, 2000).

A survey of New Zealand hospitals was undertaken in 2000 to assess compliance with the *Ten steps to successful breastfeeding* (Pownall, 2000). The results demonstrated that few hospitals had an organisation-wide breastfeeding policy, and it was noted that few hospitals actually had education programmes that informed staff about breastfeeding. The study also highlighted that hospitals were struggling to comply with the BFHI because of the inflexible nature of the ten steps, the inconsistencies inherent in the assessment process, and the financial commitment needed to the meet the initiative requirements. Probably the most significant difficulty for hospitals wishing to implement the BFHI was that independent maternity care providers did not have reporting mechanisms by which their practice could be monitored.

In 2001 the Ministry of Health released a toolkit for the District Health Boards (DHBs), called *Improve Nutrition* (Ministry of Health, 2001). The toolkit directs DHBs to support their maternity facilities to attain BFHI accreditation; however, the way in which this is achieved is left to the discretion of the DHBs.

2.7.3 2002-2003

In 2002, the World Health Assembly convened in Geneva with the goal of formulating a global strategy for infant and young child nutrition and feeding. The Assembly adopted a resolution stating that infants should be exclusively breastfed for six months, with continued breastfeeding for up to two years or beyond (World Health Organization, 2002). As a matter of urgency, the Assembly called for governments to "formulate, implement, monitor, and evaluate a comprehensive policy on infant and young child feeding" (World Health Organization, 2002, p. 13). The World Health Assembly recommendation was endorsed by the WHO, which has since adopted the global strategy.

The New Zealand Ministry of Health has yet to establish a policy to implement the World Health Assembly's resolution (Ministry of Health, 2002), although it has published *Breastfeeding: A guide to action* in 2002. This document highlights that there have been no significant changes to breastfeeding rates in New Zealand over the past ten years, and presents a plan to increase these rates in 2002/2003. It specifies seven goals, which include the establishment of a national breastfeeding coordinator, the achievement of Baby Friendly Hospitals throughout New Zealand, an increased focus on rendering culturally-appropriate breastfeeding support, enhanced support of breastfeeding promotion, improved access to antenatal education, and the provision of quality care during the postpartum period (Ministry of Health, 2002).

At the time of writing, some 13 years since the inception of the BFHI, only six of New Zealand's 85 maternity facilities have attained 'Baby Friendly Hospital Status' (Heritage, 2003). This contrasts sharply with the success of many developing nations such as Kenya, which has 232 facilities with BFHI status, Nigeria with 1147, and the Philippines with 1047 (UNICEF, 2002). Although its not clear what breastfeeding definitions have been employed, nor how strict the assessment processes and criteria for approval are, the number of approved hospitals in these developing countries does play to the spirit of the BFHI concept. The New Zealand Government has been hesitant to make the necessary changes at a policy level and pursue strategies to support breastfeeding women. Strategies that have been suggested have been primarily population-based, without emphasis on understanding the personal meaning of breastfeeding for breastfeeding women.

In 2002, Minister of Health Annette King noted that a woman's decision to breastfeed is influenced by "social norms and by the beliefs and values of women and their significant others" (Ministry of Health, 2002, p. iii). The goals recommended to increase breastfeeding rates take into account a woman's need for support from society in the form of BFHI and community strategies. However, until these societal factors and women's beliefs and values regarding breastfeeding are addressed, the suggested strategies will not alter the current demographic trends.

2.8 Summative Thoughts

To date, government-supported breastfeeding strategies have been based on biomedical research, essentially ignoring the lived experiences of breastfeeding women. Improving our understanding of the experience of breastfeeding may lead to strategies that work for women, rather than broad population-based strategies into which women must fit to receive support from well-meaning government officials and health care professionals. This is especially true for women of minority cultures whose needs may differ considerably from those of the prevailing majority.

History has demonstrated that health care professionals have essentially established and owned the language that describes both breastfeeding and breastfeeding success. The manner in which breastfeeding is articulated holds sway over how breastfeeding as a concept is understood, and significantly influences how policies at both national and international levels are developed. However, the language that exists around breastfeeding is confined by boundaries set up by those external to an individual breastfeeding dyad; as a result, this language dismisses women's understandings and individual definitions that characterise success.

It can, therefore, be argued that the language that currently contributes to the construction of breastfeeding is a language of exclusion, because it essentially ignores the language that describes the lived experience of breastfeeding. It is paramount that a language that accommodates women's experience of breastfeeding emerge, as this would facilitate meaningful understandings of the lived experience of breastfeeding women. There is also a need to embrace women's individual definitions of breastfeeding success. If this is not achieved, breastfeeding goals and definitions of success will continue to be confined to arbitrary categories that only meet the needs of policy makers.

Well-meaning health care professionals may be aware of the *Ten Steps*, but unless they have the insight and ability to meld them with women's needs and current research, breastfeeding statistics will not improve. Health care professionals need to speak a language that reflects an understanding of the breastfeeding experience, not a language that simply reflects policy. There is a need to learn a language that can accommodate experiential knowledge and

lifeworld-based research, as well as biomedical research. Only when research and experience become fused in a language that accommodates both forms of knowledge will breastfeeding be positively enhanced, promoted, and supported. A woman's reactions to the community environment, her body, and her infant have more bearing on her desire to continue breastfeeding than any policy, no matter what the source.

2.9 Conclusion

Prior to 1900, women owned and shared breastfeeding knowledge, thereby supporting one another to breastfeed. As biomedical knowledge of human lactation emerged as the dominant discourse, and artificially-contrived replacements were proposed, women's knowledge of breastfeeding was usurped. Breastfeeding was re-interpreted as a purely biological act, leaving behind generations of women's knowledge that defined breastfeeding as an art.

Research has focused on biomedical understandings of breastfeeding, and this has formed the basis for international, as well as national, strategies to enhance, support and promote breastfeeding. A woman may well have achieved all *Ten steps to successful breastfeeding*, but her experience of breastfeeding exists outside of the realm of international policy or hospital procedures. A woman's personal experience of breastfeeding her infant will hold critical and meaningful sway over her decision to continue to breastfeed, regardless of external policy or strategy. And it is her experience that will dictate whether or not she will exclusively breastfeed her infant for the first six months of his or her life and beyond, as well as what she will tell other women. There is, therefore, a need to explore research that examines and illuminates the various facets of women's experiences of breastfeeding; it is this research that is presented in the following chapter.

Chapter Three

Examining the Experience of Breastfeeding

3.1 Introduction

The previous chapter examined the historical and contextual considerations surrounding breastfeeding in New Zealand, and we now turn our attention to the literature that deals with the act of breastfeeding. There exists a large body of literature that explains breastfeeding in terms of physiological processes[3], locating breastfeeding as a mechanical, technical act within a socio-political context. It is from this biomedical framework that the majority of government-supported policies and strategies to promote breastfeeding have been derived. I have argued that a deductive approach to breastfeeding research is needed to ensure that the lived experience of breastfeeding is adequately considered. To promote breastfeeding and provide better support for breastfeeding women, an understanding of their experience of breastfeeding is essential; therefore, this chapter examines the academic literature that deals with experiential accounts of breastfeeding.

3.2 The Influence of Culture on Breastfeeding

Understandings of breasts and breastfeeding emerge within the context of community, which can be understood on different levels ranging from a broad global perspective to an individual's own social circle. These understandings are built within popular culture, which is conveyed to us through entities such as the media and art, and are coupled to the beliefs of previous generations. Anthropologists (Bryant Merrill, 1987; Long, 2003; Makhlouf Obermeyer & Castle, 1997; Morse, 1985; Paine & Dorea, 2001), feminists (Bartlett, 2002; Blum, 1993; Carter, 1995; Fellow, 1994; Galtry, 1997; Law, 2000; Meyer & de Oliveira, 2003; Ryan, 1999a; Schmied & Barclay, 1999; Schmied & Lupton,

[3] For more information see Chapter One, Section 1.3 and Chapter Two, Section 2.7.2.

2001; Vares, 1992; Yalom, 1997), and sociologists (McIntosh, 1985; Meyer & de Oliveira, 2003; Murphy, 1999) have explored societal understandings of breastfeeding and how they influence individual interpretations of breastfeeding.

Examples of the influence of the wider New Zealand society, along with international influences, on breastfeeding were explored in Chapter Two. Chapter Three focuses on the experience of breastfeeding as described by women who have breastfed, and the manner in which their experiences are reflected in the literature. It must be acknowledged that each individual breastfeeding woman is embedded within her society's culture, the effects of which are explored in Chapter Five.

Research has highlighted that there are differing types of historically-embedded knowledge that affect a woman's breastfeeding experience (Ryan & Grace, 2001). In Ryan's (2001) exploration of women's knowledge of breastfeeding over the period from 1945 to 1990, participants in her study articulated the ways in which they gathered knowledge about breastfeeding. These include instinctual knowledge, culturally-absorbed knowledge, experiential knowledge, and shared knowledge. Women also discussed how breastfeeding knowledge was acquired through their interactions with health care professionals, which assisted in forming their biomedical understandings of breastmilk.

These different ways of knowing inform the way women approach and manage breastfeeding. If women reside in communities that do not have a breastfeeding culture they are significantly hampered in their attempts to breastfeed, as they will not have access to culturally-absorbed or shared breastfeeding knowledge. It has been convincingly argued that New Zealand does not have a breastfeeding culture (Beasley, 2002; Beasley & Heritage, 1998/1999; Ryan, 1999a; Watson, 2001).

Although lactation is essentially a physiological process, breasts and breastfeeding are interpreted against a backdrop of culturally-mediated ideologies. New Zealand breastfeeding literature highlights how culture significantly influences women's decision to breastfeed, suggesting that breastfeeding is supported in theory but not in practice (Beasley, 1991; Beasley, 1996b; Beasley & Heritage, 1998/1999; Dignam, 2001; Ryan, 1999a; Thurtle, 1997; Watson, 2001).

Beasley and Heritage (1998/1999) describe how women's ability to breastfeed in New Zealand has been hindered by the historical promotion of structured infant feeding times, emphasis on a woman's right to choose the method of infant feeding, and the sexualisation of breasts. Ingrained cultural beliefs portray breastfeeding as an inconvenient feeding method that disadvantages women by 'tying' them to their infants.

Ryan (1999a) discusses how culturally-mediated discourses have constructed understandings of breastfeeding within New Zealand. During the period from the 1940s to the 1960s, women espoused a discourse of breastfeeding being "not for me", arguing that artificial formula was scientifically prepared and a suitable replacement for breastmilk. During the 1970s and 1980s the discourse espoused by women changed to one that valued the "natural earth mother - breast is best", in which breastfeeding was viewed as a right to be exercised. This discourse emerged as prevalent at a time when research studies were being published extolling the virtues of breastfeeding (Anyon, 1976; Hood et al., 1978; Roberts, 1980).

Another discourse that Ryan (1999a) claims has consistently played a role in women's breastfeeding discussions is that of "I'll give it a go." This position allows a woman the freedom to stop breastfeeding if she doesn't think it's working for her, highlighting the common belief that women's bodies may fail at breastfeeding. All of these discourses are still operating in New Zealand to varying degrees, confirming the thoughts of New Zealand-based breastfeeding experts who report that women are confined by a culture that medicalises breastfeeding, and portrays breastfeeding as problematic (Beasley, 1991; Beasley, 1996b; Beasley & Heritage, 1998/1999; Dignam, 2001; Ryan, 1999a; Thurtle, 1997; Watson, 2001).

New Zealand is legally considered a bi-cultural country, comprising the indigenous Maori race, the *Tangata Whenua* – the people of the land, and those of British descent. Quantitative New Zealand research studies contain breastfeeding statistics describing which people groups are, or are not, breastfeeding (Essex, Smale, & Geddis, 1995; Flight & Adam, 1986; Ford et al., 1995; Heath et al., 2002; Msuya et al., 1990); however, only a small number of studies have explored the values and beliefs about breastfeeding from a Maori perspective (Ellison-Loschmann, 1997; Ellison-Loschmann, 1998; Rimene, Hassan, & Broughton, 1998).

Historically, Maori people have valued women for their ability to nurture through breastfeeding. Rimene, Hassan, and Broughton (1998) describe how Maori women are considered to have the same responsibility as the land in sustaining life, through their ability to give birth and breastfeed. This role has afforded Maori women a sacred respect, referred to as *mana wahine*, that is solely the right of women, especially after they have given life to the next generation. However, in recent decades, dramatic social change, leading to urbanization (Pool, 1991; Pool & Bedford, 1996) and the loss of cultural identity, has significantly changed the life of Maori in New Zealand (Durie, 2001). These changes have altered the way Maori women see their role in the community, affecting the way women approach breastfeeding infants (Ellison-Loschmann, 1997).

Maori women typically have children at a younger age than their European-descent counterparts (Ministry of Health, 2001). This, coupled with the fact that many Maori women now live in urban environments away from the support structures present in extended family environments, does affect women's experience of breastfeeding. Women frequently find themselves isolated from the people traditionally responsible for nurturing them as new mothers, contributing to relatively low breastfeeding rates among Maori. In 1998, 39% of Maori infants were fully breastfed at three months as opposed to 55% of their European counterparts (Ministry of Health, 2001). However, for those that do breastfeed, their close connections with mothers and grandmothers are a source of invaluable support when they are in the process of establishing breastfeeding (Ellison-Loschmann, 1997; Ellison-Loschmann, 1998; Rimene et al., 1998).

The women who participated in Ellison-Loschmann's (1998) study all highlighted initial difficulties in establishing breastfeeding, including physical factors such as sore nipples, as well as a lack of support from health care professionals in the hospital setting. It is clear from other studies that these difficulties are common amongst both Maori and European-descent New Zealanders (Benn et al., 2002; Britton, 1997; Ellison-Loschmann, 1997; Hauck, Langton, & Coyle, 2002; Hill et al., 1994; Hood et al., 1978; McLeod et al., 1998; Rimene et al., 1998); however, mainstream maternity providers may be particularly prone to neglecting the cultural needs of Maori women. Areas that are often overlooked include the need for *whanau* (family) support, the need for

mana wahine to be observed, as well as the observance of *tapu* (ceremonial restriction or the sacred) and *noa* (free from ceremonial restriction), which differ between tribal groups (Rimene et al., 1998).

New mothers discussed the benefit of positive role models and support from Maori health care professionals working in the community in establishing and continuing with breastfeeding (Ellison-Loschmann, 1997; Ellison-Loschmann, 1998). Women's decisions to continue to breastfeed over time were influenced by a need to resume their own lives, as breastfeeding did not always afford them the freedom they desired. Negotiating the balance between freedom and the needs of their infants is a challenging task. Juggling the demands of multiple roles, such as that of being a partner or the need to return to paid employment, has also been cited as another significant challenge to continued breastfeeding for Maori women[4] (Rimene et al., 1998).

Although New Zealand is legally a bi-cultural nation, it is home to a number of other people groups[5], notably from Pacific Island nations including Samoa, Fiji, Cook Islands, and Tonga. While these distinct cultural groups all provide differing perspectives on breastfeeding, one value appears common to them all – that Maori and Pacific Island women understand breastfeeding, and breastmilk, to be a gift for their young (Abel, Park, Tipene-Leach, Finau, & Lennan, 2001; Rimene et al., 1998; Ryan, 1999a). Grandmothers support their daughters with food to assist in nourishing a new mother, and in doing so provide a gift for their grandchild. Grandmothers also pass on experiential knowledge about breastfeeding, and in doing so support the new mother to continue to provide nourishment for their offspring. It has been suggested that this ideology differs considerably from that of New Zealand women of European descent, who can view breastfeeding as a choice they make according to their lifestyle needs (Beasley & Heritage, 1998/1999). However, participants who were primarily of European descent in two different qualitative studies (Bottorff, 1990; Dignam, 2001) also described how breastfeeding, when successful, was considered to be a gift that encompassed emotional and physical comfort, as well as nutrition for their infants.

[4] The issue of breastfeeding and employment is further discussed in Section 3.13.

There is comparatively little published research that examines the experience of breastfeeding for Pacific Island women. Dodd (1999) describes an interview with two Pacific Island women, who were also health care professionals, that raises some commonly held beliefs among Pacific Island cultures about breastfeeding. One such held belief is that colostrum is viewed as harmful and discarded, with substitutes such as water frequently offered to infants until a woman's mature milk comes in. This belief was also discussed by Morse (1985) in her research into Fijian women's infant feeding practices. Pacific Island cultures advocate the provision of specific foods to new breastfeeding mothers, as well as the avoidance of certain foods that are believed to affect the milk's quality. Another issue affecting the continuation of breastfeeding arises when a woman's breasts become less full and feel softer, which occurs between two and four months postpartum; at this time, a woman might believe that her milk has 'flown away', necessitating the need for the introduction of artificial formula. Able and colleagues (2001) discuss how this results in women being anxious about their ability to feed their infants, leading to premature weaning.

Issues that affect Pacific Island women's breastfeeding in New Zealand are similar to those experienced by others in this country. The medicalisation of breastfeeding has eroded their confidence in their body's ability to breastfeed without professional help (Abel et al., 2001; Dodd, 1999). The need to return to paid employment also impacts upon the ability of women to sustain breastfeeding. And being part of an immigrant population, Pacific Island women may lack the extended family or community support traditionally available. However, the ongoing support of women's own mothers continues to be a defining part of a successful breastfeeding experience (Dodd, 1999).

Morse's (1985) research into breastfeeding practices in Fiji suggests that Fijian women use a combination of breast and bottle feeding, which allows them to continue to fulfil their various roles within the community. For Fijian women, a strong sense of community means that they receive the support of their extended families and cultural community when they breastfeed (Morse, 1985). No research studies have been conducted to assess how the breastfeeding

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[5] Other people groups in New Zealand include those of Asian and Indian descent; however, there is no published research exploring the breastfeeding experiences of these people groups in New Zealand.

experience is constructed in the New Zealand context where extended contact with communities or tribes may be disrupted.

In a landmark New Zealand study, Able and colleagues (Abel et al., 2001) conducted 37 focus groups to examine the differing culturally-based infant care beliefs of Maori, Tongan, Samoan, Cook Islands, Niuean and European care-givers in this country. This study clearly illustrates that these differing groups all believe breastfeeding is ideal for infants, because it is a healthy, cheap and convenient food source, and also provides for the infant's emotional needs. The study demonstrated that Pacific Island parents who have good family support do not rely on professional organisations for breastfeeding support; instead, the mother or mother-in-law are considered to be the principal source of breastfeeding advice. The majority of Pacific Island women participating in the study had endeavoured to breastfeed; however, there was general consensus that breastfeeding was difficult to establish, because of pain associated with cracked nipples and engorgement. The early introduction of complementary feeding, both artificial formula and food, was also a common theme for the Pacific Island participants, as it was believed that women were not always capable of producing enough milk to satisfy their infants. The authors of this study highlighted the tension that exists for New Zealand-born Pacific Island women, who must balance their traditionally-held beliefs with those of the prevalent Westernized culture, in which a biomedical approach to breastfeeding is valued.

3.3 Making the Decision to Breastfeed

It has been documented that women make the decision to breastfeed whilst they are pregnant, although their decisions are mediated by social and cultural ideologies (Arora et al., 2000; Baumslag & Michels, 1995; Earle, 2000; Heath et al., 2002; Ozturk Ertem et al., 2001; Schmied & Lupton, 2001). The primary reason women cite for deciding to initiate breastfeeding is that it is a natural process that provides the best source of nutrition for the baby's physiological and emotional health (Arora et al., 2000; Earle, 2002; Kessler et al., 1995; McIntosh, 1985; Murphy, 1999; Schmied & Lupton, 2001). Women who espouse these beliefs report a strong commitment to breastfeeding as a result (Schmied & Lupton, 2001).

The need to negotiate busy life schedules whilst managing complex relationships with significant others, as well as a desire to support the family's sense of well-being, all factor into a woman's decision about breastfeeding (Carter, 1995; Earle, 2000; Gigliotti, 1995; Lothian, 1994; Schmied & Lupton, 2001). Because of this, if a woman's lifestyle does not support breastfeeding and she has a baby that is experiencing difficulties at the breast, she may decide that breastfeeding is not for her and subsequently wean her infant (Carter, 1995; Ferguson, 1998; Gigliotti, 1995; Hill et al., 1994; Lothian, 1994).

Significant relationships in women's lives play a role in their decisions about breastfeeding, with significant others typically described as either the baby's father or the women's mothers (Arora et al., 2000; Chalmers, Ransome, & Herman, 1987; Cronin, 2003; Earle, 2000; Earle, 2002; Kessler et al., 1995). Women may choose to initiate breastfeeding, but the opinions of significant others impact upon a woman's confidence to continue breastfeeding (Kessler, 1995). This suggests that breastfeeding initiation is not dependent solely upon cognitive processes, but occurs in conjunction with social factors. Research also indicates that if a woman was breastfed herself she is more likely to breastfeed her own infant (Isabella & Isabella, 1994; Kessler et al., 1995; Williams, Innis, & Vogel, 1996). This correlation has been attributed to the beliefs and breastfeeding support offered by women's mothers. The issues surrounding social support and breastfeeding are explored in greater depth in section 3.6.

The length of time a woman intends to breastfeed her infant has been discussed in the New Zealand literature. Research supports the notion that women approach breastfeeding with an attitude of 'lets see how it goes', believing that if it proves to be problematic they will stop (Ryan, 1999a; Vogel & Mitchell, 1998b). Vogel and Mitchell (1998b) discovered that women do not typically set out to breastfeed for long periods; instead, they 'grow into it'. However, the decision to continue to breastfeed is mediated by many factors such as family demands, return to paid employment, social expectations, and the introduction of solids into the infant's diet.

Murphy (1999) explored women's depictions of their breastfeeding decisions within a framework of sociological deviance. Her study demonstrates that women's intention to either bottle feed or breastfeed their infants is understood to be a moral decision that, once made, dictates whether or not a woman is a

good mother, or indeed a good woman. Women who choose not to breastfeed are understood to be selfishly placing their own needs above those of their infant, particularly in light of the beneficial physiological nature of breastfeeding. When recounting decisions to formula feed antenatally, the women Murphy interviewed had what were described as 'well-rehearsed' depictions to defend why they were choosing not to breastfeed.

Women have expressed various rationales for not breastfeeding for personal as well as external reasons (Murphy, 1999). Personal issues included embarrassment at feeding in front of others, the need for self-fulfilment and returning to paid employment. External reasons for not breastfeeding included a desire to involve the infant's father in care, a belief in the superiority of formula, and that the opinion of significant others held weight over that of health care professionals. These reasons for choosing not to breastfeed have also been highlighted in other studies (Carter, 1995; Cronin, 2003; Earle, 2000; Earle, 2002).

3.4 Initial Breastfeeding Experiences

Initial experiences with breastfeeding can leave a lasting impression on a woman, and may influence future decisions about breastfeeding subsequent children (Mozingo et al., 2000). A quantitative study (Tarkka, Paunonen, & Laippala, 1998) describes how women who were provided with individualised support and education about breastfeeding in the initial postpartum period were more likely to successfully establish and maintain breastfeeding. Tarkka, Paunonen and Laippala (1998) interviewed women who had given birth in hospital to healthy, full-term infants. They discovered that women who feel positive about their initial breastfeeding experiences are more likely to continue breastfeeding following discharge from tertiary maternity services. For some women, initial breastfeeding experiences are described as positive and rewarding; unfortunately, other women recount their experiences employing terms such as disappointing, hard, exhausting and stressful (Benn et al., 2002; Benson, 2000; Britton, 1997; Mozingo et al., 2000).

Some women report that health care professionals would forcefully handle their breasts and the baby to facilitate the initial breastfeeds. This behaviour on the

part of health care professionals was interpreted by the women as uncaring, and was perceived to demonstrate a lack of understanding of both women's and infant's needs (Benn et al., 2002; Mozingo et al., 2000; Vogel & Mitchell, 1998a). Women have also cited lengthy delays in getting a response from health care professionals to requests for assistance, reporting waiting periods of up to three hours before getting assistance (Vogel & Mitchell, 1998a).

Inconsistent advice from health care professionals is cited by women as a difficulty that vandalises the initial breastfeeding experience (Benn et al., 2002; Britton, 1997; Cronin, 2003; Hood et al., 1978; Mozingo et al., 2000; Vogel & Mitchell, 1998a). This problem has been identified as an important issue for a considerable time (see Hood, 1978 #455). Along with the issue of inconsistent advice, women have also discussed how health care professionals frequently offer what has been described as 'standardised advice', that is not tailored to their individual circumstances (Hauck et al., 2002). This lack of individualised advice leaves women feeling isolated in their attempts to resolve breastfeeding difficulties.

Women participating in research have identified a number of commonly occurring impediments to establishing breastfeeding, including difficulty in positioning or latching the infant to the breast, painful or cracked nipples, perceptions of insufficient milk supply, engorgement, unsettled infants and, as noted above, inconsistent advice from health care professionals (Beasley et al., 1998; Beasley & Gordon, 1998/1999; Benn et al., 2002; Britton, 1997; Hauck et al., 2002; Hill et al., 1994; Hood et al., 1978; McLeod et al., 1998; Mozingo et al., 2000; Scott, Landers, Hughes, & Binns, 2001; Vogel & Mitchell, 1998a; Vogel & Mitchell, 1998b). Furthermore, some women have noted that, following the birth of a second baby, they were left with little support from health care professionals when attempting to establish breastfeeding, despite struggling, presumably because they were expected to be fully capable through prior experience (Benn et al., 2002; McLeod et al., 1998).

The difficulties encountered during the process of initiating breastfeeding have led women to conclude that breastfeeding is not as easy as they were led to believe by others (Benn et al., 2002; Benson, 2000; Britton, 1997; Hauck et al., 2002; Hill et al., 1994; Mozingo et al., 2000; Vogel & Mitchell, 1998a). Women relay that they felt ill-prepared for breastfeeding and that advice provided by other women and antenatal educators did not necessarily assist them in

establishing breastfeeding (Britton, 1997; Hauck et al., 2002; Hill et al., 1994; Mozingo et al., 2000; Vogel & Mitchell, 1998a). The gulf between idealised expectations and the reality of breastfeeding was, for some, extremely difficult to reconcile, resulting in disillusionment and the early cessation of breastfeeding (Mozingo et al., 2000). The follow section explores in greater depth some of the difficulties women face whilst breastfeeding.

3.5 Experiencing Breastfeeding Difficulties

While problems experienced during the initial breastfeeding period, such as engorgement, are often quickly resolved, some breastfeeding problems cause women significant distress for some time. Schmied and Lupton (2001) note that the majority of the women who participated in their study experienced difficulty breastfeeding, especially in the early weeks.

Research has demonstrated that women are frequently surprised by how difficult it can be to establish breastfeeding (Hauck et al., 2002; Schmied & Barclay, 1999; Vares, 1992), and find themselves unprepared to deal with ongoing problems. The struggle to reconcile pro-breastfeeding discourses with the reality of breastfeeding can be extremely difficult for some women (Mozingo et al., 2000; Schmied & Barclay, 1999). Some women who struggle to resolve breastfeeding difficulties end up navigating their way through a minefield of insecurity and guilt, which results in them questioning their ability to mother (Hauck et al., 2002; Mozingo et al., 2000). These issues are often compounded by the exhaustion that accompanies mothering a young infant.

Two of the most frequently cited difficulties with breastfeeding are sore and cracked nipples, which can be a source of discomfort for a number of months (Benson, 2000; Blair, Cadwell, Turner-Maffei, & Brimdyr, 2003; Carter, 1995; Chapman, Macey, Keegan, Borum, & Bennett, 1985; Davies, 1989; Hood et al., 1978; Mozingo et al., 2000; Page et al., 2003; Salmon, 1994; Schmied & Lupton, 2001; Vares, 1992; Vogel & Mitchell, 1998b). A participant in one study described breastfeeding as "very painful, very, very painful" (Benson, 2000, p. 24); others employ words such as 'excruciating' to describe their experiences (Vogel & Mitchell, 1998b). Schmied and Barclay (1999, p. 330) discussed how

the women who participated in their study described breastfeeding as a painful and violent act in which infants would attack them, resulting in 'bodily mutilation'.

It is interesting to note that sore nipples, especially for first time mothers, along with difficulties in establishing breastfeeding have been documented as problems for hundreds of years (Salmon, 1994). Yet, as outlined above, many women are surprised to find how difficult and painful breastfeeding can be to establish; that breastfeeding can be painful initially is silenced in our society. A common response from health care professionals is that painful nipples are the result of a woman's failure to establish a 'good' latch between the infant and breast. This way of framing a woman's pain can trivialize the distress she's experiencing and undermine her confidence in her ability to successfully breastfeed. Few women would want to admit they were unable to provide their infant with what is the best source of nutrition because they could not master what is essentially a mechanical skill.

Feelings of tiredness and exhaustion are commonly discussed by breastfeeding women (Beasley & Gordon, 1998/1999; Carter, 1995; Davies, 1989; Earle, 2002; Hill et al., 1994; Isabella & Isabella, 1994; Mozingo et al., 2000), especially during periods of infant growth. For adolescent mothers, tiredness associated with breastfeeding can make feeding their infants with artificial formula seem attractive, as it allows them to share infant feeding responsibilities (Benson, 2000). Feelings of fatigue and tiredness have also been highlighted as commonly experienced symptoms of postnatal depression (PND) (Bozoky & Corwin, 2001).

Breastfeeding women often gauge their performance on the behavioural messages transmitted by their infants. An unsettled infant that feeds frequently, especially overnight, and has poor weight gain sends a powerful message to women struggling to breastfeed. Women's interpretations of their infants' behaviour are meaningful because they offer women evidence by which they can measure their ability to breastfeed (Leff, Gagne, & Jefferis, 1994). This can lead women to conclude that either the quantity or quality of their milk is inadequate to sustain their infant (Arora et al., 2000; Beasley et al., 1998; Beasley & Gordon, 1998/1999; Chapman et al., 1985; Davies, 1989; Hill, 1992; Hill et al., 1994; Hochhausen, 1991; McLeod et al., 1998; Mozingo et al., 2000; Vogel & Mitchell, 1998b). Women who do not believe that their milk supply is sufficient to meet the needs of their baby frequently report suffering from

feelings of guilt (Essex et al., 1995; Hochhausen, 1991; Vogel & Mitchell, 1998b).

This phenomenon has been labelled by researchers as 'insufficient milk syndrome', and is frequently cited as the principal reason that women cease to breastfeed (Blyth et al., 2002; Essex et al., 1995; Gunn, 1984; Heath et al., 2002; Hill, 1992; Hill & Humenick, 1989; Hillervik-Lindquist, 1992; Hood et al., 1978; Ingram, Johnson, & Greenwood, 2002; Isabella & Isabella, 1994; Morse, Ewing, Gamble, & Donahue, 1992). Whether insufficient milk syndrome is real or imagined, even the perception of insufficient milk increases the likelihood that a woman will cease to breastfeed her infant before her peers who do not question their milk supply (Blyth et al., 2002; Heath et al., 2002).

The literature notes a number of physiological events that create ongoing discomfort for breastfeeding women, including engorgement, sore breasts and leaking milk (Bottorff & Morse, 1990; Carter, 1995; Hill et al., 1994; Mozingo et al., 2000; Schmied & Barclay, 1999; Schmied & Lupton, 2001; Tarkka et al., 1998). The 'always thereness' of breastmilk can, therefore, be problematic for some women. The need to engage in activities such as expressing milk to maintain personal comfort, even when away from their infants, means that breastfeeding women can never escape the demands of infant feeding (Bottorff & Morse, 1990).

Studies have also explored women's experience of the let-down reflex (Britton, 1997; Schmied & Lupton, 2001). Participants describe how their body signals a let-down of breastmilk by using phrases like 'tingly', 'tightening', and 'pins and needles sensation' (Britton, 1997, p 180). Women's descriptions of the let-down reflex emphasise that they feel powerless to control this particular bodily function, which may leave them leaking milk in awkward social circumstances. These studies highlight how women frequently feel unprepared for the presence, or absence, of a let-down sensation, which once again leads them to question their body's ability to produce milk at appropriate times.

The constant demands for milk from an infant, coupled with the demands of breasts filled with milk, lead some women to describe their lives whilst breastfeeding as being 'on hold' (Earle, 2002; Schmied & Barclay, 1999; Schmied & Lupton, 2001). Indeed some women characterise their dislike for breastfeeding by using terms like being 'sucked dry' (Schmied & Lupton, 2001,

p. 243) to illustrate the unrelenting nature of breastfeeding, which drives women to desire a sense of self that is separate from their infant.

For women with more than one child, the need to manage multiple roles and tasks factors into their decisions about breastfeeding (Arora et al., 2000; Carter, 1995; McBride, 1999; Vogel & Mitchell, 1998b). Women have discussed the social pressure to be visibly producing results, which is not fulfilled by breastfeeding a baby, at least not in the short term (Vogel & Mitchell, 1998b). Women need to fit breastfeeding around the demands of caring for other family members, which often results in the need for routines to maintain a sense of balance within the family. The maintenance of a routine can become difficult if an infant is unsettled or requires frequent feeding (McBride, 1999). The need to return to paid employment also poses significant challenges for women who choose to continue breastfeeding.

Breastfeeding problems that have persisted over some time can result in women feeling frustrated, isolated and guilty (Hauck et al., 2002; McLeod et al., 1998). This issue may be compounded if breastfeeding difficulties cause a woman to wean her infant earlier than she planned, which can lead to feelings of self doubt, failure, anger, and guilt (Earle, 2002; Hochhausen, 1991; McLeod et al., 1998; Mozingo et al., 2000). However, for some women a sense of relief characterises their decision to wean their infants, as it signals the end of what was for them an extremely stressful period (Gigliotti, 1995; Mozingo et al., 2000).

Women who have struggled to overcome breastfeeding problems talk about the need to find hope that the problems will be resolved, taking heart in even small signs of improvement (Bottorff, 1990; Hauck et al., 2002). Hope provides women with the encouragement to persist with breastfeeding. Hope that breastfeeding will get easier frequently comes through interaction with others with knowledge of breastfeeding, which is why women who receive emotional support and practical help from both individual social networks, as well as health care professionals, are more likely to report that they are coping well with breastfeeding (Tarkka et al., 1998).

3.6 The Influence of Social Support for Breastfeeding Women

The impact that women's social networks have on continued breastfeeding has been well documented (Arora et al., 2000; Chalmers et al., 1987; Hauck et al., 2002; Humphreys, Thompson, & Miner, 1998; Schafer, Vogel, Viegas, & Hausafus, 1998). Research indicates that women's social networks have more influence over their decision to breastfeed that any other factor (Humphreys et al., 1998).

According to the research, husbands[6] also play a vital role in determining whether or not women breastfeed. If a woman perceives that her husband is ambivalent or not supportive of breastfeeding, she is more likely to opt for artificial formula (Arora, et al., 2000; Charlmers, 1987; Cronin, 2003; Davies, 1989; Hauck, 2002; Kessler, et al., 1995; Isabella & Isabella, 1994; McLeod, et al., 1998; Scott, et al., 2001). Husbands with positive attitudes to breastfeeding provide both emotional and financial support for women, enabling women to continue to breastfeed. In contrast, a husband's withdrawal of support for their spouse's continued breastfeeding will result in the infant being weaned shortly thereafter (Morse & Harrison, 1987).

Women's own mothers also significantly influence breastfeeding, as they provide empathetic support, as well as information about breastfeeding (Chalmers, Ransome & Herman, 1987; Isabella & Isabella, 1994; Kessler et al., 1995; Scott, et al., 2001; Vogel & Mitchell, 1998b). Chalmer's (1987) research suggests that it is women's own mothers who provide the greatest level of both practical and emotional support for breastfeeding women. However, the helpfulness of a woman's mother may not contribute to breastfeeding success, especially if she has not breastfed her children (Isabella & Isabella, 1994).

Peer support also contributes to positive breastfeeding outcomes, as this type of support assists in removing some of the isolation women experience when

[6] Researchers interviewed women's husbands, not de-facto partners. Additional research is needed to assess the role of de-facto partners on women's breastfeeding experience.

attempting to establish breastfeeding (Dennis, 2002; Hauck et al., 2002; Humphreys et al., 1998; McLeod et al., 1998; Schafer et al., 1998). Peers allow women to observe others who are also struggling with breastfeeding, leading to solidarity that provides them with the encouragement to continue. Formalised peer support counsellors have also been demonstrated to enhance the duration of breastfeeding through the sharing of information and the provision of encouragement, which builds women's confidence in their ability to breastfeed (Dennis, 2002; Schafer et al., 1998).

La Leche League[7] also provides woman-to-woman breastfeeding support through their meetings and phone contact, which has been described as a beneficial source of support within New Zealand (McLeod et al., 1998). This organisation was formed to facilitate women's knowledge of breastfeeding, and is currently active within New Zealand. It has been contended that La Leche League was formed primarily to overcome the lack of family support for breastfeeding women (Bryant Merrill, 1987). The women involved in La Leche League formed a structure that essentially mirrors that of an extended family: it has leaders, women with experience of breastfeeding, and new mothers who want to breastfeed, all of whom meet together with the goal of supporting one another to breastfeed.

While health care professionals do affect women's perceptions of available breastfeeding support, overseas research suggests that professionals play a minimal role in influencing breastfeeding outcomes, especially following discharge from maternity facilities (Chalmers, 1987; Davies, 1989; Humphreys, 1998). However, research conducted in New Zealand highlights how unique provisions within the health care system in this country play pivotal roles in supporting women to breastfeed (Ellison-Loschmann, 1998; McLeod et al., 1998; Vogel & Mitchell, 1998b). Midwives are funded to provide home visits for the first six weeks postpartum, and Plunket Family Centres frequently employ Lactation Consultants who can provide care at an individual level. Women have highlighted the importance of encouragement offered by health care professionals in relation to their breastfeeding success. Similarly, recognition of women's breastfeeding achievements by health care professionals provides an important signal to women that they are successful mothers (McLeod et al., 1998; Vogel & Mitchell, 1998b).

3.7 Prolonged Breastfeeding

Women's sense of confidence in their ability to breastfeed is emerging as a strong indicator of prolonged breastfeeding (Blyth et al., 2002; Dennis, 1999; Hill & Humenick, 1996; Ozturk Ertem et al., 2001). A Breastfeeding Self-Efficacy theory was developed by Dennis (1999) to predict which women have confidence that they are able breastfeed their infants. Dennis reports that breastfeeding self-efficacy is mediated by four antecedent factors: performance accomplishments (or past experiences), vicarious experiences, verbal persuasion, and a woman's physiological and affective states (p. 196-197). Women's internal dialogues affect their ability to breastfeed, as confidence in one's ability will most likely produce the desired breastfeeding behaviour. Dennis also asserts that people tend to pursue activities they believe they can be successful at, which directly affects the effort and persistence women bring to breastfeeding. Finally, women's breastfeeding ability is influenced by their emotional reactions to breastfeeding. If they encounter difficulties, a strong belief that they can overcome them will most likely enable them to continue to breastfeed.

Blyth (2002) has demonstrated through testing the Breastfeeding Self-Efficacy theory that women with high self-efficacy were significantly more likely to be breastfeeding at one week postpartum than those who had low self-efficacy. Women's confidence in their ability to breastfeed was enhanced the longer they continued; consequently, women with high confidence levels breastfed for significantly longer (Blyth et al., 2002).

Women who choose to breastfeed for periods of a year or longer report that the primary reason for continuing is that breastfeeding facilitates a special time between a woman and her baby (Hills-Bonczyk et al., 1994). Participants in this study have explained that the unique and close bond that is formed through breastfeeding encourages them to continue beyond twelve months. Furthermore, they have reported that they wished to allow their infant to initiate weaning when they were ready. It is noteworthy that both Blyth (2002) and Hills-Bonczyk (1994) state that for women to continue breastfeeding beyond one year they must display considerable strength to overcome the social

[7] For more information about La Leche League please see Chapter Two, Section 2.5.

pressure they encounter, as New Zealand society portrays prolonged breastfeeding as unacceptable.

In an original and influential article, Bottorff (1990) explores what it is to persist with breastfeeding despite the difficulties women may encounter. Bottorff employed a phenomenological approach to examine women's narratives of persistence in breastfeeding. The women who participated in this study spoke of the importance of persisting through difficulties and that this was the key to continued breastfeeding. Bottorff highlights that it takes time for women to adjust to the ever-changing and unpredictable nature of breastfeeding, which pre-empts an altered sense of self. Therefore, the need for encouragement from others who understand what persevering with breastfeeding means is crucial for breastfeeding women.

Women who persist with breastfeeding are defined by the belief that breastfeeding is the best gift that they can give their infants, and this conviction encourages women to continue to offer their bodies to their infants despite the pain they might be experiencing. A woman's level of commitment to breastfeeding is what will ultimately facilitate continued breastfeeding; however, this choice does mean giving up some of her freedom (Bottorff, 1990).

Being constantly in demand, both physically and emotionally, results in confusion for some women over their bodily boundaries, and pre-empts a desire to re-gain a sense of self-autonomy and determination. In Vares's (1992) study breastfeeding women discussed feeling at times as if their infant was devouring them, because it seemed that all of their infant's needs were met through breastfeeding. Other women reported that they were able to resolve this dilemma by consciously making the choice to be available to breastfeed, and through this decision they gained a sense of self-determination otherwise missing from the relationship between a breastfeeding mother and her child.

3.8 The Act of 'Successful' Breastfeeding

Successful breastfeeding can be defined in many ways, and extensive research has been conducted to predict which women will be 'successful' at various stages of the breastfeeding process. For example, research exploring what

facilitates successful breastfeeding initiation (Heath et al., 2002; Kessler et al., 1995; Matthews, 1991) has demonstrated that successful initiation is enhanced when a woman's intention has been to breastfeed (Heath et al., 2002). Women's exposure to social modelling of breastfeeding, which increases women's self-efficacy, also enhances successful breastfeeding initiation (Kessler et al., 1995). Research into the initial breastfeeding experiences indicates that women report higher levels of satisfaction with breastfeeding if they perceive that the infant responds positively (Matthews, 1991).

Research has also demonstrated that women who were breastfeeding exclusively at one month postpartum display greater overall satisfaction with motherhood when their infants are nine months of age (Isabella & Isabella, 1994, p. 93). It has been suggested that successful breastfeeding allows women to interact with their infants in a positive manner, which in turn supports the development of an emotionally satisfying relationship for breastfeeding women. In part, this has been attributed to women learning to respond to their infant's cues, which in turn elicits a positive response from the infant, and ultimately validates women's ability to mother. The concept that women learn to respond to their infant's cues has also been supported by women participating in Dignam's (2001) study.

It has been argued that successful breastfeeding has been traditionally understood to be the responsibility of the brain, which when working effectively achieves the desired breastfeeding outcome (Bartlett, 2002). Not only does the brain regulate hormonal responses, but it also initiates emotional responses, which are understood to either support or interfere with the physiological process of breastfeeding. Bartlett (2002) proposes that, if one holds to this line of thinking, breastfeeding is solely mediated by a woman's will to breastfeed, to the exclusion of the other factors discussed above. To mediate additional understandings of breastfeeding, Bartlett (2002) suggests that we should accept that women's bodies and breasts possess their own intelligence; when breastfeeding women learn to understand and articulate this bodily knowledge, then they are more likely to breastfeed successfully. This demonstrates how traditional definitions of breastfeeding success need to be critiqued and re-framed, allowing new understandings of breastfeeding success to emerge.

Traditionally, women who have breastfed have been judged within a framework of success or failure. The use of the term 'successful' in relation to

breastfeeding has previously been critiqued by Harrison and colleagues (1985), who found that researchers and lay writers have defined and measured breastfeeding success in multiple ways, including duration (which can rate success anywhere from initiating to twelve months), prenatal variables, infant health, exclusively breastfeeding, relational achievement, and the management of breastfeeding within the context of the family (Harrison, Morse, & Prowse, 1985).

These measures of breastfeeding success are still evident in the current literature where success is measured by duration (Essex et al., 1995; Riordan & Auerbach, 1993; Schafer et al., 1998), correct technique (Henderson et al., 2001; Righard, 1998), health benefits (Australian College of Paediatrics, 1998; Ford & Labbok, 1990; Jones, 2001), and a lack of breastfeeding problems (Chapman et al., 1985; Inch & Fisher, 2000; Righard, 1998; Williams, 1997). However, definitions of breastfeeding success change across research studies, and also are mediated by cultural understandings of what constitutes successful breastfeeding (Coubrough, 1999; Hunter, 1998; Labbok, 2000; Labbok & Krasovec, 1990).

It is important to note that, to have the ability to attain breastfeeding success, it must be possible to fail at breastfeeding. Breastfeeding failure has typically been defined as breastfeeding cessation (Hunter, 1998; Laufer, 1990; Lethbridge, McClurg, Henrikson, & Wall, 1992). Laufer (1990) has developed a model to typify how breastfeeding failure occurs, which is described in the following quote:

> The complex of maternal emotions and inadequate support, ignorance about routine breastfeeding management, awkward interactions with the baby, inappropriate supplementation, poor positioning, and poorly timed feedings lead not only to impaired production of oxytocin and prolactin but is also associated with increasingly ineffective technique, a poor milk supply, and poorly conditioned letdown reflex. This, in turn, leads to inadequate drainage, nipple pain, and an unsatisfied baby with an unacceptable weight gain pattern. The mother's resultant feelings of incompetence and failure both contribute to and feed on her ever-diminishing self-esteem. She becomes increasingly awkward and ineffective... The baby does not learn how to nurse well, gets little milk,

> and requires supplementation. Breastfeeding 'failure' has occurred (p. 40).

Laufer goes on to explain that breastfeeding success occurs when women either meet or exceed their breastfeeding expectations.

As evidenced above, measures of success are frequently created for the purpose of research and have little relevance for the individual breastfeeding dyad. However, it is clear from the literature that women do measure themselves against their own internal definitions of breastfeeding success, which are mediated through knowledge of society's accepted interpretations. It has been argued that women should individually define what breastfeeding success is for them, not be held accountable to arbitrarily-assigned measures of success that leave them open to critique and feelings of guilt and shame (Auerbach, 1994; Gigliotti, 1995; Hunter, 1998).

Even though women frequently develop culturally-mediated definitions of success, research that has delved into women's own definitions of breastfeeding success offers differing understandings of what constitutes success (Dignam, 2001; Leff et al., 1994). One qualitative study of 26 women highlights how they defined successful breastfeeding according to five categories: infant health, infant satisfaction, maternal enjoyment, attainment of desired maternal role, and lifestyle compatibility (Leff et al., 1994). These categories are not mutually exclusive, but rather describe various factors that contribute to how success is rated by the participants. Of particular interest is that women did not rate success on duration of breastfeeding; rather, they rated it according to how well they achieved their ideals in the above-mentioned categories. The primary message to emerge from this study is that women believe that breastfeeding is successful when they are working in harmony with their infants. This concept is supported by Dignam's (2001) study into breastfeeding and intimacy, which demonstrates that women who have the opportunity to experience intimacy with their infants whilst breastfeeding consider themselves successful.

3.9 Exploring Sensuality, Sexuality, and Breastfeeding

Western cultures frequently objectify the breast as a sexual object (Morse, 1989; Yalom, 1997), essentially denying other existential interpretations of the breast, such as the breast as functional. The failure of society to allow for multiple interpretations of the breast can result in women experiencing difficulty adjusting to breastfeeding. Breastfeeding frequently requires women to re-conceptualise how they have understood their bodies, a concept that is explored extensively in the breastfeeding literature (Avery, Duckett, & Frantzich, 2000; Beasley, 1991; Beasley, 1996a; Beasley & Heritage, 1998/1999; Bentovim, 1976; Dignam, 1995; Dignam, 1998; McIntosh, 1985; Morse, 1989; Schmied & Lupton, 2001; Traina, 2000; Vares, 1992).

A certain amount of ambiguity exists between the terms sexuality and sensuality when exploring the issue of breastfeeding. Traditionally, researchers have employed the term 'sexuality' to explore women's understandings of their breasts, breastfeeding, and other adult relationships (Avery, et al., 2000; Morse, 1989; Traina, 2000; Yalom, 1997). However, feminist writers have tended to use the term 'sensual' to describe women's pleasurable bodily-based experiences, which captures feminist discourses surrounding breastfeeding (Carter, 1995; Schmied & Lupton, 2001; Vares, 1992). As a result, these two words, sensual and sexual, tend to be used interchangeably within the literature that explores women's bodily experience of breastfeeding.

Quantitative studies have explored how breastfeeding impacts upon women's experience of sexuality (Avery et al., 2000; Hillervik-Lindquist, 1992). Women have noted that breastfeeding did not alter their sexual relationships significantly; however, due to factors such as the need to wear a nursing bra and leaking whilst aroused, libido was reported to be diminished (Avery et al., 2000; Hillervik-Lindquist, 1992). One study highlighted how breastfeeding can be a pleasurable experience for women, although the majority of women do not experience sexual arousal whilst breastfeeding (Avery et al., 2000). Despite these issues, adjustments in sexual relationships for breastfeeding women following the birth of a baby do not differ significantly from those experienced by non-breastfeeding women, with all women citing fatigue as the major contributor to alterations in their sexual practices following birth (Maushart, 1999; Traina, 2000).

Societal perceptions on the sexual nature of women's breasts do, however, affect women's experience of breastfeeding. Bryant Merril (1987) notes that, faced with the need to satisfy both their partner's and their breastfed infant's needs, women may minimise any competition by favouring their partner. Women have also discussed how they struggled to maintain their breasts as a sexual asset whilst breastfeeding, due to such things as restrictive clothing and milk let-down whilst aroused. To continue to breastfeed, a woman must consider the needs of her infant to be more important than the sexual needs of her partner (McLeod et al., 1998).

Morse (1989) examined women's struggle to reconcile the functional breast with their understanding of the breast as sexual. One participant who had a ten month old son reported that her mother-in-law relayed that she was "afraid that her grandson is turning into a sexual pervert." Another participant, when reflecting on her own experience of her breasts whilst breastfeeding her infant, stated that she thought to herself "Euch, those are for your husband!" (Morse & Harrison, 1987, p. 229) Conceptualising the breast as a sexual object clearly inhibits breastfeeding.

Female sexuality is understood primarily in the context of adult relationships; however, a woman's sexuality can be understood to extend past this boundary to incorporate maternal sexuality. The silencing of maternal sexuality closes down upon language that explores women's experiences of pregnancy, childbirth and breastfeeding. For example, both suckling and sexual stimulation produce nipple erection and milk ejection, because the hormones that are released by a woman's body during breastfeeding are the same as those released during sexual climax (Riordan & Auerbach, 1993). It has been argued, however, that discussions about women's sexual experiences have been confined to the boundaries of adult relationships to maintain and ensure men's access to women, thereby lessening the threat to men (Morse, 1989; Traina, 2000).

The prevailing hegemonic discourse surrounding mothering is that mothers are asexual (Maushart, 1999), and that any deviations from this should be considered perverse, which essentially silences women's experience of sensual feelings whilst breastfeeding. Because of this, Traina (2000) questions whether there is a need to create a language that accepts the various forms of sensuality as sexual, thereby legitimising women's experience of breastfeeding as sexual.

However, it would be impossible to change cultural perceptions about motherhood and sexuality without the reconstruction of societal understandings of women, which would in turn affect what society considers morally acceptable behaviour (Morse, 1989; Traina, 2000).

To cope with the experience of breastfeeding in an acceptable manner within society, breastfeeding women frequently re-define their breasts as both sexual and functional (Dignam, 1998); essentially, they are re-framed as a commodity with a dual purpose. One study participant stated "We're using them [the breasts] during the day for something totally different from what they are used for at night" (Dignam, 1998, p. 82). This re-framing allows women to embrace both their roles as a breastfeeding mother, and as a sexual partner, in a society where breasts are primarily considered to be sexual.

3.10 Breastfeeding and Intimacy

To cultivate a language that describes the sensual nature and closeness that breastfeeding brings for some women, researchers have employed the term intimacy (Bottorff, 1990; Dignam, 1995; Dignam, 1998; Dignam, 2001; Schmied & Lupton, 2001). Although intimacy is most frequently associated with a sexual relationship, it can occur on many levels from friendship to a breastfeeding dyad. Intimacy is a safe and acceptable place from which to view a woman's experience of sensuality within the context of breastfeeding. This re-framing of the breastfeeding experience, which includes intimacy as an acceptable and inherent part, allows a previously-silenced part of the breastfeeding experience to be explored.

In a grounded theory study exploring the intimacy experienced by women during breastfeeding, Dignam (2001) included the phrase 'linking as one'. The women who participated in her study highlighted how intimacy through breastfeeding evolved through a process that began with 'being with' their infants. The process continued with the participants coming to know themselves as breastfeeding women, which included redefining how they understood their breasts and, therefore, their body. Finally, the journey involved coming to know their babies, with participants describing how understanding their infant's cues and body language assisted the journey towards intimacy. It is the place where

a woman knows herself, and knows her baby, that 'linking as one' occurs and intimacy through breastfeeding is achieved.

The women who participated in Dignam's (2001) study felt that breastfeeding entailed gifting their infant their milk, as well as comfort and physical contact. Dignam describes how the act of breastfeeding during an intimate moment is "mutually exclusive and mutually satisfying to both participants" (p. 246). A woman's experience of intimacy does not occur at every breastfeeding encounter; however, during moments when both the mother and baby are relaxed intimacy occurs. It is these intimate moments that foster a woman's sense of satisfaction with breastfeeding and provide her with the motivation to continue. It is acknowledged by Dignam that not all women experience intimacy with their infants whilst breastfeeding, and she asserts that this contributes to breastfeeding cessation. However, an understanding of what contributes to breastfeeding intimacy may allow health care professionals to facilitate it, supporting rather than undermining breastfeeding by doing so.

Dignam's findings are supported by Bottorff (1990) and Schmied and Lupton (2001), who also describe breastfeeding as an intimate practice. These researchers describe how women experience breastfeeding as an act that supports harmonious intimacy between a woman and her infant, the ultimate gift given by a mother to her infant. Women who participated in these studies articulated that they felt connected with their infants because of breastfeeding, and this interconnectedness persisted throughout the time they breastfed their infants. A woman's experience of breastfeeding intimacy was also unavoidably sensual and pleasurable, due to the nature of the physical contact and the emotional dependence of the infant on its mother (Schmied & Lupton, 2001).

Some of the women who participated in Schmied and Lupton's (2001) study discussed how they strongly desired to experience intimacy and harmony within their breastfeeding relationship with their children. This desire fuelled their commitment to persevere with breastfeeding despite difficulties. Those women who continued to breastfeed stated that they were 'glad' that they had because it afforded them the opportunity to experience an intimate relationship with their infant.

The idea of breastfeeding and intimacy appears elsewhere briefly in the breastfeeding literature; however, with the exception of the research into

breastfeeding intimacy described above, the primary lens through which intimacy is interpreted is women's struggle to re-conceptualise the breast as non-sexual. A woman's need to re-conceptualise the breast as functional versus sexual is exposed when women discuss their experiences of breastfeeding in public places.

3.11 The Process of Weaning

The process of weaning can be initiated by either the breastfeeding mother or the infant. Many of the reasons why women initiate weaning earlier than planned emerge from the above discussions on breastfeeding experience. As highlighted previously, women choose to initiate breastfeeding because it is by far the best source of nutrition for infants (see section 3.3). However, women's knowledge of, and commitment to, this ideal is not always sufficient to enable them to continue to breastfeed in the face of difficulties, with many women opting to wean earlier than planned (Blyth et al., 2002; Chezem, Montgomery, & Fortman, 1997; Gunn, 1984; Matulonis Williams & Morse, 1989; Morse & Harrison, 1987; Mozingo et al., 2000; Vogel & Mitchell, 1998b; Williams et al., 1996).

It has been demonstrated that women who lack confidence that they can breastfeed are more likely to wean their infant before two months postpartum (Blyth et al., 2002; Hill & Humenick, 1996; Ozturk Ertem et al., 2001). One study reveals that, if a woman believes her infant likes artificial formula more than breastmilk, she is also more likely to wean within two weeks of the infant's birth (Ozturk Ertem et al., 2001). This study suggests that neither breastfeeding difficulties nor perceptions of insufficient milk are directly related to premature weaning. However, women's confidence in their decision to breastfeed was predictive of longer periods of breastfeeding.

Maclean (1990) describes how the women who participated in her study weaned their infants earlier than planned for a variety of reasons, including a desire to re-claim their previous lifestyle, the physical discomfort of breastfeeding, infant responses to the breast, un-met or unrealistic expectations, a lack of knowledge about the breastfeeding process, medical advice, and the resumption of paid employment. These findings are supported

by other research studies (McLeod et al., 1998; Vogel & Mitchell, 1998b). However, simply itemising reasons for premature weaning fails to convey the emotional impact that early weaning has on a woman (see discussion in section 3.4 & 3.5). It also ignores the social context in which weaning occurs, which frequently mediates the length of time women breastfeed their infants.

In a qualitative study that examined the social coercion that exists around infant weaning, Morse (1987) found that during the initial breastfeeding period, women's social networks are supportive; however, by the time the infant is between nine and ten months of age people actively start encouraging women to wean. For the women who participated in Morse's study, this frequently meant that continuing to breastfeed required a withdrawal from social situations that drew critique of their infant feeding method. If a woman was breastfeeding when her infant was 12 months old, the infant's grandparents began to comment about the physically draining nature of breastfeeding for a woman. It is interesting to note that once husbands were no longer supportive of breastfeeding most women weaned within weeks.

Western cultures espouse strong discourses that dictate the expected duration of breastfeeding (Baumslag & Michels, 1995; Hills-Bonczyk et al., 1994; Morse & Harrison, 1987; Vares, 1992). Dignam (2001) suggests that women wean their infants prematurely because breastfeeding is a socially restricted practice that is often viewed as unacceptable. Coupled with this are perceptions of sexuality and partner support of breastfeeding, which can also significantly influence a woman's decision to wean. Murphy (1999) highlights how even breastfeeding women will verbally distance themselves from prolonged breastfeeding. Women report that prolonged breastfeeding indicates an inappropriate relationship between a mother and child, claiming that a child will become too dependent upon their mother. This idea was also discussed briefly by the women in Vares's (1992) study, who reported that they understood that society considered prolonged breastfeeding to be inappropriate.

Whenever a woman decides to wean, she engages in a process of letting go. If she has struggled to overcome breastfeeding difficulties and feels a sense of success in her accomplishment, weaning can signal a big adjustment, a letting go of something that was 'hard won' (Bottorff, 1990; Maclean, 1990; Vares, 1992). Weaning signals the end of an era, and the beginning of a new phase in a woman's and her offspring's life. As difficult as breastfeeding can be to

establish, many women have noted that they have experienced feelings of loss and pain at their last breastfeed (Bottorff, 1990; Maclean, 1990; McLeod et al., 1998; Vares, 1992).

3.12 Breastfeeding in the Presence of Other

New Zealand's Victorian legacy has had a significant influence on breastfeeding, and the mere fact that breastfeeding around others is an issue that warrants investigation gives credence to history's influence on the present. The sexualisation of the breast has left women with the need to cover this part of their bodies, significantly affecting how women experience breastfeeding. Even the commonly used phrase 'breastfeeding in public' alludes to the unacceptability of breastfeeding in the presence of others.

Understanding women's experience of breastfeeding around others provides valuable insight into how, as a culture, we interpret breastfeeding. Literature that examines this issue highlights the impact that societal depictions of the breast as a sexual commodity have on breastfeeding (Abel et al., 2001; Beasley, 1996a; Carter, 1995; Earle, 2002; Ellison-Loschmann, 1998; McLeod et al., 1998). Women who breastfeed in public frequently experience difficulty in navigating societal expectations of modesty whilst providing for the needs of their babies.

Breastfeeding in public can be an uncomfortable experience, as women often have heightened awareness of social attitudes and responses when breastfeeding in the presence of others (Benson, 2000; Carter, 1995; Dignam, 1998; Heath et al., 2002; McIntosh, 1985; Murphy, 1999; Sheeshka et al., 2001). Some women have even felt that they needed to overcome their own perception that breastfeeding in public is a deviant behaviour (Heath et al., 2002; Sheeshka et al., 2001). Research demonstrates that women who are embarrassed to breastfeed in any situation find breastfeeding less enjoyable and fulfilling, and as a result are more likely to wean early or opt for artificial formula (Heath et al., 2002; McIntosh, 1985). Research also demonstrates that some women's partners find breastfeeding in public embarrassing and offensive, opinions that negatively affect women's decisions about

breastfeeding (Earle, 2002; McIntosh, 1985; Murphy, 1999; Shepherd, Power, & Carter, 2000).

To minimise their discomfort over breastfeeding in public, women will try to find places where they can feed their infants whilst maintaining their modesty, which is usually achieved by either behaving in a discrete manner or securing a visually private place (Beasley, 1996a; Dignam, 1998; McLeod et al., 1998; Murphy, 1999). Women have stated that it is their commitment to breastfeeding that motivates them to breastfeed in public when their infants require feeding (Heath et al., 2002; Sheeshka et al., 2001).

Despite the pressure to keep the act of breastfeeding hidden, women have expressed strong resistance to resorting to feeding their infants in places like public bathrooms (McLeod et al., 1998; Vares, 1992). The mere fact that women would ever consider breastfeeding in a public toilet is an offensive proposition; no other population group, no matter how unacceptable they were perceived to be to society, would ever be forced to consider eating a meal in a toilet. However, for women who have difficulty breastfeeding around others this is sometimes considered to be an option. It is not surprising that some women comment on how grateful they are for facilities provided specifically for breastfeeding women (McLeod et al., 1998); however, if a mother feeding her infant in public was viewed with acceptance within our society, such narratives from breastfeeding women need not emerge when considering the experience of breastfeeding.

The desire to challenge societal mores by the act of breastfeeding in public raises awareness of the prejudices surrounding breastfeeding and, therefore, factors into some women's decision to purposely breastfeed in front of others (Ellison-Loschmann, 1998; Vares, 1992). Breastfeeding in the presence of others provides society with a visual statement about their sense of femininity, and also the importance of breastfeeding in nurturing their infants (Ellison-Loschmann, 1998; McLeod et al., 1998; Vares, 1992).

It is interesting to note that some of the teenage mothers who participated in Ellison-Loschmann's (1998) New Zealand-based research reported that the needs of their infants took precedence over the needs of others when they considered breastfeeding in public. These beliefs are also highlighted by Beasley (1996a). This has led some researchers to propose that young women

are less confined by definitions of socially acceptable behaviour (Beasley, 1996a; Ellison-Loschmann, 1998). However, the findings of a different New Zealand study that examined the experience of breastfeeding for adolescent women contradicts this view, with participants claiming that they felt conspicuous, embarrassed, and had a heightened sense of self-awareness when breastfeeding around others (Benson, 2000).

In a more recent New Zealand-based study, Abel and colleagues (2001) found that women and their partners did not cite breastfeeding in public as an issue. Although the study did not explore why this change may be occurring, it could indicate changes in the perceptions of both breastfeeding women and society at large regarding breastfeeding in public places. A recent Australian study also noted that women did not indicate that breastfeeding in public influenced their decisions to not breastfeed, supporting the notion that a shift in societal values is occurring (Schmied & Barclay, 1999). Nevertheless, it is clear that women who are embarrassed to breastfeed in public are likely to breastfeed for shorter periods than those who are not (Heath et al., 2002; McIntosh, 1985).

3.13 Breastfeeding and Employment

Research demonstrates that if women return to paid employment before one year postpartum they face considerable challenges if they wish to continue breastfeeding (Arora et al., 2000; Galtry, 1998; Vogel & Mitchell, 1998b). It has also been demonstrated that women engaged in paid employment are significantly more likely to feed their infants for shorter periods of time than those who are not in paid employment (Carlson Gielen et al., 1991; Hills-Bonczyk et al., 1993; Ryan & Martinez, 1989). The economic benefits of breastfeeding are undeniable; not only do women save the cost of artificial formula, women that breastfeed contribute to reducing the financial cost of the nation's health care (Galtry, 1997; Waring, 2000). These benefits are often invisible, and women do return to paid employment motivated by factors such as financial need and the preservation of previously-established careers.

Over the past twenty years, women in New Zealand have increasingly returned to paid employment following the birth of a baby (Callister, Podmore, Galtry, & Sawicka, 1995). However, they do not have access to paid breastfeeding

breaks (Galtry, 1998), which has a significant impact upon women who wish to return to paid employment whilst breastfeeding. This has been borne out through research, which indicates that New Zealand women frequently decide to wean their infants between six weeks and three months because they are returning to paid employment (Essex et al., 1995).[8]

Women who choose to combine breastfeeding and paid employment face a variety of challenges (Chezem et al., 1997; Hills-Bonczyk et al., 1993; Hochhausen, 1991; Ryan & Martinez, 1989). On a daily basis they must deal with practical issues such as securing resources for expressing and storing of milk, and coping with leaking milk at inappropriate times (Auerbach, 1984; Hochhausen, 1991; Ryan & Martinez, 1989). Role overload resulting in fatigue is also a major factor cited by women who are in paid employment. Having to address these issues on a daily basis means that some women decide to wean despite intentions to continue to breastfeed (Carlson Gielen et al., 1991; Hochhausen, 1991; Maclean, 1990; Ryan & Martinez, 1989). Some studies have determined that the main reason for women weaning their infant is directly related to their return to paid employment, especially if a woman is employed in a full time capacity (Chezem et al., 1997; Matulonis Williams & Morse, 1989). Other studies have noted that returning to work is a primary consideration when opting to artificially feed an infant (Arora et al., 2000; Maclean, 1990; Morse, Bottorff, & Boman, 1989). This appears to be true regardless of whether women are engaged in part-time or full-time employment (Morse et al., 1989).

The consequences of weaning earlier than planned for employed women are overarching feelings of guilt (Hochhausen, 1991; Maclean, 1990). Chezem and colleague's (1997) study reveals that women who do not manage to fulfil their breastfeeding goals whilst employed suffer from feelings of sadness, depression and guilt more than their counterparts, who may have weaned because of other maternal or infant issues.

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[8] In 2002, the New Zealand Government made a new provision for women in paid employment who choose to take parental leave; women now receive funding for the first six weeks following the birth of their infants. This funding will increase to cover the first 13 weeks postpartum in December 2004. Research is needed to assess if this positively impacts on women's experience of breastfeeding; of particular interest are women who are in relatively low-paid positions.

Galtry (1998) points out that for women to successfully combine breastfeeding and paid employment, they need both employer and collegial support. As there is no legal requirement for paid breastfeeding breaks, women need support from their employers to take the time needed to either express milk or feed their infants, and also have access to milk storage facilities as needed. Colleagues also need to be respectful of women's need for privacy if expressing milk in the work place. Women in professional positions frequently have access to private office space, which is a luxury often not afforded to their counterparts in lower-paid positions (Callister et al., 1995; Galtry, 1998).[9]

Research that has examined the profile of women who successfully continue to breastfeed whilst engaged in paid employment describe women who work part-time in professional positions, are well educated, over 25 years of age, and earn a good income (Carlson Gielen et al., 1991; Hills-Bonczyk et al., 1993; Ryan & Martinez, 1989; Williams et al., 1996). Despite the picture this demographic profile paints, women engaged in paid employment breastfeed for shorter duration than their unpaid counterparts (Hills-Bonczyk et al., 1993; Ryan & Martinez, 1989). However, women are significantly more likely to continue to breastfeed their infants whilst employed if they are able to feed their infants during the working day. Unfortunately very few employed women have this luxury (Morse et al., 1989)

Women who manage to successfully combine breastfeeding and paid employment report a sense of satisfaction with their accomplishment (Auerbach, 1984; Hills-Bonczyk et al., 1993; Maclean, 1990). The research participants relay that the difficulties they had to overcome to continue to breastfeed were worth the effort, as they were able to continue to offer their infants a unique gift that they otherwise would never have received.

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[9] To facilitate women breastfeeding whilst engaging in paid employment, many suggestions have been put forth by researchers; however, a full exploration of these issues is beyond the scope of this discussion. Please refer to the sources indicated for additional information (Auerbach, 1984; Callister et al., 1995; Carlson Gielen et al., 1991; Chalmers et al., 1987; Chezem et al., 1997; Galtry, 1997; Galtry, 1998; Hills-Bonczyk et al., 1993; Hochhausen, 1991; Morse et al., 1989).

3.14 Summative Thoughts

This chapter has explored the literature that has been constructed around experiential accounts of breastfeeding. Historical, cultural and societal understandings mediate individual women's interpretations of their breastfeeding experience, and within this context, substantive patterns emerge when exploring this literature. One such pattern is that people within society construct cultural understandings of breasts and breastfeeding, and it is these constructs that mediate women's decisions about their infant feeding practices. Women's confidence in their ability to breastfeed can be determined by myriad factors such as internal dialogues and emotional responses to the situations in which they find themselves. Women's social networks also play a major role in supporting women to breastfeed.

However, the pattern that emerges as overwhelmingly dominant is 'breastfeeding as problematic' – a pattern containing a subversive dialogue that is quietly evident in the available research on breastfeeding, to the effect that health care professionals are considered to own the solutions to women's breastfeeding problems. This is demonstrated in the vast amount of literature authored by health care professionals who examine women's negative breastfeeding experiences, then go on to propose solutions to the problems women encounter.

Auerbach (1994, p. 70) offers her critique of the impact of research on women's perceptions of their breastfeeding experience when she states "if we characterise their experiences based on methodologically relevant definitions that are not necessarily reflective of women's experiences or their own views, we do a serious disservice to ourselves, our research science colleagues, the readers of our own research reports, and the women we profess to assist". Auerbach's comments highlight the effect that the framing of breastfeeding within research has on breastfeeding women and the society in which they reside.

Within the literature, women are often portrayed as ignorant, without knowledge of either their bodies or breastfeeding. This is evidenced by the phrases such as 'women struggled to put it into words' (for example see Schmied & Lupton, 2001). Such comments highlight how silenced women are in relation to bodily

knowledge. Researchers' discussions render women as incapable of competently articulating bodily functions and experiences; instead, they give words to women's experience, thereby taking ownership of what is not theirs.

It is important that researchers examine the experience of breastfeeding with a stance of openness. There is a need to return to the phenomenon afresh, examining what it is to be a breastfeeding woman without preconceived ideas about how it is defined and understood in the current research environment. Reflective lifeworld research provides a methodology for examining a phenomenon without the need for a pre-defined theoretical framework to guide the analysis and control the emergence of findings. It is through research that examines breastfeeding without the prejudices of previously-held understandings that what it is to be a women who is breastfeeding can emerge, as it exists for those who are experiencing it. To fully expound on the currency that reflective lifeworld research has for women's experience of breastfeeding, the following chapter examines the philosophical approach taken to understand the phenomenon under study – what it is to be a breastfeeding woman in New Zealand.

Chapter Four

Interpretive Lifeworld Research

4.1 Introduction

The term lifeworld stems from Husserl's philosophical exploration of phenomena, and describes the world as it is experienced everyday[10]. The philosophical contributions of Husserl (1967), Heidegger (1962), Gadamer (1989) and Merleau-Ponty (1981) provide a foundation for the inquirer seeking an enhanced understanding of the lifeworld. To better understand interpretive lifeworld research[11], on which this present work is based, it is useful to contextualise its philosophical underpinnings within the development of Western philosophy.

Traditionally, the phases of Western philosophy are set chronologically within their distinct periods of development: Ancient, Medieval and Modern Philosophy (Magee, 1987). A chronological approach allows the inquirer to understand and appreciate how the development of philosophical thought occurred through a process of calling forth new understandings, which in turn quickens further advances. The following examination of the history of philosophy, from its origins through to the relatively recent emergence of phenomenology and hermeneutics, is set out accordingly.

The principles that have guided this research into women's experiences of breastfeeding are explored in the context of this historical review. The work of the philosophers Heidegger, Gadamer, and Merleau-Ponty have emphasised the need to attend to phenomena with a stance of openness if our understandings of being are to be enhanced. It is also recognised that history has a significant influence on understanding, and the journey to understanding must necessarily involve an exploration of what has gone before. Finally, the

[10] Husserl's conception of the lifeworld is discussed in section 4.3.1.

[11] The philosophy of interpretive lifeworld research is discussed in detail in sections 4.4.1 through 4.4.3.

principle of the hermeneutic circle has played a crucial role in this research. This principle tells us that the whole and the parts of a phenomenon have value and must be attended to for understandings to emerge. These guiding principles are traced through the history of philosophical thought in the following sections of this chapter.

4.2 History of Philosophical Thought

Western philosophy traces its origins to the Ancient Greek philosophers of the sixth century BC, whose thoughts affected the manner in which life during that period was interpreted (Kenny, 1998). Traditionally, classical Greek cultural beliefs were expressed in myths (Parker & Gibbs, 1998), which communicated "important lessons about a person's place and value within society and articulated the values, beliefs and laws of conduct of the culture they represented" (Parker & Gibbs, 1998, p. 147). In contrast, the philosophers of the Greek era, such as Pythagorus (582-500 B.C.), Anaximander (611-549 B.C.), Xenophanes (570-474 B.C.), Parmenides[12] (540-470 B.C.), and Heraclitus (540-475 B.C.), concerned themselves with the origin of the universe, developing theories about water, air, fire and earth to explain the composition and genesis of the world (Cavendish, 1964; Needham, 1999). They questioned beliefs and values that were not based in reason, logic and the observation of naturally-occurring phenomena, and thus challenged the classical Greeks' methods and ways of knowing.

During the fifth century B.C., professional educators, known as Sophists (which comes from the Greek word *sophia* meaning wisdom), became popular (Cavendish, 1964). They attempted to teach young men how to make rational decisions to facilitate successful lives. To achieve this, the sophists focused on the development of persuasive linguistic skills and the critical examination of taken-for-granted beliefs about the gods, morals and the State, all the while espousing the primacy of man. Protagorus (480-411 B.C.), the most famous of the Sophists, concerned himself with humanity through his focus on the primacy of education and the meaning of human essence (Needham, 1999). As a result

[12] It is interesting to note that Parmenides is the first recorded philosopher who was concerned with 'Being' (Kenny, 1998), a concept that is explored in section 4.3.1.

of the Sophists' extreme views of humanity, a philosophical transformation was ushered in, paving the way for Socrates (470-399 B.C.) and Plato (427-347 B.C.) (Cavendish, 1964; Kenny, 1998)

Socrates was most well known for examining the issues of ethics and politics (Huby, 1964), and was especially concerned with issues surrounding justice, morality and human existence (Magee, 1987; Needham, 1999). He believed that uncovering knowledge would result in virtue and happiness, and spent much of his life in dialogue with young men so that the knowledge generated through their discussions would provide them with the keys to virtue, happiness and morality (Kenny, 1998; Magee, 1987). Unfortunately, Socrates' teachings were not recorded in writing, but rather were passed on orally, so little is actually known about his philosophy other than inconsistent reports from other philosophers of the time, such as Plato, and Xenophon (Kenny, 1998; Huby, 1964).

After Socrates' death, Plato, one of his most noted followers, founded the 'Academy', a school for those interested in learning about issues of morality, metaphysics and mathematics (Kenny, 1998). He believed the everyday world that we experience is a façade, but that knowledge is real because it is enduring and beyond error, and, therefore, must be grounded in something outside of the everyday world (Huby, 1964). For man to be able to have knowledge of, and express, such things as happiness or justice, albeit imperfectly, happiness and justice must exist somewhere outside of the everyday world, in a universally applicable, unchangeable, perfect form (Ironside, 1997; Huby, 1964; Magee, 1987). Plato's ideas about knowledge represent the first attempt at understanding epistemology[13] (Ironside, 1997; Magee, 1987).

Aristotle (384-322 BC) was the most distinguished of Plato's students (Magee, 1987; O'Connor, 1964). He was concerned with human experience (Magee, 1987) and disagreed with Plato's rationalistic dismissal and distrust of human senses as being 'unreal'. In his approach to the senses, he was "empirical, cautious, and anxious to consult all relevant facts and opinions before making up his mind" (O'Connor, 1964, p. 47).

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[13] Epistemology is the theory of the basis and methods of knowledge; the study of how knowledge is formed (Ironside, 1997; Palmer, 1969).

Aristotle believed that rationalism and logic provided a method to progress philosophical understandings (O'Connor, 1964). He developed a logical process based on an examination of the totality of what is known about a phenomenon (Magee, 1987), and the belief that if foundational premises about the phenomenon are valid and true, then the conclusions drawn logically from them must also be valid and true (Kenny, 1998; O'Connor, 1964). This theory of formal logic has been described as the science of deductive proof (O'Connor, 1964), and provides a means of explaining phenomena in greater structure and depth (Magee, 1987). Amongst Aristotle's writings were works that centred on epistemology and the nature of Being, which were known as the 'first philosophy', later becoming known as 'metaphysics' (Kenny, 1998; Rutty, 1998). Although fraught with problems, Aristotle's theories provided some legitimate basis for research that seeks to understand phenomena (Magee, 1987; O'Connor, 1964).

Development of what has become known as Medieval Philosophy spanned approximately one thousand years, from the fall of the Roman Empire during the fifth century to the Renaissance of the fifteenth century (Russell, 1996). During this period, commonly referred to as the Dark Ages, the church exercised dominion over philosophical development, and philosophers who did not adhere to the theocentric view were considered heretics, subject to imprisonment or execution. The philosophical work of this era focussed on the open pursuit of thought confirming the existence of the Christian God. There was a generalised dismissal of astronomy, music and mathematics; instead, Medieval philosophers espoused that God enveloped knowledge and eternal truth, and that this God could never be fully known.

Medieval philosophers strove to distinguish between knowledge that was divinely inspired and knowledge that was developed through human reasoning. The works of Plato and Aristotle were critically examined in an attempt to reconcile them with a monotheistic worldview. St. Augustine (354-430) and St. Aquinas (1225-1274) problematised the concepts of realism[14] and idealism[15], claiming that, in the quest for knowledge, faith versus reason was pivotal

[14] Realism is the belief that physical entities have structures that exist independent of the human mind.

[15] Idealism is the belief that physical entities only exist because the human mind perceives that they do.

(Kenny, 1998; Magee, 1987; Markus, 1964). However, this era is not associated with significant advancement in philosophical thought, as the main focus for its philosophers was the desire to reconcile Greek philosophy with Christianity (Magee, 1987).

The arrival of the Renaissance, towards the close of the Medieval era, ushered in an awakening of philosophical thought. The re-emergence of the Greek language encouraged philosophers to return to the writings of the early Greek philosophers, which led to a re-interpretation of the early Greeks' original works. More (1478-1535) offered his *Utopia*, which had similarities to Plato's *Republic*, as a critique of the current political and social environment, and Pico della Mirandola (1463-1494) argued for the supremacy of human nature. Because of such writings, humanistic philosophy came to the fore (Kenny, 1998).

In the early sixteenth century, Luther (1483-1546) challenged the blanket acceptance of Catholicism, and in the years following, strong debate about religion significantly affected the dominant philosophical discourses. Eventually, due to the complete lack of consensus amongst philosophers, scepticism gained favour (Kenny, 1998). Philosophers, such as Montaigne (1533-1592), who adhered to scepticism, argued that one could never be sure that he or she had acquired genuine knowledge due to the deceptiveness of the senses, the prevalent belief being that there would never be a method by which knowledge could be firmly and universally established (Ironside, 1997; Kenny 1998; Magee, 1987).

One of the important advances of the sixteenth century was that the science of physics began to be conceived as separate from the philosophy of nature. This followed from arguments claiming that observation and theory development took precedence over the conceptual analysis that was traditionally conducted by philosophers. This division of thought was subsequently pre-empted by Bacon (1561-1626), who categorised philosophy into differing branches, making distinctions between natural theology, natural philosophy (which included the natural sciences), and human philosophy. The major shift in the division of physics and philosophy during this era was appropriated by the philosopher Bruno (1548-1600) and the scientist Galileo (1564-1642), who believed that physics was advanced through the formalisation of hypotheses, observation and theory (Kenny, 1998). Although the demarcation was not clear until the eighteenth century, this era marked the beginning of the separation of

philosophy and physics, and ultimately philosophy and science (Kenny, 1998; Magee, 1987).

The predominance of scepticism during the sixteenth century promulgated the belief that there was no certain method by which knowledge could be determined. This position concerned Descartes (1596-1650), who became fixated on discovering a method through which absolute knowledge could be ascertained (Magee, 1987). To achieve this, he emulated the sceptics, and developed a method that commenced with a process of hyperbolic, or exaggerated, doubting of the entity under study (Burnham & Fieser, 2001; Magee, 1987; Sorrell, 1987). To undertake this process of hyperbolic doubting, Descartes believed that he must be capable of thinking; therefore, he is a thinking thing. This led him to coin the phrase 'I think, therefore I am' (Kenny, 1998; Magee, 1987; Sorrell, 1987). He argued that he could conceive himself without a body, but conception is not possible without a mind that is conscious of occurrences and thoughts; thus, the mind is the subject and the body is an object, an idea which has come to be known as Cartesian dualism. He proposed that people gain knowledge because they are subjects capable of scrutinising objects.

In keeping with the philosophical position that man's mind is a subject that is capable of knowing objects, Descartes claimed that the world was knowable as an object. This was an important advancement for the natural sciences, as it suggested that truth could be discovered through the science of observation (Burnham & Fieser, 2001; Leder, 1984; Sorrell, 1987). This desire for absolute truth led to the development of theories, concepts and thus knowledge (Magee, 1987). As a result of the contributions he made to philosophy through his work on epistemology, Descartes became known as the inaugurator of the era of Modern Philosophy (Kenny, 1998; Magee, 1987).

Descartes paved the way for rationalists such as Spinoza (1632-1677) and Leibniz (1646-1716), who believed that knowledge of reality stemmed from one's ability to use their mind (Magee, 1987). Rationalists adhered to the belief that the mind has an inherent capability to discern truth about existence and the earth (Cooper, 1999). These philosophers, using the concept of Cartesian dualism, believed that the world was understandable because their philosophy recognised that knowledge comes through observation and experience. For example, Spinoza believed that the reality of the world, which existed as an

amalgamated substance, could be fully explained through the employment of a systematic geometrical method (Kenny, 1998; Magee, 1987; Nidditch, 1964). Leibniz claimed that entities within the world are ordered and complex, and must be reducible to parts to facilitate analysis. Upon completion of analysis, what is left are simple indivisible phenomena; therefore, the 'whole' can be understood through knowledge of its various 'parts' (Kenny, 1998; Magee, 1987). And as such, rationalists held that science and the scientific method, as developed by philosophers, would provide knowledge and, thus, 'truth' about the world (Cooper, 1999).

In contrast to the rationalist position, the empiricists Hobbs (1588-1679), Locke (1632-1704), Berkeley (1685-1753) and Hume (1711-1776) adhered to the belief that all knowledge has a foundation in human experience (Cooper, 1999). Hobbs argued against Descartes' philosophy of Cartesian dualism, contending that experience was based on human senses, and thus knowledge is gained from an embodied experience (Cooper, 1999; Ironside, 1997; Kenny, 1998). Locke examined the underpinnings of human epistemology, and to achieve this he endeavoured to outline categories of human experience (Kenny, 1998; Magee, 1987; O'Connor, 1964). An important part of the epistemology of Locke is his belief that humans are born with a 'blank slate' upon which ideas are written, resulting in knowledge; however, to gain knowledge, individuals must be able think for themselves (Magee, 1987). Berkeley was also concerned with understanding epistemology through examining what it is to exist. He believed that existence was revealed through perceptions of existence. To exist, one must be able to acknowledge that he or she does exist, and this ability to perceive one's own existence forms the basis for knowledge acquisition (Kenny, 1998; Magee, 1987; Thomson, 1964).

Hume's philosophical thesis influenced the thinking of the German philosopher Kant (1724-1804) (Magee, 1987), who wrote *The Critique of Pure Reason* in 1781, in which he set out to offer a scientific basis for philosophy (Kant, 1999; Kenny, 1998; Magee, 1987). Kant wished to elevate metaphysics to the status of being *a priori* to knowledge. He outlined how not all knowledge arises from experience and, therefore, there must be an *a priori* knowledge, including such things as mathematics and physics that exist before experiential awareness. Kant called this *a priori* knowledge 'transcendental metaphysics' (Kenny, 1998).

The German philosopher Hegel (1770-1831) believed that ideas and concepts were historical and constantly evolving, thus facilitating the appropriation of new knowledge (Magee, 1987). In his book *The Phenomenology of Spirit*, the 'spirit' was driven to actualise its utmost potential, which it achieved through the accumulation of knowledge throughout the historical development of thought (Kenny, 1998). Hegel emphasised knowledge through the process of the dialectic: the resolution of the contradictions between the thesis and antithesis to ultimately achieve a greater level of synthesis (Ironside, 1997; Kenny, 1998; Magee, 1987).

It is at this point in philosophical development that the concept of phenomenology emerged as a distinct theme within the tradition of philosophy, primarily as a result of the philosophical thesis of Husserl (1859-1938). The following section focuses specifically on the philosophical development of phenomenology.

4.3 Philosophical Underpinnings of Phenomenology

The term 'phenomenology' is derived from the Greek words *phainomena*, meaning 'to show itself' or 'to appear', and *logos*, which means 'reason', 'ground' or 'saying' (Heidegger, 1962; Inwood, 1999). Heidegger (1889-1976) defined phenomenology as that which shows itself (1962). It "can be understood as an object, a 'thing' or a 'part' of the world, as it presents itself to, or, as it is experienced by, a subject" (Dahlberg, Drew, & Nystrom, 2001, p. 45).

Phenomenology emerged as a concept in the work of Brentano (1838-1916) (MacIntyre, 1964). An existentialist, he employed the term in opposition to the British empiricists and the predominant reductionist philosophies that claimed truth could be discovered if entities were reduced to the lowest common denominator (Dahlberg et al., 2001; Ironside, 1997; MacIntyre, 1964). He believed that natural science was the method of true philosophy (Spiegelberg, 1969), and focused on examining the structure of such things as believing, love and hatred to define his method of philosophical analysis, a method that mirrored those used in the natural sciences (Spiegelberg, 1969). It has been suggested that Brentano wished to facilitate the dominance of Cartesian

philosophy, because he claimed that one cannot doubt their inner experiences (MacIntyre, 1964).

Husserl went on to more fully develop Brentano's philosophy and thus became a predominant figure in the development of phenomenology. He proffered a strong critique of popular reductionist philosophies, arguing for experience-based knowledge (Dahlberg et al., 2001; Magee, 1987).

4.3.1 Husserl: The Father of Phenomenology

Husserl, known as the father of phenomenology (Gadamer, 1994), was a German philosopher who lectured at Freiberg University at the beginning of the twentieth century. He desired to turn philosophy into a rigorous science (Palmer, 1969), and his ultimate goal was to develop a philosophical approach to both the natural and human sciences. To fulfil his goal he focused on epistemology, in keeping with the philosophical tradition.

In his quest to uncover epistemological truth, Husserl espoused that 'conscious awareness' is the one foundational premise upon which knowledge can be established (Magee, 1987). Consciousness is directed out into the world from us to an object. The object projects itself back to the consciousness, and in doing so, the object presents itself as something – as meaning (Dahlberg et al., 2001; Husserl, 1967; Magee, 1987). He believed that for an object to exist, someone must perceive that it does. A person is conscious of an object that exists in nature; therefore, meaning is formed, resulting in knowledge. "Husserl points out that there can be absolutely no doubt whatsoever that the objects of our consciousness do exist as objects of consciousness for us" (Magee, 1987, p. 254).

Husserl believed that what is in the 'world' is learned through 'consciousnesses, and consciousness in turn becomes the source of a person's reality. He described this consciousness as a "uni-dimensional sequence of mental events" (Swearingen, 1977, p. 50). These two entities, the world and consciousness, are interrelated and inseparable (Moustakas, 1994; Spiegelberg, 1969), and to describe them he employed the terms 'embodiment' and 'lifeworld' (Polit & Hungler, 1995; Spiegelberg, 1969).

Husserl believed that the lifeworld was the central theme of phenomenology (Dahlberg et al., 2001; Husserl, 1967). Lifeworld describes "the world as it is experienced; it is a phenomenological concept because phenomenology is concerned with the human experience of phenomena, that is, the objects and events of everyday life" (Dahlberg & Drew, 1997, p. 303). Husserl desired to describe the lifeworld and thereby construct knowledge. Gadamer (1989) described Husserl's lifeworld as the "whole in which we live as historical creatures" (p. 247). The lifeworld is a communal world in which we live with others (Gadamer, 1989), and the task of phenomenology is to return to the everyday taken-for-grantedness of the lifeworld and examine experiences (Gadamer, 1989; Koch, 1994). Husserl attempted, through the development of phenomenology, to provide a way by which the structure of the lifeworld could be described and understood (Fjelland & Gjengedal, 1994).

A crucial part of phenomenology, according to Husserl, is the need for subjective openness that recognises the importance of 'returning to the self' to uncover the essential nature and meaning of phenomena (Moustakas, 1994). However, we dwell primarily in the 'natural attitude,' which describes "the everyday immersion in one's existence and experience in which we take for granted that the world is as we perceive it, and that others experience the world as we do. In the natural attitude we do not critically reflect on our immediate action and response to the world... we just are" (Dahlberg et al., 2001, p. 45-46). Whilst in the natural attitude we are unable to engage in critical analysis, and so we are unable to uncover the essence of phenomena.

A key concept in phenomenology is that of 'intentionality' (Husserl, 1970). Husserl utilised this term to more fully expound and describe the natural attitude (Dahlberg et al., 2001). Intentionality is our most basic, or primordial, mode of being, in which we unthinkingly navigate our way through everyday life (Husserl, 1967; Magee, 1987; Spiegelberg, 1969). We engage with our world uncritically using our pre-formed meanings of objects. Husserl (1967) espoused that these pre-formed meanings were 'intentional content' upon which the meanings of objects were inscribed, and thus consciousness was directed accordingly. Intentionally, our consciousness is directed towards an entity because it has meaning for us. For example, if a person wishes to write a note, they are conscious that a pen is needed to write the note, even if one does not exist within their perceptual field at that moment. When they see the pen, they are

conscious of it, pick it up, and commence writing the note; however, when writing, they are not critically engaged in thinking about the pen, but instead are focused on the meaning of the words being written.

It is the recognition of intentionality, and the conscious decision to overcome it that allows a philosopher or researcher to engage in 'epoche.' Epoche is the process of setting aside one's pre-conceived ideas about the world, allowing a person to approach a subject with open receptiveness (Moustakas, 1994). To achieve epoche, a person must engage in 'reduction', which is the process of identifying one's judgements, biases and prejudices regarding phenomena. Once reduction is completed one 'brackets' his or her beliefs and judgements. Bracketing is the process of putting aside previously-held understandings about a phenomenon so that preconceptions about a phenomenon are not subjectively reflected in his or her description of the experience (Parahoo, 1997). Through bracketing one's pre-conceptions, a person is able to engage in the process of 'intuiting' – looking at phenomena without any presuppositions or biases. It allows an individual to become absorbed in the phenomenon, to peel away the layers of experience and gain a fresh understanding of the 'essence' or true reality of them (Baker, Wuest, & Stern, 1992; Dahlberg et al., 2001; Husserl, 1967; Spiegelberg, 1969).

Husserl was concerned with why things present themselves in a form that veils their true essence (Husserl, 1967; Merleau-Ponty, 1981; Spiegelberg, 1969). He determined that all phenomena have meaning in both a historical and future context, and it is only when phenomena are understood in these contexts that they are truly known (Dahlberg et al., 2001; Merleau-Ponty, 1981). "Meaning is never finally complete but is always expandable, limited only by our readiness to enlarge our understanding" (Dahlberg et al., 2001, p. 59).

Husserl named Heidegger his successor at Freiberg University upon his retirement in 1929; however, the two had very different agendas for the development of philosophical thought. Husserl idealised that philosophy could be the basis for all science, and believed that Heidegger would further develop his phenomenological philosophy. However, while Husserl's philosophy of subjective consciousness epitomized the Cartesian tradition, Heidegger sought a more meaningful and adequate way to understand our relation to objects (Magee, 1987; Spiegelberg, 1969).

It has been contended that, due to Heidegger's departure from Husserl's original intent, he actually contributed to the corruption of pure phenomenology. Heidegger believed that Husserl "remained captive to the tradition he inadequately explored" (Inwood, 1999, p. 161) and he highlighted his concerns about traditional philosophical approaches to epistemology, in the form of Cartesian ideologies, to free himself from such beliefs (Heidegger, 1962; Inwood, 1999; Magee, 1987). Therefore, these two philosophers focused on the development of different spheres of thought – Husserl on epistemology and Heidegger on ontology[16].

Despite Heidegger's unwillingness to accept that human consciousness held the key to understanding all phenomena, he used the concepts expressed in Husserl's phenomenological method to underpin, open-up, and expound on the being of humanity (Ironside, 1997; Palmer, 1969). In doing so, he dramatically altered both phenomenology and the phenomenological method. To emphasise this, Heidegger employed the term 'hermeneutic' to describe his philosophical project, signifying his departure from a scientific approach to phenomenology, in contrast to Husserl's desire for philosophy to become a rigorous science (Palmer, 1969). Whereas Husserl focused on describing phenomena as they appeared to the consciousness (Dahlberg et al., 2001; Koch, 1994), Heidegger asserted that phenomenology was historical, "a creative recovery of the past, a form of interpretation" (Palmer, 1969, p. 126).

4.4 Hermeneutics

The Greek word *hermeneutik* means "a method of interpretation" or "the doctrine or study of interpretation" (Inwood, 1999, p 87). It has its origins in the words for philology (historical linguistics) and theology (the study of gods), and the Greek word *Hermēnuein*, meaning 'to interpret' (Inwood, 1999). The ultimate goal of hermeneutics is to achieve a deeper understanding of phenomena (Palmer, 1969).

Schleiermacher (1768-1834) desired to develop a science that understood language, introducing the term hermeneutics to describe a systematic

[16] Ontology is the science and study of being (Ironside, 1997; Palmer, 1969)

procedure for interpreting both theory and understanding (Dahlberg et al., 2001; Palmer, 1969). He also believed that it could be extended to the domain of the human sciences, in that hermeneutics could be employed to understand such things as art and history (Dahlberg et al., 2001; Inwood, 1999). He believed that hermeneutics involved the "reconstruction and re-experience" of the thought processes of an author, as the original intent of the author was needed to fully understand the text (Ironside, 1997, p. 85). To achieve this, Schleiermacher sought to access the principles or processes by which a formalised objective method for interpretation could be developed.

An important aspect of Schleiermacher's formalised interpretative method was the need to attend to the context in which the original author was writing. To understand a text one must understand the author's culture and life circumstances (Dahlberg et al., 2001; Gadamer, 1989); one must attend to the parts (words) and the whole (context) of that text (Annells, 1996; Dahlberg et al., 2001) – a concept that later became known as the hermeneutic circle (Annells, 1996).

Another philosopher who contributed to the development of hermeneutics was Dilthey (1833-1911), a contemporary of Schleiermacher, who continued to focus on the development of objective hermeneutics with the hope of discovering a method by which to uncover apodictic knowledge (Ironside, 1997; Palmer, 1969). However, Dilthey was opposed to the reductionist ideologies of his time, and sought to develop a method of uncovering meaning that would be more appropriate for human sciences (Dahlberg et al., 2001). In the process, he re-defined hermeneutics to include the interpretation of written and spoken text, so that the focus of understanding was not just on an author's intent, thereby introducing hermeneutics as a fundamental way by which human sciences could be understood (Dahlberg et al., 2001; Ironside, 1997).

Dilthey was stimulated by a quest for understanding life (Heidegger, 1962). He conceived that man had the power of understanding, and personally sought to understand "life from out of life itself" (Palmer, 1969, 124). "Starting from 'life' itself as a whole, he tried to understand its 'experiences' in their structural and developmental inter-connections" (Heidegger, 1962, p. 72). Dilthey espoused that all humanity has life, or lived, experiences, and through these common structures others' experience of life is understandable (Dahlberg et al., 2001; Ironside, 1997).

The philosophies of Schleiermacher and Dilthey provided the foundation for hermeneutics, and their ideas influenced and informed Heidegger's understanding of it (Dahlberg et al., 2001; Gadamer, 1994; Palmer, 1969). He subsequently interpreted phenomenology as hermeneutical, and as such he sought to use it to extricate "the meaning of a text as a whole, a text obscured by past interpretations of it" (Inwood, 1999, p. 161).

Heidegger applied Schleiermacher's and Dilthey's understandings of hermeneutics and life, and in doing so constructed a hermeneutic of ontology (Inwood, 1999; Palmer, 1969). His understandings of hermeneutics provide a foundation for understanding human existence, by linking the theories of lived experience, ontology and phenomenology (Palmer, 1969). He "points to a ground for hermeneutics not in subjectivity but in the facticity of world and in the historicality of understanding..." by embedding the essence of hermeneutics in "the ontological power of understanding and interpretation which renders possible the disclosure of being of things and ultimately the potentialities of Being's own being" (Palmer, 1969, p. 130 & 137).

4.4.1 Heidegger

In *Being and Time*, Heidegger disputed the focus of traditional philosophy that sought to understand epistemology, believing instead that philosophy should focus on understanding ontology (Ironside, 1997; Palmer, 1969). Ontology embraces such issues as the nature of existence and the structure of reality, providing the basis for epistemology. In other words, we must exist before we can gain knowledge. Therefore, Heidegger believed that the path to understanding humanity does not lie in examination of how we gain knowledge; rather, it lies in inquiry into the nature of being.

Heidegger (1962) examined the ontological and proposed that we understand the world through being. He focused his arguments around the understanding of a Being which is there, otherwise understood as: the being there of existence (Dahlberg et al., 2001), the being of humans or the person who has this being (Inwood, 1999). This has also been defined as a being capable of understanding (Guignon, 1983). Heidegger named this type of being, which exists and is capable of understanding, '*dasein*'. He positioned his beliefs in binary opposition to Cartesian dualism and argued instead that *dasein* is

embodied; we exist as whole human beings, not as a mind, body or spirit that is capable of separation. Typically, we are not cognisant of our bodies, as our bodies are transparent to us unless something shows itself as problematic, such as in the case of illness (Inwood, 1997).

Dasein is always situated and engaged in a world; it is impossible to understand *dasein* apart from the world; therefore, Heidegger proposed that *dasein* is a 'being-in-the-world' (Heidegger, 1962; Magee, 1987). The term being-in-the-world describes the enduring connection between humanity and the world (Dahlberg et al., 2001). The world is *a priori* to all understanding and meaning, as the world houses culturally-mediated ideas, languages, and common practices, as well as meaningful relationships (Heidegger, 1962; Palmer, 1969). Meanings are formed and entities are understood because *dasein* has, as its mode, that of being-in-the-world; it is, therefore, constituted by, and also constituting, the world in which it is situated (Leonard, 1994). The world is not necessarily visible to us as it is the taken-for-granted backdrop upon which existence is played out.

It has been contended that Heidegger used the expression being-in-the-world instead of the term lifeworld, which was employed by Husserl (Dahlberg et al., 2001); however, for Heidegger, the word world meant more than just 'the everyday world about us', as described by Husserl; it also embraced the concept of the familiar world as a workplace, a place that is known, and in which one experiences and builds experience. The familiar world exists within a world that is unfamiliar; however, when the unfamiliar world is accessed, that too becomes the familiar world. The world exists in "indefinitely expanding circles of decreasing familiarity" (Inwood, 1997, 247).

The world is *a priori* and, as such, *dasein* does not choose the world in which it is found; instead, *dasein* is 'thrown' into a world, and inhabits the world in a position of 'thrownness' (Heidegger, 1962). *Dasein's* thrownness mediates understanding of such things as language and culture. For example, one can understand that a fork is for eating only if one exists in a 'world' in which forks are used for eating. Therefore, *dasein's* interpretive freedom is mediated by the world into which it is thrown (Heidegger, 1962; Leonard, 1994).

Dasein is always interpreting the world into which it is thrown. Heidegger (1962) proposes three foundational concepts that form the basis of the ability to

interpret and, thus, understand: 'fore-having', 'fore-sight', and 'fore-conception'. When one turns his or her attention to an object with a previously-formed understanding of what the object is, the object is approached with the fore-having of understanding. Before attention can be focused on an object, a person must be able to see the object in advance, which is fore-sight. One must also be able to grasp and conceive an understanding of an object prior to approaching the object, which is the result of fore-conception. "Whenever something is interpreted as something, the interpretation will be founded essentially upon fore-having, fore-sight, and fore-conception. An interpretation is never a presuppositionless apprehending of something presented to us" (Heidegger, 1962, p. 193). Fore-having, fore-sight and fore-conception exhibit themselves in commonly-formed meanings that are developed as a result of our thrownness in a world where these meanings already exist. These commonly-formed meanings provide the basis for interpretations of objects that appear in the world. If one does not obtain fore-having, fore-sight, and fore-conception, one is incapable of understanding the object one approaches, and no interpretation can occur.

Dasein can focus attention on objects because *dasein's* primordial and essential mode of being within the world is that of focus or 'care'. This primordial mode of care provides *dasein* with an ontological basis for understanding, and thereby provides the ability to navigate the world into which it is thrown (Heidegger, 1962). Through care we are comported to that which we are concerned with, and thereby we come to understand being through the everyday things that capture our focus or care (Heidegger, 1962; Inwood, 1999). In accordance with our thrownness, our care is directed towards entities that call for our attention, and thus through care meanings are formed (Heidegger, 1962; Leonard, 1994). There is no uniformity to what calls out for our attention – it is particular to each individual being.

Dasein exists in the world 'with-other' – with-other people as well as with-other objects – and through the structure of care, as outlined by Heidegger, *dasein* is able to be mindful of and connect with-other (Heidegger, 1962). When encountering objects, *dasein's* attention is directed by 'concern' about the object; concern manoeuvres and uses objects to achieve desired outcomes (Heidegger, 1962). However, the care with which *dasein* attends to other people differs from the type of care, or concern, that facilitates the manipulation

of objects: *Dasein* attends to other people with 'solicitude' (Heidegger, 1962). In its most authentic state, solicitude can facilitate another reaching their ownmost potential for being.

Just as Heidegger employed the phrase being-with-other to describe how we are with others in the world, the others are also with-other (Dahlberg et al., 2001; Heidegger, 1962). As a result of being-with-others and the 'others-being-with-others', commonly-formed meanings and understandings emerge through the interactions of the others or 'the they'. The understandings formed by 'the they' produce a set of expected ways of behaving, and thus provide a framework for interpreting which practices are acceptable and which are not. Thus, 'the they' can hold sway over one's decisions and ways of being within the world in which one exists (Heidegger, 1962).

Although traditional scientific thought has conceived time as linear, with properties or experiences perceived as encapsulated events (Leonard, 1994), Heidegger (1962) proposed a new way of conceptualising time. He claimed that the linear view of time fails to embrace the manner in which a being will interpret the future in light of previous experience. Our expectations and experiences, which are formulated by our past, will essentially shape our interpretations of the future. Therefore, the past is always ahead of us (Heidegger, 1962).

Heidegger desired to highlight how humanity had become estranged from its essential being, claiming that being's ownmost potentiality had been lost through misunderstandings and concealment of being (Cooper, 1999; Wood & Giddings, 2001). Heidegger (1962) employed the terms authentic and inauthentic to describe how *dasein* becomes estranged from its essential being. *Dasein* is authentic if it is owned by truth, and 'being' is the priority. To be authentic means making one's own decisions separate from 'the they'. Conversely, if *dasein* submerges its interpretive capabilities amongst 'the they' it is being inauthentic (Heidegger, 1962; Inwood, 1999). The call to authenticity always exists for *dasein*, and while it may respond to the call in part, *dasein* struggles to find its essential being (Inwood, 1999).

Heidegger (1962) wrote extensively on how being is understood only superficially through such things as the scientific understandings of the world (Cooper, 1999). He highlighted how being's essential modes appear through letting the meaning of entities, such as events, time, equipment and being-with-

others, emerge. Heidegger's exposition of being is a call to thinking (Cooper, 1999), a call to meditate upon being, a call to uncover being's ownmost potential.

4.4.2 Gadamer

A contemporary of Heidegger, Gadamer (1900-2002) wrote *Truth and Method*, in which he laid out a highly critical account of positivism. He claimed that any scientific method designed to understand being would be pointless, because understanding existence would never occur through the use of a particular positivist method. Instead, he suggested that understanding must occur through being 'open' to the world. If we wish to see and understand the 'otherness' of something, we must have an open mind when approaching phenomena.

Gadamer believed that it was possible to uncover the otherness of phenomena, and to achieve this he turned to hermeneutics. In attending to the philosophical basis of hermeneutics, Gadamer problematised Schleiermacher's belief that historical reconstruction facilitated understanding of an author's intent and indeed of the author himself. Instead, Gadamer argued that such reconstructions were impossible because any attempt to do so fails to grasp the historical context in which the writing occurred, thus doing a disservice to the author's original meaning: "a hermeneutics that regarded understanding as reconstructing the original would be no more than handling on a dead meaning" (Gadamer, 1989, p. 167). All literature, artwork, and events that have gone before are tradition and are only ever interpreted via presently-held conceptions.

Both history and tradition provide the foundation for the present; therefore, any understandings or meanings emerge accordingly (Gadamer, 1989). It is upon this premise that Gadamer builds his exposition of hermeneutics. He believed that awareness of this historical consciousness is central to the human sciences because "understanding is, essentially, a historically effected event" (p. 300).

Historical consciousness is primarily unrecognised and not under conscious control; however, it is the mechanism that directs one's attention to points of significance. At the same time, the significance of any particular experience will highlight what is important to the individual involved. This rising up of

significance results in certain aspects of the phenomenon being veiled, thereby blocking the whole truth about the phenomenon. Gadamer (1989) states that "we should learn to understand ourselves better and recognise that in all understanding, whether we are expressly aware of it or not, the efficacy of history is at work" (p. 301). To be aware of one's own historical consciousness, one must adopt a reflective attitude toward one's own selfhood, current situation and any inherited traditions. One "understands itself in terms of its own history"; therefore, "historical consciousness is a mode of self-knowledge" (Gadamer, 1989, p. 235). It is acknowledged that complete knowledge of one's historicity is unattainable because one's vision is limited by the situation in which one exists.

In part, our vision is limited because our historical consciousness facilitates the creation of 'prejudices' (Gadamer, 1989). Such prejudices govern and limit ones ability to understand, as they close down upon one's ability to attend to another's meaning. Through acknowledging a prejudice, its existence is called into question, and thus, fresh understandings previously hidden by the exposed prejudice can emerge (Gadamer, 1989). A prejudice will function unnoticed unless it is provoked through being called into question. Through a process of seeking to understand the historical consciousness, and the prejudices created as a result, a researcher comes to appreciate how his or her own horizon may close down upon the ability to be open to new understandings. Prejudices "represent that beyond which it is impossible to see" (Gadamer, 1989, p. 307).

Gadamer (1987) explored how one's own horizon influenced understandings of the world. This concept, first employed by Husserl (1967), acknowledges that one's horizon incorporates a personal history that, combined with the horizon of tradition, provides the canvas for understanding. "The horizon of the past, out of which all human life lives and which exists in the form of tradition, is always in motion" (Gadamer, 1989, p. 304). One's thrownness – both the past and present context in which one occurs – constitutes a particular horizon, and thus, an interpretation of the world that in turn gives rise to an individual's understanding. A horizon might be narrow or wide, and the significance of an issue varies according to its position within a horizon.

This philosophy might be interpreted as reinforcing solipsistic[17] ideals; however Gadamer (1998) believed that language, which never occurs in a vacuum, stems from tradition. It is language that is the fundamental mode of being-in-the-world. Because of this, individuals interpret their horizons through language. Understanding occurs when individuals experience a 'fusion of horizons'; this transpires when one fuses his or her horizon with another's horizon through the use of language (Annells, 1996; Gadamer, 1989). When a fusion of horizons occurs between two individuals, understanding develops, a common language is created, and a new community is formed; the emergent, and jointly held, horizon becomes the antecedent for a transformation where individuals are irreversibly altered because of the new understanding that has occurred (Gadamer, 1989). The portal of language provides a way to understand another; through the dialogical process we gain the ability to meld and constitute our individual horizons; therefore, we constitute, and are co-constituted by, each other's worlds.

Gadamer believed that those engaged in hermeneutic research must acquire a horizon that enables them to question the lifeworld, since without it, significant questions can never be called forth. The failure to ask significant questions results in an inability to truly understand. Gadamer (1989), therefore, claims that true understanding emerges through a dialectical process of questioning and considering others' horizonal position. This questioning does not take the path of arguing, but of thinking: "for in this process what is said is continually transformed into the uttermost possibilities of its rightness and truth, and overcomes all opposition that tries to limit its validity" (Gadamer, 1987, p. 367).

Ultimately, Gadamer (1989) criticised strict adherence to any one method as a means of understanding existence. This position has implications for phenomenological researchers in relation to the development of the research method. If a researcher adheres to a previously-developed and prescribed method, openness to the phenomenon under study is potentially compromised and access to true understanding is closed down upon. "What the tool of method does not achieve must – and really can – be achieved by a discipline of questioning and inquiring, a discipline that guarantees truth" (Gadamer, 1989, p. 491).

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[17] Solipsism is a branch of philosophy that espouses that no comprehension exists other

4.4.3 Merleau-Ponty

Merleau-Ponty (1907-1961) was a prominent French philosopher who explored theories of human perception. He argued that the existent theories on this topic failed to fully explain bodily perception, because they were confined by the inherited Cartesian tradition that conceived the body as an object. Bodily perception, due to its complexity, could never be explained through a Cartesian philosophy that promulgated a rational scientific method; therefore, he argued that one must call forth a language that precedes science and Cartesian dualism.

The position for Merleau-Ponty's examination of bodily perception is the lifeworld; he believed the lifeworld preceded all knowledge because it is pre-reflective (Dahlberg et al., 2001). The lifeworld is the starting point for all experience and understanding. It is through this pre-reflective lived world that any bodily perceptions are experienced; as a result, our bodies belong to our lifeworld, and because of this belonging, our bodies become the portals by which experience comes to us. Merleau-Ponty (1981) stated that "I am the absolute source, my existence does not stem from my antecedents, from my physical and social environment; instead it moves out towards them and sustains them, for I alone bring into being for myself..." (p. ix). The body and the world are bound together, and through this union subjectivity is conceived; as subjectivity is born through existence, human existence exists as a body, and this body is one with the world (Merleau-Ponty, 1981).

Merleau-Ponty (1981) set forth to redefine the manner in which our existence is interpreted. Traditional interpretations of the body, as a subject that is known by an object (the brain), inadequately articulated the complexity of how a body perceives and operates within the world. He described how we exist as embodied; we exist as a body capable of both physical movements and non-physical reasoning, not just a mind that thinks and exists separately from a body, which moves, as commanded, around a physical environment. "The union of soul and body is not an amalgamation between two mutually external terms, subject and object, brought about by arbitrary decree. It is enacted at every instant in the movement of existence" (Merleau-Ponty, 1981, p. 89). The

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than one's existential knowledge.

human body is always a lived body and it is this lived body that provides humanity with meaning.

In arguing for embodied understanding, Merleau-Ponty (1961) demonstrated how one's body is experienced differently from other objects. One's body is always present. One cannot observe their body as they do a chair that can be examined at a distance or from differing positions. One is incapable of seeing his or her face or back without using a mirror. It is impossible to be without one's body because it is always already present. One cannot turn away from their body. The "body is constantly perceived" (Merleau-Ponty, 1961, p. 90). One's body is the portal by which one gains access to sensual experience through the world; our knowledge of the world and all experience comes to us through our bodies. It is, therefore, understood that one is the body because they are jointly physical and mental; it is impossible to sustain either without the other (Merleau-Ponty, 1981; Priest, 2000).

Merleau-Ponty (1981) described how understanding emerges as one's body facilitates experiences, and thus the body provides the ability to function within the world. Understanding, and ultimately meaning, come through being a body "which rises towards the world" (p. 75). Our bodies are, therefore, the primary receptacle for information from the external world, and it is from this position of being-in-the-world that we gain experience (Merleau-Ponty, 1981). We are a body that exists intrinsically bound to the world; through our bodily being-in-the-world, the experienced world is sustained and constituted because through this interplay systems of meaning are formed. These systems are supported by, and sustain, the world and allow for the development of complex social structures that have resulted in conceptualising notions such as that of the objective body.

As with Husserl (1967) and Gadamer (1989), Merleau-Ponty (1981) employed the word horizon to explain how one's experiential history constitutes the present. Experience causes the living present to open upon a past horizon, as well as potential future horizons that have not yet been lived. These experiential horizons also grant one access to social horizons that have been constituted by societal history. Combined, these differing horizons form a collective horizon that is carried forth by one's existence and forms the basis for interpretations.

Merleau-Ponty (1981) facilitated a full and complete re-conception of how to understand the human body through his philosophy of perception. The starting place for his philosophy is the pre-reflective lifeworld, or phenomenal field. He explains how we are embodied and that experience of the world comes to us through our embodiment. This experience of the world facilitates the formation of interpretations and meaning, and ultimately creates horizons. It is through this process that complex social structures develop and are sustained through the embodied body that always rises towards the world.

4.5 Application of the Methodology to the Current Study

4.5.1 Situating this Study

This inquiry is situated in the philosophical tradition of those that sought to understand the lifeworld. Throughout its course, I have been immersed in the works of lifeworld philosophers such as Husserl (1967), Heidegger (1962), Gadamer (1989) and Merleau-Ponty (1981), along with the interpretations of lifeworld philosophies belonging to a number of modern philosophers and nursing researchers. This research represents my interpretations of Husserl, Heidegger, Gadamer, and Merleau-Ponty's work, and in some respects will differ from their original intent; however, they have been dialogical partners in this journey, assisting in my attempt to understand what it is to be a woman who breastfeeds in New Zealand. These philosophers have co-constituted my understandings and interpretations of being, as have the women who participated in this study.

The writings offered by the above-mentioned philosophers give the lifeworld researcher direction on how one might examine the experiences of humans who reside within a world of customary understandings. It is a world that a researcher is also embedded in experientially, which highlights the need for a researcher to be aware of the meanings and understandings that are brought to any phenomenon under study.

The philosophical work of those that strove to understand the lifeworld has provided principles by which phenomena can be explored, analysed, and

understood. These principles guide and assist an interpretive lifeworld researcher when seeking to understand and call forth the essential meaning of a phenomenon. The fundamental principle that has guided this research into the experience of being a breastfeeding woman is the need to approach the phenomenon with openness. Openness comes from understanding how history has influenced previously-held interpretations of this phenomenon. Holding to the principle that it is the combination of many parts that constitutes the whole of a phenomenon is also important when attempting to engage a full understanding. Finally, there is the need to ensure that all interpretations are firmly established in, and accurately reflect, the participants' narratives so no departures from their original intent occur.

The following discussion explores the foundational principles that have governed this research project, and the way I have approached the phenomenon of breastfeeding within New Zealand. It is the principles of openness, historicity, and the hermeneutic circle that have given rise to the process for this research[18].

4.5.2 Openness to the Phenomenon

Traditional methods of inquiry have limited the questions we can ask as we attempt to uncover and enhance our understanding of what it is to be a human (Leonard, 1994). Such inquiry does not lend itself to quantitative methods, as "*dasein's* shared way of behaving... contains an understanding of being that must be studied as an interpretation" (Dreyfus, 1991, p. 19). However, interpretive phenomenology has created a way forward through the concept of openness. Openness has been described as "a perspective free of unexamined assumptions" (Dahlberg & Drew, 1997, p. 304), and thereby a means of attending to the phenomenon as it presents itself (Dahlberg et al., 2001; Gadamer 1989). Although the researcher is not able to achieve this completely, openness is constantly strived for – calling into question one's historically-effected consciousness, and prejudices, and vigilantly assessing how these pre-understandings affect one's interpretations of the narratives (Gadamer, 1989). "The important thing is to be aware of one's own bias, so that the text can

[18] The specific process undertaken for this research is elaborated on in Chapter Five.

present itself in all its otherness and thus assert its own truth against one's own fore-meanings" (Gadamer, 1989, p. 269).

Openness involves waiting for the "phenomenon to reveal its own complexity rather than imposing an external structure on it, such as the dogmatic use of theories or models" (Dahlberg et al., 2001, p. 111). The researcher must seek to become the servant of the text, through being open and listening to the text; it is in that place that the researcher will hear what the text is saying (Palmer, 1969). There is a need to engage in a process of waiting, and of willingly submitting oneself to openness, for it is in this place that understandings come (Gadamer, 1989; Smythe, 1998). It is through approaching the phenomenon with such a stance that the 'otherness' of the phenomenon can emerge (Gadamer, 1989; Smythe, 1998). Therefore, the guiding principle of this study has been openness to the participants' narratives, so that the phenomenon of what it is to be a woman breastfeeding in New Zealand could emerge, providing a deeper understanding of what it is to be in that place.

4.5.3 The Influence of History on Understanding

One cannot separate oneself from the world in which he or she exists; therefore, all of one's interpretations will emerge from the pre-understandings that they hold of their world. It is important when examining any phenomenon that one attends to the historical narratives that surround it. One cannot examine the future, nor seek to uncover pre-understandings, without first dissecting what has gone before, as traditions, values, and historical discourses all affect how we interpret the present (Gadamer, 1989; Heidegger, 1962). By attending to the historical influences, pre-understandings can emerge and be acknowledged (Smythe, 1998). All interpretations will emerge through one's historical context because it is this that forms the basis of currently-held meanings and understandings.

This research project examines how breastfeeding has been traditionally understood in New Zealand through a review of historical descriptions (see Chapter Two). As a New Zealander, I have been immersed in the country's culture and history, and my understandings of breastfeeding will be affected accordingly. It is acknowledged that one can never completely 'free' oneself from the influence of history on one's understandings. One can make clear their

'horizon' through careful articulation of their world view, but one can never divorce oneself from one's pre-understandings, culture and traditions (Gadamer, 1989). Throughout this study, I have been constantly mindful of the need to examine that which may be veiled by my prejudices and pre-understandings, calling into question all interpretations accordingly.

4.5.4 The Hermeneutic Circle

Schleiermacher, when developing his formalised interpretative method, discussed the importance of attending to both the whole as well as the parts of a text. When reading a part of an interpretation, one must always be mindful of the context in which the interpretation occurs (Dahlberg et al., 2001; Gadamer, 1989). There is a constant flux between the whole and the parts that must occur for understanding to emerge, which describes the hermeneutic circle.

One's understanding of a phenomenon is never complete. Understandings change with time as they are always contextualised in ever-evolving cultures and traditions (Gadamer, 1989). "Each understanding is taken back to all previous understandings, and moves forward to all new understandings. No one understanding stays static or fixed" (Smythe, 1998, p. 94). Therefore, this interpretation is a call to the reader to engage in the hermeneutic circle. It is a call for the reader to commence their own dialogue with this interpretation as well as the women's narratives as they appear; it is a call to re-interpret the words held here, in accordance with the time and place in which you, the reader, are situated.

4.6 Conclusion

Chapter four has explored the philosophical underpinnings of this study, which is situated within the tradition of lifeworld research. It began by reviewing the development of Western philosophical thought, then explored the philosophical traditions of phenomenology and hermeneutics. The writings of Husserl, Heidegger, Gadamer, and Merleau-Ponty were examined in greater depth, as it is their work that provides the foundation for the philosophical framework of this research; their work has provided understandings of the lifeworld, and how one

attends to phenomena with the openness needed to achieve understanding. They have acted as philosophical dialogical partners in this journey of uncovering the experience of what it means to be a breastfeeding woman in New Zealand.

In this study, the phenomenon of breastfeeding is examined through a stance of openness, which allows the otherness of the phenomenon to emerge. Examination of the historical context in which a phenomenon occurs is critical to achieving an understanding of it (Gadamer, 1989); therefore, the historical context of breastfeeding in New Zealand was explored in Chapter Two. Finally, the hermeneutic circle provides the context in which understandings and meaning emerge. This philosophical position provides the foundation for this research, and has informed the method by which this study has been undertaken. This method, or 'frame', is discussed in detail in Chapter Five.

Chapter Five

The Research Journey

5.1 Introduction

This chapter details the process undertaken for this research, beginning with an exploration of the principles that have guided the development of the research method. The ethical considerations of this research and the process of recruiting participants are also discussed, as is the process by which the interviews have been analysed. Finally, this chapter concludes with a discussion of the trustworthiness of this interpretive account exploring the phenomenon of breastfeeding.

In attending to the issues of method, I am aware of the tension that exists for the interpretive lifeworld researcher. Adherence to method is considered to be antithetical, as method can close down upon potential interpretations (Gadamer, 1989). Commitment to a method that requires strict adherence to a prescribed, rigid process prohibits the spontaneity required to fully examine and, thus, understand a phenomenon. A rigid process may prevent a researcher from utilising a particular lens or perspective that does not adhere to the theoretical underpinnings of said method. Therefore, nurse researchers who have undertaken lifeworld research have suggested employing a narrative approach to addressing the issue of the process used for the research (Ironside, 1997; Smythe, 1998). This narrative account begins by exploring the philosophical underpinnings that have guided the development of the interpretive process.

5.2 Guiding Principles for the Development of the Research Process

In *Truth and Method*, Gadamer (1989) offers a strong critique of method-based research, claiming that rigid adherence to a particular method closes down upon the emergence of a full understanding of phenomena. Instead, he suggests that

the development of a research method be based on the following principles : the need to attend to the phenomenon with openness, the importance of being aware of how one's historical effected consciousness impacts upon the interpretations that are made when examining a phenomenon, and the need to search for the otherness of the phenomenon under study, meaning that attention must be paid to the understandings that emerge as distinct from any that were previously held (Dahlberg et al., 2002; Gadamer, 1989; Heidegger, 1962; Merleau-Ponty, 1981). These principles do not operate independently, but rather act in a circular, inter-related manner, each informing an understanding of the others. It is these principles that inform the process undertaken for this research project.

A concept that has also guided this research is the need to restrain the use of theory in the initial phase of analysis (Dahlberg et al., 2001; Gadamer, 1989). Adherence to this concept assists in limiting the effect that previous theories might have on subsequent interpretations.

In responding to these four principles I have been vigilant in my attempts to be open to the phenomenon of breastfeeding as it has emerged through the participants' narratives. To achieve this, I have adopted a stance of questioning – critically assessing my pre-understandings and making these explicit (see Chapter One, Section 1.5), and acknowledging the role that history has played in my understandings of breastfeeding as a New Zealander (see Chapter Two). I have immersed myself in the narratives to allow the meaning within the text to emerge through the voice of my own pre-understandings, constantly returning to the text in an attempt to be owned by the text, and in doing so allowing the text to speak. I have also engaged in a continuous process of questioning any interpretations that have emerged. Openness cannot be forced; it involves a process of being quiet and allowing interpretations to come, no matter how long it might take.

Attending to one's historical effected consciousness is a difficult task. It involves mindful examination of one's beliefs, values, culture and history. Gadamer (1989) discusses how awareness of historical effected consciousness is the first step in understanding its impact on one's horizon of understanding. Throughout this research journey I have kept a journal in which I have written my reflections, my analysis of which allows me to make my pre-understandings and personal horizon increasingly transparent. The important prejudices that

emerged, and that I had to lay aside to be open to the phenomenon of breastfeeding, are outlined in Chapter One. It must be acknowledged that it is impossible to remove oneself from the world of history, language, and culture in which they exist; however, awareness of these entities is the first step in uncovering that which might prevent me from fully understanding the phenomenon of breastfeeding.

Attending to the otherness of the phenomenon of breastfeeding required me to constantly examine what pre-understandings were interrupting the emergence of new understandings. I had to be constantly mindful of what was known about breastfeeding, and search for those aspects that had previously remained unexplored. This seems somewhat paradoxical in light of the need to limit the use of theory when seeking to understand a phenomenon. However, this principle encourages the researcher to attend to what is not known about a phenomenon, or equally, turn to what is known and examine it afresh, which may lead to new understandings.

The principle that required me to restrain the use of theory during the active researching phase was an extremely difficult one to adhere to. The initial phase of a research project requires a justification of the project itself through identification of gaps in the published literature, which may have influenced the way I understood the phenomenon of women's experience of breastfeeding. However, once the research proposal was completed, I made a conscious decision to step away from the literature and focus instead on the narratives as offered by the participants. The literature was examined in depth only after the interpretations had been completed.

As highlighted in the previous paragraphs, these four tenets have guided the development of the method and also the examination of the phenomenon of breastfeeding. Being vigilant to the development of a process that would incorporate these four principles as an integral part of the research design was of utmost importance to me as a lifeworld researcher. The following section examines the development of this research process.

5.3 Attending to Ethical Considerations

Attention to ethical management of this study was an integral aspect of the research process. Ethics approval was acquired through Massey University Human Ethics Committee, and the Royal New Zealand Plunket Society Ethics Committee.

All the women who participated in this study were self-selected, and were made aware of the study through advertisements placed in Auckland Plunket Area Clinics. Plunket clinics were chosen for this purpose because The Royal New Zealand Plunket Society provides approximately 93 percent of well child health services within New Zealand. Plunket Nurses were notified of the study through informal presentations given in various Auckland Region Plunket offices; however, the Plunket Nurses themselves were not required to promote the research. Women who were interested in participating in the study contacted the researcher directly.

Each participant received both an information sheet (Appendix I) and a consent form (Appendix II). The information sheet discussed the aim of the research and provided information about the study. It also explained that I was a child health nurse, but did not state the name of my employer. The consent form addressed voluntary participation, the right to confidentiality, any potential harm that might result from being involved in the research, and information about how the results would be made available to the participants. Completed consent forms were collected from each participant at the start of their interview, and stored separately from the transcribed narratives. Each participant nominated the time and venue for a single individual interview, with all participants in the study electing to be interviewed in their home.

The narratives were recorded, and tapes, transcripts and other computer-generated data were stored in either secured files or under lock and key. Access to these files was limited to the researcher and the research supervisors. A typist transcribed tape-recorded narratives and signed a confidentiality agreement (Appendix III). Once the narratives were transcribed, all identifying data was removed, interview numbers were assigned, and each paragraph was numbered. The chapters that explore the interpretations contain

portions of narratives, which are identifiable only through a pseudonym, interview number, and paragraph number (e.g., Amy. Int. 1. Para. 45).

The transcripts were returned to each participant for validation of the narrative. Each participant was free to withdraw from the study at any time until she returned the transcript, or verbally acknowledged its validity, and verbally agreed that her transcript could be included in the analysis. All participants gave either their verbal or written consent after reading their transcript. The ongoing mandate that the participants' confidentiality was to be maintained continues to be an important part of the research process.

It was important that the participants knew that I was a registered nurse, but that my role as a researcher would preclude me from offering a professional service; the request to offer health care advice did not arise during the process of gathering the participants' narratives. Two participants became distressed during their interviews. In both cases, they were asked at that point if they wanted to discontinue the interview, and both elected to continue. At the close of the interview I offered them the name of a family counsellor to provide them with support as needed. Neither participant wished to discuss their experience with another person. Instead, they responded that telling their stories was cathartic for them, and had provided them with the opportunity to speak about their experience. One other participant, as a result of the interview, decided to contact a medical practitioner to discuss postnatal depression, as she recognised the need to seek help to resolve her breastfeeding experience.

5.4 The Research Participants

The nineteen women who participated in this study were all born in New Zealand, with ages ranging from mid-twenties to late thirties, and had experienced the phenomenon of breastfeeding an infant. They were predominantly of European descent, with one participant identifying herself as Maori, and another as Samoan. All of the participants' specific cultural values and experiences were explored with the participants.

Ten of the participants had given birth once and subsequently breastfed their child. Seven had given birth to, and breastfed, two children each. One woman

had three children whose ages ranged from five months to three years, while another woman had four children aged two to seven years. Both of these women had breastfed all their children.

Nine of the participants were not breastfeeding at the time of the interview, but had breastfed within the last three to 32 months. Of those women who had weaned their children at the time of the interviews, the length of time spent breastfeeding had been between three weeks and 22 months. With one exception, all of the participants had partners.

Many of the participants were on maternity leave; however, there was a range of occupations that the women had either held before giving birth, or were actively engaged in at the time of the interviews. These included dental surgeon, child-care worker, fast-food worker, registered nurse, office manager, bar manager, early-childhood teacher, home manager, town planner, actress, business manager, radiographer, laboratory technician, and insurance manager.

The participants' educational backgrounds were not formally elicited during the interviews, although some women did discuss their education. For example, one was in the final year of an undergraduate degree programme, four had completed undergraduate degrees, and three reported having Master degrees.

5.5 Gathering Participants' Narratives

As noted above, the interviews all took place in the women's homes and were recorded on audiotape. The average interview lasted approximately 90 minutes, with the longest taking three hours. Each tape was listened to within two hours of completion of the interview, which assisted me to crystallise each individual interview encounter in my mind. This also allowed me to pay attention to the embodied nature of the interview, including such things as emotional reactions and non-verbal responses that had transpired during the interview.

The interviews took the form of a conversation between the women and myself. I did not go into the interview with a list of structured questions, but typically

started the interview by asking the women to speak about their first memory of breastfeeding; in most cases their stories of breastfeeding flowed easily from that point. I would ask questions if an aspect of what was being said needed clarification; however, the interviews focused on that which emerged as significant about the breastfeeding experience for each individual woman.

During the interviews I had an overwhelming sense that the women were gifting me a great treasure. These women, who did not know me personally, opened up their lives and horizons; they blessed me by sharing the intimate experiences that they had had with their children. Throughout the process of 'doing' the research I have been constantly mindful of the value of the women's narratives; this knowledge has made me strive to represent the experience of breastfeeding with clarity and trustworthiness.

5.5.1 Continuing the Conversation

As the interviews progressed, insights into the phenomenon of breastfeeding that I gained through conversations with the participants were brought to subsequent interviews; as a result, each interview became a continuing conversation between the women that participated in the study. The conversation that was carried into the subsequent interviews provided the opportunity to explore issues in greater depth, leading to enhanced understandings of various parts of the whole breastfeeding experience. For example, one participant talked about breastfeeding being an experience of tiredness. During subsequent interviews with other participants, I would ask if they too had found breastfeeding to be tiring. Their responses would frequently build on and develop the picture of what tiredness was within the context of the experience of breastfeeding.

5.5.2 Transcribing the Participants' Narratives

Following a review of each completed interview, the audiotapes were given to the transcriber. The validity of the written transcription was then checked by comparing it to the interview tapes. At that time I corrected any discrepancies between the interview tapes and the transcripts. After corrections had been made, the transcripts were returned to the participants for verification of

accuracy. At that time, the women could make any changes or corrections of their own, after which they returned the transcripts. Three women returned their transcripts, each with only grammatical changes. After two weeks I contacted the women who had not returned their transcripts and requested verbal consent for the transcripts to be included in the study. All the women who had been interviewed agreed to let their interview be a part of this research.

5.5.3 Deciding to Stop Gathering Narratives

The decision to stop gathering narratives was difficult. It is impossible to provide an interpretation that would represent the whole population of breastfeeding women, nor is this the goal of any qualitative research study. The lifeworld research methodology embraces the belief that people exist in their individual history, culture and world; therefore, the researcher only seeks to increase understanding about the phenomenon under investigation.

At the time the interviews were completed, the amount, and depth, of the information contained in the narratives was overwhelming, with each story shared resulting in pages of script. There was also the growing awareness within me of a desire to do 'justice' to the stories gifted to me by these women. It was important to not neglect the 'part' offered by the individual whose narrative might potentially become subsumed by the 'whole'.

Although no interpretation that is brought forth will ever be complete, this study offers a place to begin to understand the experience of breastfeeding. Smythe (1998) discussed experiencing the tension of not knowing whether she had gathered enough data for her doctoral thesis. She wrote: "I knew it was enough, while at the same time I knew it never would be enough" (p. 115). I acknowledge that this tension was clearly evident when I came to completion of the process of collecting data.

5.6 Data Analysis

It is difficult to articulate the process of data analysis – it is a difficult and time-consuming process of calling forth interpretations. The interpretations that

emerged through undertaking this study came through a process of thematic analysis, constant questioning, and engaging in the dialogical conversation between the philosophy, the participants, the narratives and myself as a researcher. Finally, the process became one of writing and re-writing interpretations. The steps are outlined in greater detail in the following sections.

5.6.1 Initial Thematic Analysis

Repeatedly reading the narratives led to the content of the transcripts being organised into 85 distinct themes, based on the language used by the participants to describe their experiences. The development of these themes allowed me to explore specific parts of the participants' narratives, and their inter-relatedness allowed the themes to be organised into three groupings. At this point I returned to each narrative and re-immersed myself in the whole, constantly mindful of both the parts and the whole of the phenomenon under study.

5.6.2 Constant Dialogue Between Participants and Philosophy

The process of lifeworld research is grounded in the need for a dialogical relationship between the participants, the narratives, the philosophy and the researcher. From the project's conception I have embraced the dialogical process; it has provided the path by which I gained understanding of lifeworld research as well as the phenomenon of breastfeeding. The journey began with a dialogue with the philosophy, and continued through conversations with colleagues and research supervisors. It then proceeded to become a dialogue with the women who gifted their understandings of breastfeeding in the form of narratives. Finally, it became a conversation with the literature on breastfeeding, and thus new understandings and meanings about what it is to be a woman who breastfeeds emerged.

The intimate dialogue between myself, the philosophy, and the participants' narratives constituted the interpretive phase of the journey; it was, at times, a difficult path to navigate that required isolation and retreat from others. Interpretation requires that the researcher maintain the dialogue through constant questioning of the narratives, philosophy, and any emergent

interpretations. It also involved a great deal of time spent reading, reflecting, journaling and thinking. During this time I was embedded in the process of calling forth hidden meanings, attending to the otherness of the phenomenon, whilst maintaining a dialogue that sought to clarify and identify my own pre-understandings and horizon.

The interpretations laid out in subsequent chapters have emerged from this process of constant questioning, and examination of the phenomenon of breastfeeding. They are my interpretations. The journey now continues with you the reader. As you read my interpretations you will begin your own dialogue, you may engage in a process of questioning my interpretations, and through this process new interpretations will emerge – they will be your interpretations. Through this dialogue new understandings will emerge and horizons will be shaped.

5.6.3 Writing and Re-writing

Finally, this project has evolved through the writing and re-writing of interpretations. The writing began after I had devoted considerable time to the process of dialogical questioning. The act of writing once again triggered the dialogical process, which in turn assisted the process of refining, clarifying and honing in on the phenomenon of breastfeeding.

5.6.4 Sharing Interpretations

As the interpretations neared completion I began to seek opportunities to share the results with others. The sharing occurred through returning to one of the participants, presentations to a number of community and academic groups, the research supervisors, and discussions with other health professionals.

Returning interpretive accounts to participants has been a contentious issue amongst qualitative researchers. Some researchers claim that returning to participants should be an integral aspect of the research process (Bergum, 1991; Dahlberg et al., 2001; Krasner, 1997; Leipert, 1996; Meighan, Davis, Thomas, & Droppleman, 1999; Smythe, 1998; Walters, 1995). This solidifies the significance of the participants' contributions and verifies that any

interpretations are reflective of the actual experience under investigation. Other researchers claim that any interpretations made are the researcher's alone (Geanellos, 1998; Ironside, 1997; Reinharz, 1983). The process of interpretation is strongly influenced by the particular world view held by the researcher and, therefore, any other person's interpretations would differ significantly.

For the purposes of this research one participant demonstrated a strong willingness to read the interpretations, and she did so. Because I had not experienced the phenomenon of breastfeeding until the project was nearing its completion, it was important that at least one of the participants had the opportunity to respond to the interpretations. The research was also presented to a community group who had an interest in breastfeeding.

I am privileged to have two research supervisors who are both midwives, and have overseen the project from its conception. They have engaged in the dialogical process with me, calling for clarification and noticing important aspects that I had left unsaid.

Sharing the research interpretations with health professionals occurred in both formal and informal settings. I have had the opportunity to present the research to postgraduate nursing students on numerous occasions. Members of the faculty at the University where I am employed have informally discussed the research project with me, and I have also made a formal presentation at another New Zealand University. These audiences were made up of both registered nurses and midwives.

A group of fellow phenomenologists, who are either midwives or nurses, have also assisted my journey into understanding the phenomenon of breastfeeding. They have asked important questions and provided valuable feedback throughout the journey, and in doing so, have assisted in cultivating my understandings of lifeworld research and breastfeeding.

5.7 Attending to Accuracy of Interpretations

Walters (1995) believes that any interpretation made by a lifeworld researcher is tentative. She suggests that the researcher must provide enough information to ensure that the processes undertaken to arrive at interpretations are evident. This is achieved through illustrating interpretations by the inclusion of interview narrative. Koch (1994) suggests that rigour is evident in the research account when a clear audit trail is evident. Such audit trails allow for trustworthiness to be established.

Dahlberg, Drew and Nystrom (2001, p. 203) suggest that the accuracy of any lifeworld account needs to be assessed through the reader engaging in a dialogical process with the research. They recommend that a series of five questions should be asked of the research. The first involves questioning the use of data and the process by which the data has been gathered. Next, the reader needs to ask what questions have been asked to uncover the phenomenon. Has the researcher practised openness? How has the relevance of the interpretations been verified? Finally, the reader must ask "what influence has the researcher's pre-understandings had on the interpretation?"; which includes examining whether the researcher has sought to expose pre-understandings through critical reflections.

Throughout this chapter I have sought to demonstrate how I have answered these questions. All the interpretations offered in this research project are tentative. The interpretations presented are mine; they are influenced by my pre-understandings, and grounded in my world as a woman, a breastfeeding mother, and a health professional, despite my diligent attempts to be open to the phenomenon as it emerges. I continue to be overwhelmed with the knowledge that there is no end to the process of understanding or interpretation.

5.8 Summary

This chapter has examined the 'happenings' of this research project. It has highlighted the tensions that exist for a lifeworld researcher, as it is critical that the process allows the phenomenon under study to emerge in all its otherness. Therefore, the philosophical principles that guided the choice of method were

examined. The process of the research and the manner in which any interpretations emerged were also discussed. Finally, the way in which I have approached the issues of trustworthiness and accuracy of the interpretations has been addressed. The following chapters offer the interpretations that have emerged from attending to the phenomenon of breastfeeding.

Chapter Six

Breastfeeding Women's Experience of 'The They'

6.1 Introduction

A unique aspect of women's experience with breastfeeding is coming to an understanding of what it is to exist in a world that contains culturally-mediated interpretations of lifeworld experiences. This chapter examines the 'world' in which women come to know what it is to be a breastfeeding woman. It explores how women come to understand the breast, and how these understandings are mediated by 'the they' or the public sphere. It is through 'the they' that women's interpretations about breastfeeding are formed, and thus women measure their success according to the standards of 'the they's' view of what it is to be 'average'. It will be established that these notions of averageness hold women to ransom as they attempt to conform to the contrived, ideal breastfeeding mother. This chapter begins with an exploration of how women come to know about breastfeeding, highlighting the cultural frameworks by which women interpret their breastfeeding experiences.

6.2 Coming to Understand Breasts and Breastfeeding

6.2.1 The 'Always-already-ness' of Breastfeeding

We have all been 'thrown' into a world that we share with others (Benner, 1994; Dreyfus, 1991; Heidegger, 1962). We come to understand and gather meaning through 'being-with-others'; thus, *dasein*[19] is revealed through the world shared 'with-others' (Inwood, 1999). People agree to act and judge in particular ways,

[19] Heidegger used the term *dasein* to describe a being that exists and is capable of understanding or to describe the being there of existence (Dahlberg et al., 2001; Heidegger, 1962; Inwood, 1999). Refer to Chapter Four, section 4.4.1 for additional information.

and these agreed ways of behaving form public sources of meaning (Dreyfus, 1991; Heidegger, 1962; Olafson, 1987). An individual's understandings stem from previously-formed collective, public sources of meaning, which are taken up through 'being-with-others'. According to Dreyfus (1991, p. 144), by the time an individual has "*dasein* in them, they are 'always already' socialised". Therefore, to gain an understanding of the meaning that breastfeeding holds for women, it is important to examine the world of 'being-with-others'.

The narratives used in this study include many examples of women's experience of 'always already' being socialised into a world that contains previously-formed collective sources of meaning. The following excerpts grant insight into how society forms public sources of meaning in relation to breastfeeding.

When an infant is young, he or she learns that events are meaningful. Meanings are taken up through being-in-the-world and being-with-others, a process dictated by the world in which we are thrown. One could describe meaning as being 'always-already' present. If the world in which *dasein* is 'thrown' is a world in which 'other' supports breastfeeding through the formation of agreed ways of acting, *dasein* will understand breastfeeding as a part of that world. This is supported by research, which has demonstrated that those who have been breastfed are more likely to breastfeed than those who were not (Isabella & Isabella, 1994; Kessler et al., 1995; Scott et al., 2001). Essentially, *dasein* will engage and act in accordance with its thrownness, and submerge its beliefs in consensus with the 'others'. For example, a woman will embrace the cultural ideologies of the group of people with whom she dwells.

> *I guess it's 28 years of being told, or knowing that breastfeeding is better for the baby than bottle-feeding. If you were brainwashed for the next 28 years that bottle-feeding is great and better for the baby, then that's what you'd believe.*
> *(Cathy. Int. 18. Para. 69).*

> *I hadn't done a lot of reading about breastfeeding, but you do pick up the knowledge that it's best for your baby and that as a teenager he's likely to be more intelligent because of having been breastfed. That kind of thing seeps into knowledge, without necessarily making a conscious effort to find it out.*

(Sam. Int. 12. Para. 40).

Alice painted an apt description of the young in New Zealand as they are 'always already' being socialised. As a child, one learns to take up meaning from an event or situation through being-with-others; children, therefore, learn to act and judge by observing others as they engage with the 'world', and thus modify their way-of-being accordingly.

> *One of the other women in the Plunket group has had another child and it's so funny and sweet to see her little girl pretending to breastfeed her little doll and also to bottle feed it because the mother is doing both. Little girls pick up what they're supposed to do when they grow up, if they see other women breastfeeding it's - 'yes, that's what you do', if they see other women bottle feeding they think 'that's what you do'. (Alice. Int. 5. Para. 130).*

The 'always-already' taking up of meaning results from being thrown into a world, which provides us with a backdrop for understanding phenomena; however, these understandings are mediated by the actions of others.

6.2.2 Breastfeeding Women 'With-Other'

Understandings are not produced in a vacuum; instead they are formed as one interacts with an entity, or 'with-other' (Heidegger, 1962). It is in this interaction that interpretations are made and understandings are formed. This sharing of understanding takes place through media such as books, and languaging 'with-other.' Abby spoke of how she sought out common understandings as a way of knowing about breastfeeding, by engaging in languaging 'with-other' through written and spoken word.

> *When I found out I was pregnant I read as much as I could so I was aware. It doesn't mean just because you've read about it that you're going to know when it happens. It's just easier. I talked to ladies at work and they said 'I've heard about this book and that book'. I also got information from antenatal classes and the antenatal clinic and also from my doctor. Whatever I found I read.*
> *(Abby. Int. 2. Para. 16-29).*

As the women in this study engaged 'with-other,' understandings about the importance of breastfeeding emerged – a commonly-cited aspect being the benefit of the immunological properties of breastmilk for the infant. Amy offered a picture of how new mothers come to learn about breastfeeding, demonstrating how understandings emerge; they blossom as one dwells with a phenomenon.

> *It's a combination of the nutrition, providing him with the best possible nutrition, and also the immunological aspects of it have been really important to me. By breastfeeding him I knew that I'm giving him really good protection against bugs and infection and on top of that is the building of the relationship. The building of the relationship isn't something I thought about until later on. I looked back at it retrospectively and I thought the breastfeeding relationship has built our relationship whereas initially to me it was always the nutrition and the immunological factors that were important in breastfeeding him. (Amy. Int. 1. Para. 50).*

Common understandings about breastfeeding have developed over generations. In New Zealand, breastfeeding has come to be primarily understood as the optimal food source for infants[20], sometimes to the exclusion of other understandings, such as breastfeeding facilitating the relationship between a woman and her infant. As the boundaries of what is known are explored and new meanings evolve, women's acceptance of the previously-established understandings are unpacked, and further developed in light of the 'newly-formed' meanings.

Kate told the following story of how generational understandings of breastfeeding have evolved. These evolved understandings provided the illumination needed to more fully interpret the experiences that Kate's mother and grandmother had in relation to breastfeeding, and also provided Kate with guidance and the courage to persevere with feeding her child.

> *My grandmother, I was speaking to her this morning, she's 82 and she's going 'Are you keeping up with him? Have you got enough milk for him?' My girlfriend who read a bit of that La Leche literature was saying*

[20] See Chapter Two for more information about how breastfeeding is understood in New Zealand society.

to me that you won't ever run out and I can't imagine that nature would let me run out. I do believe that the quality, I know from expressing, that my milk is totally different at different times of day. The look of it is totally different. So the generations from my 82 year old grandmother, who has stories about an old lady taking my uncle, because he was a colicky baby, and feeding him milk and sugar and when he came back he was fine. God it makes everyone's toes curl . To my mum, who when I was pregnant and I heard all these negative things and all this pressure and mum just said 'I never had any problems breastfeeding', she got mastitis, which, I haven't had. She just said she so enjoyed the experience. She said breastfeeding was really special and she was very positive about the whole thing so I did tend to sort of think well, I can't see why I should have any problems, I suppose was my approach to it. (Kate. Int. 3. Para. 52).

'Being-with-others' means that common understandings are generated in relation to what it is to be a mother, an aspect of which is uncovered through sharing the reproduction of life 'with-others'. Eva relays how the meaning of what it is to be a mother came from dwelling 'with-other'.

I do feel quite proud that I have given birth and have a little baby. So I walk around and feel really happy about that especially when I see other women with prams. It's a really lovely feeling like we've all done something quite similar to each other, and all wanted to obviously bring a new life into the world and share that life with others and create a new little being for society.
(Eva. Int. 19. Para. 111).

A Samoan woman, Mai, who participated in this study revealed how the 'other' in her 'world' led to a shared understanding that breastfeeding comes naturally for women of her ethnicity. This realisation came to her, and gave meaning, through 'being-with' European cultures; thus, some taken-for-granted meanings emerged through contrast 'with-other.'

I'm not criticizing European cultures, it's not a downfall for them or anything, but for Pacific Island mothers' breastfeeding comes naturally (laugh). After a few days we're, you know... [able to breastfeed].
(Mai. Int. 4. Para. 72).

In the following narratives, participants Sue and Eva reveal the meanings about breastfeeding that they had gathered through 'being-with' health care professionals. These meanings highlight that breastfeeding is the best nutrition for a baby, that all women can breastfeed, and that all women must breastfeed. Eva and Sue interpreted these as pressure to breastfeed, which came at a time when their experience of breastfeeding was at odds with what 'the they' espoused breastfeeding to be.

> *I assumed that breastfeeding was a natural thing and that it would happen, and if you choose formula... it was a choice, for whatever reason they chose not to breastfeed. You're told about the benefits of breastfeeding all the time i.e.: less chance of SIDS, the perfect food results in a good digestive system, complete food, formula equals poison, increased immunity with breastmilk was also a biggie along with the allergy thing. It never occurred to me that it was a difficult thing, even with the antenatal classes that wasn't really suggested. So doing the right thing was breastfeeding your child. And like I said I assumed it would just be easy and it wasn't.*
> *(Sue. Int. 6. Para. 12).*

> *There's two sides to it, one is the head part where you've been told constantly all through your pregnancy, at antenatal classes and by your midwives, that you must breastfeed, and that everybody can breastfeed. [There's] no reason that you can't breastfeed, breastfeeding is best for the baby and that's it that's what you're going to do. You've got this pressure to do that. The second thing is the heart thing, which is probably more powerful. That you so badly want to be able to feed your own baby, you have these breasts that are full of milk, and ready to feed and you're the only person that can do it for her in the whole world; and that's what you're here for, like your sole purpose. It's the one special thing - other people can look after your baby, they can change her nappy and give her bottles and cuddle her and sing her songs but no one else can breastfeed.*
> *(Eva. Int. 19. Para. 9).*

It is interesting to note that the messages received from the health care professionals paled in comparison to the internal pressure that Eva placed upon herself to breastfeed. Eva's own 'thrownness' led her to the interpretation that

her sole purpose was to feed her infant. She believed she was the only one who could nourish her daughter, with her breastmilk. This is reflective of a cultural belief amongst New Zealander's of European descent, which can be traced back to Victorian England, that a woman should take the responsibility of breastfeeding her own children (Kedgley, 1996; Yalom, 1997). If a woman did not assume her breastfeeding responsibility, she was considered to be selfish and unfit to mother (Yalom, 1997).

As highlighted above, 'being-with' others allows interpretations about the role of women's breasts to emerge and become culturally established, which includes the role of women whilst breastfeeding. The following section highlights another culturally-established rendering – that a woman's breasts are integrally sexual.

6.2.3 Understanding the Breast as Functional

An integral part of understanding the 'world' into which a woman of New Zealand descent is 'thrown' is the awareness that the breast is interpreted as sexual. The perception of the breast as sexual has a long history in Western culture (Maushart, 1999; Morse, 1989; Yalom, 1997), which has silenced the understanding that breasts can exist as lactating breasts; thus, this knowledge has been confined to a private, unknown, unrealised world. In the 'thrownness' of mothering the women who participated in this study experienced a transition that enabled them to embrace the concept of breasts as a functional part of the body. The following excerpts highlight how women initially came to know their breasts as sexual, a perception that was altered by their experience of breastfeeding.

> *We're mammals, that's why we've got breasts. We've turned them into these sexual icons and, to be fair, when you're dating of course that's all they are. You don't think of them as being anything vaguely useful other than being attractive on the female.*
> *(Kate. Int. 3. Para. 27).*

> *I was aware that breasts were used for breastfeeding but because I hadn't had any personal experience of that I hadn't really made the transition in my mind. I hadn't thought about it - breasts are everywhere, if you look in all the magazines they're there and they're usually half*

> *uncovered, and they're always used for glamour or to turn men and women on or to look sexy.*
> *(Eva. Int. 19. Para. 125).*

Another culturally-mediated interpretation of the breast includes acceptance of the breast as functional, as capable of providing nutrition for an infant. For women in New Zealand, the socialisation process leads to the acceptance of general understandings of breastfeeding, and there appear to be definite boundaries on a breast as functional. One such boundary dictates that there is an acceptable length of time for the breast to be functional. Sally spoke of the general understanding that a woman who breastfeeds for a significant length of time must subscribe to fringe Bohemian ideals, a view supported by other participants.

> *I don't know where I've picked this up from - it's just been a general understanding that women that breastfeed for a long period of time tend to be supposedly your free-age, new-age hippies.*
> *(Sally. Int. 11. Para. 78).*

'The-other' let women know their disapproval of unacceptable behaviours, such as prolonged breastfeeding, in covert ways. In the following example, Amy was made aware of 'the-others' disapproval through critical facial expressions being directed towards her. Thus, Amy gained the understanding that feeding an infant of such age was not an agreed-upon way of behaving 'with-other.'

> *We were in Christchurch at the airport waiting for a plane. He needed a feed and there's nowhere really private to go. I don't have a problem with feeding in public so I sat down to feed him in public, in a seat in the airport and all these people were walking past all the time and all they could do was look. Their expressions, at least my impression of what they were looking at, was 'what is that really big child doing breastfeeding at that age'. He wasn't one year then, he was about 11 1/2 months - but that was the way that I felt about it. I felt exposed, uncomfortable. That was the only time I ever felt uncomfortable [breastfeeding]. It was kind of strange, a societal pressure.*
> *(Amy. Int. 1. Para. 10).*

Dasein is 'thrown' into a 'world' in which meanings exist, which are 'always-already' present and taken-up through 'being-with-others'. It is these taken-up meanings that form the basis for interpreting experience; the commonly-held meanings and interpretations that represent cultural standards are owned by 'the they'.

6.3 'The They'

Women understand breastfeeding in accordance with the understandings that are created through being 'with-others'. Heidegger (1962) claims that the authors of commonly-held understandings are 'the other' or 'the they.' I am in the 'world' with-others and these others are also with-others (Inwood, 1999).

> In this inconspicuousness and unascertainability, the real dictatorship of the 'they' is unfolded. We take pleasure and enjoy ourselves as *they [or man]* take pleasure; we read, see, and judge about literature and art as *they* see and judge; likewise we shrink back from the 'great mass' as *they* shrink back; we find 'shocking' what *they* find shocking. The 'they', which is nothing definite, and which all are, though not as the sum, prescribes the kind of Being of everydayness (Heidegger, 1962, p. 127).

Thus, it is 'the they' that provides the framework for interpretation, by establishing boundaries for the acceptable ways of existing. To conform to these boundaries, one constantly engages in attempts to mirror 'the they', doing no better or no worse than 'the they' (Inwood, 1999).

One of the primary influences of 'the they' can be found in one of 'the-they's' existential aspects – that of the call to averageness (Heidegger, 1962), which dictates what is success or failure, what is possible or impossible. As a direct result of this dictatorship of 'the they', or this call to averageness, a process of "'leveling-down' of all possibilities of Being" occurs (Heidegger, 1962, p.128). The ability of *dasein* to achieve possibilities is closed down upon in the call to averageness; thus, 'leveling-down' prevents the emergence of modes of being that are distinct from the sphere of 'the they.'

As a result of engagement with 'the they', "*dasein's* everyday possibilities of being are for the others [the they] to dispose of as they please" (Heidegger, 1962, p. 127). The possibilities of being are 'taken-over' through 'being-with', which occurs as one is submerged into 'being-with-the-they.' *Dasein* has become "entirely subsumed under this essentially anonymous public identity" (Olafson, 1998, p. 35). Thus *dasein* is freed from responsibility, as interpretive choices are given over to 'the they'; *dasein's* giving over of responsibility means that "it has not yet come to itself and can constantly be in this world without having to come to itself" (Inwood, 1999, p. 213). This process of 'giving over' reveals how *dasein* comes to be inauthentic, as responsibility for choices and decisions are essentially deferred to 'the they' (Inwood, 1997). However, one can exist in apparent conformity with the expectations of 'the they', but at the same time be authentic, provided one has thoughtfully chosen to express his or her individuality in that manner (Inwood, 1997; Olafson, 1998).

6.3.1 Mirroring and the Call to Averageness

The women in this study were constantly engaged in the act of mirroring; constantly striving to fulfil the requirements of the 'perfect mother,' as dictated by 'the they's' interpretation. Eva is highly educated with a successful career, having obtained a certain level of standing within her field of expertise; despite that, she still spoke of the image of the perfect mother and how this image held sway over her. She described how women strive to mirror the image of the perfect mother, noting that she was 'constantly disappointed' that she did not 'measure up'.

> *The perfect mother can do everything; she can breastfeed while holding down a full-time professional job, earning truck loads of money, can manage a household, drives the perfect car, has great skin every day, lovely shiny hair, and goes to the gym, eats the perfect diet, and does all this and can still be having a good sex life, and be a gourmet chef (laugh). It's just expectation that we build up in ourselves to do with breastfeeding, natural birth, perfect career and the perfect marriage. I don't know why we do it to ourselves because we're constantly disappointed.*
> *(Eva. Int. 19. Para. 168).*

The narratives offer many examples of how the drive to be the perfect mother was an aspect of the participants' experience as breastfeeding mothers. Failure to achieve this image meant they were failing not only themselves, but also their infants, family and society.

In the following story, Sam tells of how, in persevering with breastfeeding, she strove to mirror the 'other.' She relates how she gauged her success at breastfeeding in relation to 'other', and how the knowledge that she had achieved a certain length of time breastfeeding meant that she could wean and not feel like she failed 'the they' or her child. By engaging in this action of mirroring, Sam inadvertently closes down on the possibilities that her experience of breastfeeding might hold.

> *I remember thinking, and saying to my partner, that I didn't want to be the only one at our first antenatal get together to be bottle-feeding. I couldn't think of anything worse in the world than being in a group of a dozen other women and being the only one that couldn't breastfeed. It's a silly pressure that you put on yourself but to me it seems like that would be the worst thing. (Participant had tears in her eyes). But sometimes I wonder if it was really worth it. (Participant was crying). I know that it is in terms of the nutritional value and all of that kind of thing, but the stress that I put myself through, I don't know whether it was worth it really.*
>
> *We're at ten weeks now; I don't plan to give up in the near future but if something happened and I did that would be fine. I have a good friend who breastfed her first baby for three months and is at the moment feeding her second baby and plans to feed her for three months. That makes me feel better about it as well that we're nearly at three months and if I can get to that then I've kind-of done as well as she did. I don't know why that makes me feel better, but it does.*
> *(Sam. Int. 12. Para. 54, 56 & 80).*

Pat describes how pressure to be the perfect breastfeeding mother causes women to shy away from situations that leave them open to criticism, if they perceive that they are not reflecting the perfect image. Her infant suffered from severe reflux, and she spoke of an experience with health care professionals in which she believed she was being scrutinized by 'the they.'

> *Mum didn't know what to do with me so she sent me off to the Family Centre but I didn't want to go there…. I guess in a way I felt a bit of a failure and I didn't want to expose myself to whatever criticism they were going to give me, not knowing what they were going to do. When I did get there [to the Family Centre] the little horror performed perfectly, (small laugh) so then it was back to 'what is it about me that wasn't right.' (Pat. Int. 7. Para. 62).*

When being assessed, Pat's infant 'performed perfectly'; thus, she was left feeling insecure in her ability to mother her infant. She perceived that others were evaluating her ability to cope with parenting, which left her feeling exposed and inadequate. This resulted in her wishing that she could withdraw from those who may have been able to assist her with the difficulties of trying to breastfeed an infant with severe reflux.

Debbie provided a poignant example of a woman struggling to mirror 'the they's' ideal. She strove to breastfeed her son despite significant pain because of severely cracked nipples. Despite frequently expressing breastmilk and trying to persevere with the pain, she finally weaned her son when he was approximately eight weeks of age. Debbie's experience led her to resent her infant; she spoke of her belief that she had developed postnatal depression as a result of the physical pain caused by breastfeeding her son.

> *I didn't want to bottle-feed but I knew I would eventually have to do [so]. I couldn't carry on the way I was because I was depressed; it was just horrible. But because of this stigma about breastfeeding, everyone makes out that if you bottle-feed you're a bad parent that's why I struggled on for so long. We didn't bond until I started bottle-feeding him. It was the resentment of him hurting my body. (Debbie. Int. 15. Para. 48).*

Despite her depression, she persisted with breastfeeding for eight weeks because she did not wish to be perceived as a bad parent, and confided that she continued to feel guilty for two months after she decided to wean her son.

Cathy discussed how the pressure to mirror the perfect breastfeeding mother was so great that, although she knew that adhering to the image was destructive, the need to conform still held sway. She believed that by not

breastfeeding she had failed as a mother, and strongly wished she could have the opportunity to breastfeed her next child without difficulty, and not have to endure the associated feelings of guilt. Cathy longed to flee the grasp of 'the they's' interpretations; however, she responded to the summoning to conform to the image of the perfect mother epitomized by 'the they', despite the pain and the negative emotional impact that her breastfeeding experience held for her.

> *If I had a third child I'd have an elective caesarian and put them [sic] straight on the bottle. That would be exactly what I would want to do because the first two goes have been awful. But why wouldn't I do that if I had a third? Why do I carry on doing it?.... I don't know. I don't know, because nobody actually says "you're a bad mother for bottle-feeding." I guess when I do see my other friends' feeding it makes it hard. But honestly with all my heart if I had another one I would want to feed them [sic], I would love it to work. I would love to have one baby, for it to be perfect, for her or him to latch on and for it to work. But to know if I had to go through this experience again... it would be awful. It would be awful.*
> *(Cathy. Int. 18. Para. 45).*

Cathy also provided a story of how her husband was influenced by the call to averageness, and the effect this had on her breastfeeding. Her husband struggled with the idea that she might deviate from the averageness of 'the they' and thus became the vehicle by which the 'voice' of 'the they' was carried. Her ability to make decisions about her breastfeeding was closed down upon in order that she fulfil the call to averageness.

> *One day we had a really good talk about it because I felt so hurt that he would put the baby above me, above his wife. He would rather me suffer in pain - I'd be biting on hammers, sticks, clothes, and balling my eyes out while she was latching on - and he would say "I think it's best for her for you to be feeding." And I would just be bawling my eyes out in pain and that really hurt that he would do that. He's happy that we've been able to carry on for a little bit longer so that she has had what they say is the best.*
>
> *I don't know why I didn't give up because it's awful, it was absolutely awful and I should have because it's stressful enough what you have to*

> *go through without having to be in pain feeding. It was stupid not to give it up because it was almost marriage-breakable material because I was so upset the whole time and just crying the whole time feeding. And causing stress between us because I was so down. And he's brought up thinking that breastfeeding is best for baby too. It was interesting because I said to him one day "I know why you don't want me to stop, it's because you don't want to tell your parents that I can't feed our children" and I think that, that was what it was. He was scared that they'd see me as a failure and I think that was what he was also more upset about. That pressure when his parents ask "how's the feeding going?" "Well you know she can't feed, the baby's on the bottle." (Cathy. Int. 18. Para. 49 & 54).*

Jan provided another example of how the call to averageness provides barriers to experience. Jan was supportive of breastfeeding, and was involved in a voluntary organisation that assisted new mothers in the transition to motherhood; yet she offered the following narrative expressing a commonly-held meaning. Her sentiments provided an example of how 'the they' levels down and provides measures of averageness, and may offer an explanation of why a woman would discontinue breastfeeding prematurely, as she would hardly wish for her actions to be interpreted in this light.

> *I've heard lots of stories of people still breastfeeding children who are going to school. To each their own but I wouldn't like to see that in public. I think whatever you do in your own home is up to you but I don't think I would like to see a five year-old in public running up and opening your shirt and having a drink. I would just find that a little bit hard. I suppose because I consider five year-olds to be little people at that age. It's kind of like going to the side of the road and toileting at five. (Jan. Int. 13. Para. 74).*

While Jan's narrative describes an extreme example that is not often seen in New Zealand, it is common for New Zealand mothers to feel pressure to discontinue breastfeeding a baby who is over one year of age. Kay was continuing to breastfeed her son, who was one year old at the time of the interview. She talked in-depth about the pressure she experienced from 'the they' to discontinue breastfeeding her son, describing two opposing views that hold sway over women's breastfeeding decisions: she spoke of the research

highlighting the importance of prolonged breastfeeding, and also spoke of how this knowledge is silenced in the face of commonly-formed meanings that dictate women's actions in relation to prolonging breastfeeding, especially if a woman is in the vulnerable position of being a first-time mother. Through such meanings the call to averageness is issued, and women's experiences are leveled down; their choices are closed down upon, which may lead them to wean their infant earlier than they wished.

> *Some women don't get a choice and it doesn't seem fair. I think women should get to choose but she needs help though, especially a first time mother who has no idea, like me. If for some reason research shows the longer you breastfeed the better, but people get pressured to stop earlier, I think that's wrong. I think it's the same with anything though, you don't get to choose. You should be able to choose what you want to do. You shouldn't be pressured. Like people I know that have been pressured to stop…. It's people in society. It's not the 'in' thing anymore. For the first few months everybody thinks you're doing a really great job but after that when they [the infant] get older they think you should stop. "They're old enough, they don't need it." That's wrong. The beginning and the end of it are the two things that annoy me most about it. Which is stupid really cause everything is fine in the middle. But you shouldn't be pressured.*
> *(Kay. Int. 8. Para. 136-138).*

Kay highlights the pressure in 'the beginning and the end' of a woman's breastfeeding experience. During the interview, she spoke of the societal demand to commence breastfeeding, even if breastfeeding had become a source of stress and trauma for the woman. If a woman chose not to breastfeed she became subject to the scrutiny of 'the they.' 'The they' have many voices, and women who could no longer breastfeed had no difficulty in heeding the message that they had committed a transgression by not complying with the call to averageness.

Jan had an incredible ordeal with breastfeeding her son, struggling through painful cracked nipples, mastitis, hospitalisation and surgery before choosing to wean her infant. She spoke of her experience with 'the they' after weaning her infant when he was approximately one month of age.

> *People just asked you all the time, if they saw you bring out a bottle this look came over their face like 'wow, you've decided' - our antenatal group was like that initially and Plunket group were like that, because I was the very first to bottle-feed. There was an assumption that it was my choice completely, which at the end of the day it probably was, but there was no understanding behind the reasons why we had done that. (Jan. Int. 13. Para. 24).*

Eva provided an example of a woman who succeeded at breastfeeding despite the 'odds.' She struggled through tremendous pain, pain she likened to the pain of giving birthing, cracked nipples, five days in hospital because of mastitis, and still she managed to continue to breastfeed her daughter. She mindfully articulated how she could potentially contribute to the pressure 'the they' places on women to continue to breastfeed, but also celebrated the special place that breastfeeding has in her experience as a mother.

> *Now that I'm breastfeeding 'successfully' I suppose you might say, almost fully breastfeeding, and I've had so many problems and I have overcome them I'd like to think that everyone else would try as hard as I have. I've joined the club of people that says "anyone can do it" but I have to be careful because I could have easily given up and been on the other side of the fence. I don't want to put pressure on people.*
>
> *Just looking at her growing and looking so healthy, she hasn't been sick at all, almost all the weight she's put on has been from me and it's such a satisfactory feeling. It's like the best feeling in the world. People will say how healthy and beautiful she looks and I think I'm actually growing her myself. She's thrived on breastmilk and those times of discomfort you don't even remember them really physically anymore. I'm not, you know, delighted with the pain but knowing that there's a higher purpose. (Eva. Int. 19. Para. 11 & 85).*

The women who participated in this study attempted to mirror the publicly-espoused ideal breastfeeding mother, thereby responding to 'the they's' call to averageness. For those women who did not mirror the requisite image, breastfeeding was an experience of struggling in silence.

6.3.2 Breastfeeding as Struggling in Silence

The pressure to be silent, or act out something, was the hallmark of the women in this study who perceived that they were failing to mirror the image of the perfect breastfeeding mother. An aspect of this silence exhibited itself in the need to hide the difficulty they experienced with breastfeeding. Sam tells this story about how she is silent about her struggles with breastfeeding to all but those that may be having, or have had, a similar experience.

> *When I'm out I guess I feel the pressure more, and again it's probably a pressure I put on myself. Pressure to make it work. I don't want to have a screaming baby in public because he won't breastfeed properly. And that's never happened, but it's something I worry about. I'd probably feel like I'm failing in some way... There are some people that I'm happy to tell about my problems... but others I think do perceive that I've failed in some way if I tell them that things aren't going well.*
> *(Sam. Int. 12. Para. 39 & 66).*

Eva also spoke of the pressure to remain silent about how difficult breastfeeding was, and provided these sentiments supporting Sam's experience of breastfeeding in public.

> *There's definitely pressure if you are out in public to make it look easy. The image of the perfect breastfeeding thing and pressure to live up to it. (Eva. Int. 19. Para. 39).*

Women also concerned themselves with how their babies mirrored the image of the perfect infant, the achievement of which is directly attributable to a perfect mother. If their infant reflected a less than perfect image, women interpreted it as an indication of failure on their part. Sam gave birth to a healthy, eight-pound infant, who subsequently lost 11 percent of his birth weight within the first week post-birth. Sam struggled anxiously to establish breastfeeding, frequenting a local Family Centre to gain some reassurance that her breastmilk was sufficient to nurture her child.

Sam valiantly endeavoured to mirror the perfect mother who had the perfect infant. In her insecurity, she concernfully examined her infant and analysed 'the

they's' perceptions for signs or proof that she lacked the ability to be a 'good' mother, with enough breastmilk to adequately nurture her child.

> *People will say things like "Oh he doesn't look like an eight pound baby" or "He looks small for his age." I'm constantly comparing him with other babies of the same age, which I know you're not meant to do, but you just can't help yourself. I do, I always worry about his weight gain. I weigh him usually once a week to make sure it's OK and it has been OK. (Sam. Int. 12. Para. 36).*

Mel, like Pat[21] (Int. 7. Para.62), exerted significant effort to establish and maintain breastfeeding after she gave birth to an infant who suffered from severe reflux. During the first weeks after giving birth, she vigilantly visited her midwife, doctor, the local Plunket Nurse and Family Centre in an effort to establish breastfeeding. She finally weaned her daughter when she was six weeks of age. Mel reported that she agonised over the decision, but finally decided that she could no longer cope with the physical and emotional trauma of breastfeeding. She spoke in-depth of the difficulty of living with the failure to portray the image of the perfect mother with the perfect infant.

> *Failure because you haven't done it, and envy too because I was in a coffee group and only one of the other mothers had gone onto formula. The others were all breastfeeding and all their babies looked so good and I thought 'Oh god, why can't my daughter be feeding like that?' Helplessness too, 'why isn't it working for me? Pity - 'why isn't it working for me?' I can remember saying to my mother when I was holding her, 'I wonder if I can exchange her' like you exchange an item of clothing. That's dreadful, I didn't mean it. But it crossed my mind, 'these pair of shoes don't fit I wonder if I'll exchange them next week. This baby is not quite right I wonder if I can exchange it next week?' And I thought 'Oh my god, that's awful!' But it's what goes through your head; this baby's not fit to the mould of what it was meant to be so where's my one that is meant to be perfect? Where's my perfect baby that latches on and feeds perfectly and doesn't have reflux..*
> *(Mel. Int. 17. Para. 18).*

[21] See section 6.3.1.

Emma's narrative illustrates how women, as breastfeeding mothers, give the responsibility of interpreting their individual experience over to 'the they.' Her story reflects a common sentiment among the women in this study, regarding the need to conform to the ideals espoused by 'the they.' Through accepting 'the they's' judgement of what constitutes a perfect breastfeeding mother, a woman may inadvertently experience guilt if she chooses to not conform to the esteemed ideals, even if she might be choosing the best option for her and her child. The ideals articulated by Emma show that what might be a good decision for a woman and her child can become a source of guilt, and possibly a sense of failure, if a woman adheres to 'the they's' judgement. Emma uses the term 'going against the grain' to describe a decision to not adhere to 'the they's' judgements – choosing to do the unexpected by not mirroring 'the they'. A woman who chooses not to heed the call to averageness will suffer the consequences; in this case, a woman will suffer from feelings of guilt if she does not breastfeed her infant.

> *I saw this ad on TV about women that leave their babies in daycare while they continue with their career. It said the day you give birth you give birth to guilt. You will always feel guilty if you make decisions that go against the 'grain'.*
> *(Emma. Int. 14. Para. 234).*

The following story, as told by Eva, reveals her perseverance, despite enormous discomfort from breastfeeding. Eva spoke of how she, at least in part, relinquished the responsibility to a health care practitioner for choosing whether to continue to breastfeed or wean her infant. This responsibility is not easily relinquished, but as Eva felt insecure about her ability to make the best decisions for her child, she gave over her interpretive choices believing 'the they' knew better.

> *Despite the mastitis, despite having cracked nipples that got infected, despite being in tears... It's really quite difficult. I feel quite sad for people who have tried but haven't been able to continue. But I also feel an admiration for women who totally know that they just don't want to breastfeed and they just go onto a bottle straight away. It's all about being comfortable in your decision. Maybe with the second or third child down the track it would be much easier to be clear in what you want. But with your first child it's all so new and different and you are so reliant*

> *on the health people, because you don't have any experience of it yourself. So it's tricky and hard.*
> *(Eva. Int. 19. Para. 29).*

It has been argued that New Zealand does not have a breastfeeding culture (Beasley & Trlin, 1998; Beasley & Heritage, 1998/1999; Watson, 2001); however, the participants' responses indicate that New Zealand society expects women to breastfeed, but women do not believe they have access to appropriate support so they can breastfeed their infants without difficulty.

Women will struggle in silence with breastfeeding if they perceive that they are failing to aspire to the ideal breastfeeding mother as espoused by 'the they'. There may come a time though when a woman will see through 'the they's' espoused image, but to do so she must concernfully uncover the 'they-self'.

6.3.3 Concernfully Uncovering the 'They-Self'

> *It comes down to the idyllic things through the media, magazines and TV where the perfect baby sleeps through the night and latches on instantly and smiles and goo-goos all day, hardly has any wet or dirty nappies. If you ask any other women they might say "yea that's the idea, but it's just not a reality." It doesn't happen. I don't know why. Like mother's looking glamorous and walking out of the hospital in size eight jeans after just giving birth, and having nice shiny hair, and make up on days after giving birth. It doesn't happen (laugh) to most of us anyway, not to me. I don't know why we do it to ourselves in society, why all these images go out when they're not truthful and they do put pressure on women to look a certain way*
> *(Eva. Int. 19. Para. 87).*

In some cases, the participants in this study attempted to understand and liberate themselves from the demands to submerge their created meanings in the public identity of 'the they.' Heidegger (1962, p. 317) suggests that it is in being concernful as we are 'with-others' that we understand 'the they.' This understanding develops out of listening to the call of one's conscience. Only as one engages in listening to this call is *dasein* summoned "from its lostness in 'the they'" (Heidegger, 1962, p. 319).

Heidegger discusses how it is one's conscience that calls us into what is *ownmost* to us, describing this call as a "momentum of a push – of an abrupt arousal" that "reaches him who wants to be brought back" (Heidegger, 1962, p. 316). It is through this call that *dasein* is drawn from its hiding place, within 'the they', into what is most true, its *ownmost*. This section of narratives depicts women who have become concernful in their interaction 'with-others', enabling them to revise their interpretations of their experience as breastfeeding women, freeing themselves from the lostness of 'the they.'

In the following story, Kate describes how she heard the summoning of 'the they' but chose to flee the pressure to conform; instead, Kate navigated her own path that enabled her to see through the superficial facade presented by 'the they' and remain true to her conscience. She was still feeding her seven-month-old child at the time of the interview.

> *I didn't have an overwhelming fear of breastfeeding, and before, while I was pregnant I really talked myself into not being intimidated by being forced to breastfeed. There's a real sector out there that put the fear of God into you. People just browbeating you into persevering with cracked nipples and nipples falling off, and cracked. I thought I'm going to have a really good go at this, but if I can't do it, I can't do it. It was a really healthy attitude in hindsight because I didn't put any pressure on myself. But for the first few days it's a bit like breaking in a pair of running shoes. (Kate. Int. 3. Para. 10).*

The following narrative was provided by Kay, a single parent with limited support who fell into a low socio-economic bracket, had limited education, and had experienced extremely negative reactions from close family members to her breastfeeding. Had she been assessed in light of predictive research findings, it might have been suggested that she would fail to breastfeed her child (Isabella & Isabella, 1994; Kessler et al., 1995). Despite these factors, she continued to breastfeed, believing strongly that it was the best thing for both herself and her son.

> *I want to do what I think is best for me and my son. I'm the one that's raising him. I'm the one that's there 24 hours, no one else is here helping me. So the way I see it is what right do they have to tell me what to do?*

(Kay. Int. 8. Para. 111).

Sue struggled through insufficient milk syndrome for three months before she decided to cease trying to breastfeed her baby. During the interview she talked of the hours she spent letting her son 'graze' at the breast, as her son screamed constantly when not suckling at the breast. On one occasion during the first six weeks postpartum, she found urine crystals in his diaper, and yet the midwives encouraged her to persevere as her milk still had not 'come-in.' Throughout the time she breastfed, she had the growing awareness that she did not produce the quantity of milk her infant needed. Despite this knowing, she battled internally to defend her decision to discontinue breastfeeding as she struggled through the prevalent pro-breastfeeding pressure. It was only as she came to her own conclusions about breastfeeding that she gained the courage she needed to stop.

> *All the stuff that you get told about breastfeeding and it isn't actually right for everybody. You've got to wonder what it's founded on. I read that book by Adelia Ferguson[22] and she had the excerpt from the WHO about why 'breast is best' and why they're pumping it so much; it's largely propaganda. They don't want third world countries going the formula route because babies do die due to the water supplies. We don't live in a third world country. Everything else is based around convenience in our day and age, convenience foods etc, except for this. You've got to go back to nature and do it the natural way. I think it's wrong. They're prejudiced against women, forcing women to do something that may not work. And there's no information to tell you that or what to do if it doesn't work. It's not fair... To be quite honest I think that people that breastfeed their babies exclusively are nuts. I'm angry in some respects that the downfalls of breastfeeding are not told to you at all. It's a real slap in the face, you think that there's something wrong with you because it's not happening for you. But I don't have feelings of guilt anymore, blow that. The most important thing is that he's happy. (Sue. Int. 6. Para. 80 & 100).*

[22] Adelia Ferguson authored a book called *Bottle babies: A New Zealand guide to guilt-free bottle feeding* (Ferguson, 1998).

Women who were able to concernfully uncover the 'they-self' were able to form interpretations based on their own embodied experience, thus freeing themselves from the tyranny of 'the they's' edicts. However, while some women were able to understand the inconsistencies within 'the they's' espoused ideals, they could not free themselves from striving to attain averageness – 'the they' held sway.

6.3.4 When 'The They' Holds Sway

At the time of her interview, Cathy was still persevering with breastfeeding despite numerous obstacles. Her daughter had reflux and refused to latch on for more than 10 to 20 seconds at a time; she also experienced severe pain, and described how she would bite on objects so she could cope with the pain of initially latching her daughter on her breast. Cathy's comments characterised the women in this study who could understand there were inconsistencies with the image portrayed by 'the they' in relation to breastfeeding and the reality of this experience for some women. Despite this acknowledgement, Cathy could not flee the summoning and sought to fulfil her obligation to 'the they.'

> *I would love, if I had a third one, to feed it but I would also like not even to try, to go straight onto the bottle and not have that stress. Why am I still persisting with expressing? I'd hate another woman to go through what I've gone through. And I'm stupid, I'm stupid to carry on, I'm not in pain like I used to be at all, but the hassle of having to express and be sore when she does come on and off, why don't I just bottle-feed her? I would love to say to another woman "just give it up, if it's not working just give it up, you're still OK, your children will be OK and you're not a bad mother." I don't think it makes any difference whatsoever in terms of bonding at all. I didn't bond with my son for the first month but now we've bonded heaps and he was on a bottle. You can actually look into their eyes more when you're giving them a bottle than when they're looking straight at your boob. They say skin to skin but I don't know what that is because the only skin to skin is his mouth to my nipple. They say that skin to skin contact is important but it's not like I take all her clothes off and all my clothes off to feed her so I don't know what skin to skin contact they're talking about is? When you're bottle-feeding them you can look them in the eye and talk to them but when they're*

> *breastfeeding they're looking straight at your boob. So yea so I would just like for women to know that it is OK, she's still ok, she hasn't failed but I don't believe it myself.*
> *(Cathy. Int. 18. Para. 45).*

Cathy discussed the internal dialogue and decision making process she engaged in when thinking through her experience of breastfeeding. She stated that she did not think it made a difference whether she breastfed or not, but could not flee the summoning of 'the they.' She discussed the arguments used by health care professionals, anthropologists and sociologists to promote breastfeeding. She wrestled thoughtfully with these arguments in light of her embodied experience and her solicitude for women who may have similar breastfeeding experiences to her own.

Cathy went on to speak of breastfeeding using the term 'hellish' to describe her experience; however, she continued to try to breastfeed. She shared at length her feelings, her desperation to breastfeed, and how she believed she was failing as a mother because she couldn't fully breastfeed.

> *I have a friend and she gave up breastfeeding her daughter after two months and that led to her getting postnatal depression. But she felt that pressure to feed. So we talked about how hellish it is. To me it's just like hell on earth breastfeeding. I don't know who recommends it. Why people recommend it because it's…hell.*
> *(Cathy. Int. 18. Para. 43).*

Sam provided another example of how 'the they's' edicts hold sway over women as breastfeeding mothers. Women feel obliged to adhere to publicly-held beliefs, although they are able to accept that 'other', for good reason, may not. Thus, it might appear that 'other' is freed without consequence. However, Sam also provides insight into how 'other' are also held sway by the same obligations and seeming struggle with the failure to portray the perfect image.

> *It's funny how I say, that you can be a great, successful mother, because when I look at women who bottle-feed their babies I don't think they've failed, and yet I apply that judgement differently to myself. I would have thought I had failed but I don't think other women have. And the women I know who did bottle-feed they must have put themselves*

under that same pressure because they do get defensive and they do tell you why. One of them was 'I got mastitis,' and what ever, there's always a reason for it and I can completely understand where they're coming from. You do put yourself under pressure and you do feel that you need almost an excuse for it, if it didn't go well.
(Sam. Int. 12. Para. 1112-114).

The women who were held sway by 'the they' were unable to free themselves from the call to averageness emitted by 'the they'; in consequence, these women's experiences were interpreted in accordance with publicly-held sources of meaning.

6.3.5 Interpretations as Formed by 'The They'

The breastfeeding women in this study were certainly not immune to 'being-with-the-they'. Their language painted pictures of how their worlds were interpreted in accordance with 'the they', revealing how their experiences of breastfeeding hinged on 'the they's' interpretation of breastfeeding.

Eva was persevering with breastfeeding despite extremely painful cracks in her nipples – she practiced crystal gazing and deep breathing to facilitate coping with the pain of latching – and a five-day hospitalisation for mastitis. She spoke at length of her struggle to breastfeed and how, when her midwife presented her with the option of ceasing to breastfeed, she chose to continue as it was best for her infant. Three months into the experience the thoughts were coming to her that she had forgotten to listen to her embodied knowledge. This embodied knowledge had been silenced; she had been deafened by the information offered by 'the they.'

I've got this huge pile, full of information, almost all of this is on breastfeeding. I've got this huge clear file that's four inches thick and I've got six or seven books on breastfeeding. There's so much information that you've almost forgotten how to listen to your own body. You become reliant on other people to say its OK, such as midwives and doctors, or books or pamphlets, to say how things should be done. I also think that because the 'breast is best' slogan is told to you over and over again before giving birth you're so hyped into that mindset that you

actually need to hear someone professional say that "well actually bottle is OK too."
(Eva. Int. 19. Para. 16).

The strong messages offered by 'the they' rendered some participants incapable of making decisions that would promote the well being of both themselves and their infant. Mel, who provided the following narrative, spoke of her attempts to breastfeed her infant daughter. To ease the reflux, Mel would breastfeed with her baby in a sitting-up position, at the same time attempting to support her large breasts and splint her caesarean wound. She found this method of feeding impossible, but felt incapable of making the decision to stop breastfeeding.

I don't know why somebody didn't tell me in the beginning to give up. It's really horrible because people are saying to you "breastfeeding is the best thing for your baby", but it's emotionally crippling for you to have to give it up. Or with the Plunket nurse saying 'I'll support you no matter what', that is really nice but I didn't want that, I wanted someone to say "it's not working, go to formula it's a lot easier, don't berate yourself over this and just don't worry about it", but they don't. They try and convince you to do otherwise. It's really hard.

I was so disappointed to give up, that's probably why I persevered for so long with my daughter when it was getting quite awkward in the end. But yea, yes - failing her and failing me and failing what other people think of you too. People that don't have children or mothers that do and have breastfed successfully six, seven times, they are so opinionated on what you could be doing wrong or why you aren't breastfeeding.
(Mel. Int. 17. Para. 2 & 24).

Sam had embraced the idea that the only entity capable of making her 'a good mother', was her ability to breastfeed. Thus she became lost in 'the they's' interpretation that anyone can 'nurture' a baby, but only a mother can breastfeed. As she struggled to establish breastfeeding, she began to question her ability to be a good mother, especially in light of her partner's ability to nurture their child. This resulted in her becoming insecure and feeling like a failure.

> *My partner is so good as a father and I wanted to be able to do something that he couldn't do. I wanted to be able to be the mother of this baby. And my partner's mother was saying, "if he had a pair of boobs he'd be happy." I thought 'great, thanks, so I do nothing.' That really upset me at the time and still upsets me now when I think about it. (Participant had tears in her eyes). It was like that is one thing that I can do to demonstrate that I am a mother, and a good mother that my partner can't do. It wasn't like I resented him being a good father, I'm really lucky, it's just that I wanted to be able to do the things that my body should be able to do.*
> *(Sam. Int. 12. Para. 95-96).*

Jan's sentiments echoed Sam's. 'The they's' created meanings leave women believing they are not good mothers if they cannot breastfeed. From the first breastfeed, shortly after giving birth to her first child, she and her son had difficulty. Jan reported that, by day ten, "he had basically eaten off my right nipple completely" (Int. 13. Para. 6). She went on to subsequently develop mastitis which resulted in hospitalisation and surgery. Despite all of these obstacles, she still struggled with the belief she was a bad parent because she could not continue to breastfeed. She spoke of the guilt that was so pervasive she cried for three to four months because she could not breastfeed. 'The they' reinforced these notions by being unable to accept her bottle feeding her son.

> *I think you have this expectation that you can do it and that it's relatively easy. People say "it's painful but you can get through it, if you keep persevering it will be fine." My midwife was fantastic, she was visiting me every day so I wasn't unsupported it was just that it wasn't going to work with him and myself. And I think I started thinking that it was all me, and that I should be able do it. People kept saying "just keep going and it will go OK, it will go away", but we should have stopped heaps earlier. We shouldn't have got to such a state where I couldn't stand up, I couldn't eat - I couldn't do anything. I was useless to everyone including my son. I felt terribly, terribly guilty about not being able to breastfeed. You get all this stuff shoved at you all the time about how breastfeeding is best and you almost feel like you're not a good parent if you can't.*

It's a thought in the back of your mind all the time, that there's something not right. That there's something I should be doing but I'm not. It was a very emotional, teary thing for me that breastfeeding guilt. Tears were never far away for three to four months. I guess because it's like an unknown with that particular question 'am I really affecting my child in such a way so that when he goes to school he's going to be so different from everybody else?' He was also a relatively sickly child and that's because he wasn't breastfed. That he didn't get all the goodness he needed and became a sickly child and I've actually done that to him by not being able to breastfeed. So you have all this baggage that you carry around with you. And I think it was very in my face because people would talk to me about bottle-feeding a lot, and you'd go out and people would look at you bottle-feeding I mean that's your perception. And think 'Oh, she's got a wee, wee baby and it's being bottle-fed'

At the end of the day, when you're in the middle of being really sick, you're not sure and you don't have the ability to make the right decision sometimes, well I didn't. I got to the stage where I was told that I had to stop. And if I hadn't been told I would have kept going, and going, and getting sicker, and sicker. I was lucky, I suppose, that somebody said "this is the end of the road, we are going to stop now". And so maybe that helped because it wasn't my choice. Maybe if I had, had to make that decision I might not have got over the guilt as easily.
(Jan. Int. 13. Para. 8, 56 & 58).

Jan gave over the interpretation of her breastfeeding experience to 'the they' – she relinquished the decision to wean her son to health professionals, leading her to believe that she did not own the decision, and was thus freed from responsibility. However, she still gave credence to 'the they's' interpretation that all good mothers breastfeed, succumbing to feelings of guilt that she resolved only when she accepted that she had not actually made the decision to wean her son.

It is not the purpose of this exposé to critically analyse the 'hidden' purpose of 'the they'; 'the they' is neither good nor bad (Inwood, 1999). Instead, the purpose is to highlight the manner in which women interpret their experience of breastfeeding. The call to comply with the practices of 'the they', the pull to averageness, the 'levelling-down' experienced by women at a vulnerable time in

their lives, are very powerful effects. "We cannot be average if what is averagely expected is beyond the reach of most of us" (Inwood, 1999, p. 213). Due to the vulnerability experienced during the transition to motherhood, women are at the mercy of 'the they'; thus, 'the they' powerfully influences women's interpretations of their breastfeeding experiences.

6.4 Summary

This chapter has laid out an interpretation of how 'the they' influences women's breastfeeding experiences. I have discussed how 'being-in-a-world' 'with-other' provides the foundation for commonly-formed meanings, that provide the framework for the interpretations made about women and their experiences with breastfeeding. At times, the participants chose to flee the summoning to submerge their created meanings in the public identity, and as a result had to learn to navigate their way through 'the they's' scrutiny. Women who failed to concernfully navigate 'the they's' inspection struggled in silence through an emotional minefield of guilt and a sense of failure. The following chapter explores how women have inherited a language that describes breasts and breastfeeding in an objectified manner.

Chapter Seven

Inherited Understandings: The Breast as Object

7.1 Introduction

This chapter explores how women have come to understand their bodies and, therefore, their breasts, as objects. The interpretation of the breast-as-object has emerged from the philosophical work of Descartes, who positioned the body as an object. Descartes' interpretation and associated language was long ago embraced by the medical fraternity, and has been handed down over centuries to describe human experience of our bodies; as a result, this language has become embedded in our understanding of the body (Inwood, 1999; Leder, 1984). The participants in this study relayed how their breasts were objects to be handled and managed, and therefore Heidegger's philosophical work on objects is used to explicate women's experience of breastfeeding.

7.2 Cartesian Dualism

During the Medieval era[23], people viewed bodies as mystical entities that contained the essence of life. Such beliefs had prevailed since the time of Aristotle and were problematised by Descartes, who, instead of focusing on the mystical quality of life, argued for a monotheistic approach to teleology, claiming that God was the source of all truth and purposefully-ordered existence (Leder, 1984). It is on this foundational premise that he based his philosophical quest for an epistemology that transcends historicity and subjective experience (Inwood, 1997; Inwood, 1999; Leonard, 1994).

One of the aims of Descartes' philosophy was to advance medicine through a mathematical and philosophical analysis of the body (Burnham & Fieser, 2001;

[23] The Medieval era spanned approximately one thousand years, from the fifth century to the fifteenth century (Russel, 1996).

Leder, 1984). He believed that the physical world is a mathematical world and that, to achieve this revisioning of the physical body, a systematic mathematical approach must be employed (Burnham & Fieser, 2001; Inwood, 1999).

According to Descartes, the first act of any systematic analysis must begin with *hyperbolic doubt,* through which all knowledge is exposed to critical philosophical examination (Sorrell, 1987). To distinguish and clarify knowledge, the philosopher must undertake hyperbolic doubting to uncover that which is indubitably true (Burnham & Fieser, 2001; Sorrell, 1987). An integral part of hyperbolic doubt involves examining any information received through the body with extreme caution. Descartes believed that such secondary knowledge, received through the senses, has the capacity to deceive the mind, thus blinding the examiner to truth (Burnham & Fieser, 2001; Leonard, 1994; Sorrell, 1987).

Ultimately, Descartes came to believe that he existed essentially as a 'thinking thing', and to describe this he employed the phrase *cogito ergo sum* - 'I think therefore I exist' (Burnham & Fieser, 2001; Dreyfus, 1991; Inwood, 1999; Sorrell, 1987). Descartes ameliorated the mind as the source of intelligence and life for humans and, although the mind and body are intrinsically linked, he relegated the body to the domain of *res extensa* (i.e., extended thing) (Burnham & Fieser, 2001; Dreyfus, 1991; Inwood, 1999; Leder, 1984; Leonard, 1994). By arguing that the mind completely controlled the body, Descartes relegated the human body to the realm of machine – a machine completely incapable of spontaneous mystical behaviour, intelligence or purposeful movement (Burnham & Fieser, 2001; Leonard, 1994). This understanding rendered the body as an object controlled by the human mind; thus, people gained knowledge through examining objects, which included the human body. This separation of mind and body has become known as Cartesian dualism (Inwood, 1999; Leder, 1984; Leonard, 1994; Sorrell, 1987).

Due to the prevalent belief in the seventeenth century that the body was the sacred source of life, doctors were prevented from dissecting or interfering with a body in any way (Leder, 1984). With Descartes' revisioning of the body as an object, medical practitioners were no longer subject to such social taboos – the body could now be operated on, dissected and analysed in accordance with mathematical and scientific paradigmatic ideals (Leder, 1984). Thus, Descartes had a significant impact on the medical establishment, which adopted the philosophical thesis of the body as an object (Inwood, 1999), and Cartesian

dualism emerged as the major paradigm for medical practitioners (Gadamer, 1996; Leder, 1984).

The medical discourses that exist in our society still embrace notions of Cartesian dualism (Gadow, 2000; Leder, 1984; Leonard, 1994). Due to their significant exposure to health care professionals, women in New Zealand gain access to medical discourses during pregnancy. Therefore, their interpretations of their birthing and breastfeeding experiences are strongly informed by these discourses (Gadow, 2000), as evidenced by the consistent appearance of notions of Cartesian dualism in the initial stages of the interviews described in this study.

7.2.1 The Body as an Object

Medical discourses that adhere to notions of Cartesian dualism have influenced the beliefs of the women who participated in this study. These notions were reflected when the women initially discussed their breastfeeding experiences using medical terms such as mastitis, antibiotics, and colostrum, and referring explicitly to their bodies as objects.

Eva discussed how her body was being used as 'nature intended', through giving birth and having breasts that produced milk. Eva's body was something she possessed, and she attributed some of her body's success to modern medicine's ability to manage it.

> *It does feel good to have used your body for the purpose that nature intended for it. And that applies to breasts - I've utilised what I've got. I feel pleased that everything worked as much as modern medicine allowed... and that my body produced a baby and I'm producing milk. (Eva. Int. 19. Para. 145).*

Cathy spoke of delivering her second baby by caesarean section. Having had a particularly bad experience with breastfeeding her son, she was relieved to have a lactation consultant midwife who could put her little girl 'on' so that she was 'latched' properly. Cathy believed she was unable to get her first baby 'latched' onto the breast properly, and therefore having a health professional

present to manage her body meant that the initial breastfeeding experience with her daughter was successful.

> *The second day in hospital I had a caesarean but I was very fortunate because a lactation consultant was my midwife in the operation room. She came with me to the recovery room and put my little girl on [the breast] and she suckled for probably about half an hour and latched on really well.*
> *(Cathy. Int. 18. Para. 6).*

Women in this study were exposed to mechanical devices to help them manage their object bodies. Liz came to understand and possess a language about breasts and breastfeeding through being exposed to, and using, multiple devices: she expressed, she syringed, and she steamed.

> *I ended up expressing [colostrum], syringing colostrum out and syringing colostrum into her [my daughter's] mouth trying to get her to get some of the colostrum. So it was kind of squeezing in machines, the works; expressing machines and then one night we had the steam unit on. You know we 'steamed the nipples.'*
> *(Liz. Int. 9. Para. 8).*

Jan talked of her experience of her body producing milk for her first son, which included discussions about mastitis, homeopathy, antibiotics and a 'whole body' infection. Her narrative did not explore the experience of how it was to have a whole body that was infected; instead, she focused on treatments that were unsuccessful.

> *Once the milk came through it [the breast] didn't reduce in size so I was getting continual mastitis. We tried homeopathy and all sorts of things then we tried antibiotics but nothing worked and in the end my whole body became really infected.*
> *(Jan. Int. 13. Para. 6).*

Kate discussed her first experience with breastfeeding. She told how she struggled to comprehend that her body was producing anything that could nourish a baby. She spoke of how 'they' put him on the breast and that feeding was something that was happening to her body, not to her.

> *Breastfeeding - it was probably just after he [my son] was born when they actually put him on the breast, it was only colostrum obviously. It was one of the things I couldn't get my head around, like it's all happening to your body.*
> *(Kate. Int. 3. Para. 6).*

Kate went on to say that the infant had her functional, nurturing breasts on lease; in part, she knew and understood her body as an object that could be loaned to her infant, having previously shared it only with her partner. Whilst breastfeeding, the baby was in possession of the breasts.

> *What was yours as a couple is now a functioning organ, it's not even an organ, but it's a functioning part of your body that's nurturing your child. [My husband and I] we've got this big joke here that the baby's got them on lease, we will actually get them back into our relationship at some stage.*
> *(Kate. Int. 3. Para. 60).*

Mel reiterated this idea of breasts as objects that are capable of being shared, and felt that her breasts had ceased to be hers. Instead, they were an object that she could loan out to others.

> *You don't feel that your breasts are yours and you're certainly not sharing them with your husband (laugh). Sometimes it's like 'when will I get my body back? I'm not sharing it anymore'.*
> *(Mel. Int. 17. Para. 38).*

7.2.2 Understanding Objects

One could apply Heidegger's (1962) philosophy to these objective accounts of the body, interpreting the participants' narratives in light of his comments about *equipment*. It is important to note that Heidegger *never* intended for the human body to be seen as an object or *res extensa*; instead, his philosophical work was, in part, an attempt to destroy notions of Cartesian dualism. However, because of their inherited understandings, some of the women in this study came to know and understand their bodies within the context of a subject-object perspective. Therefore, an exploration of this abstraction is appropriate to fully

illustrate the participants' experience, because "in every case...interpretation is grounded in something we have in advance" (Heidegger, 1962, p. 191), and "an interpretation is never a presuppositionless apprehending of something presented to us" (Heidegger, 1962, p. 193). In this research, the women interpreted their experiences through the lens of the body as object.

The foundational concepts of how the participants came to understand and interpret breasts and breastfeeding were examined in Chapter Six. These concepts exhibit themselves in commonly-formed meanings that are developed as a result of our 'thrownness' in a world that already contains these commonly-formed meanings. Examples of this are found in the interpretations of the 'always-alreadyness' of breastfeeding, the breast as sexual, and breastfeeding as an intrinsic function of mothering, which were discussed previously. Such understandings form the basis for how these women interpret their bodies, breasts and breastfeeding. These commonly-formed meanings also form the basis for interpreting objects that appear in the world.

When interpreting the human body as *res extensa,* breasts are considered to be objects that can be manipulated, a concept that becomes increasingly evident when a woman desires to breastfeed. Within this framework, a woman needs to manipulate her object-breast to be able to breastfeed. To more fully explain how people experience objects or equipment, Heidegger (1962) discusses how objects are understood to be either 'ready-to-hand', 'present-at-hand' or 'unready-to-hand'.

7.2.3 Ready-to-Hand

'Ready-to-hand' describes how we proximally encounter entities or objects (Heidegger, 1962,p. 121). 'Ready-to-hand' occurs when one takes hold of an object and uses it. The object itself becomes transparent to us, and we focus on the outcome of what is being done rather than the object. All the women who participated in this study had breastfed; therefore, they all had the requisite bodily 'equipment' in the form of functioning breasts. To some extent the women understood and, therefore, encountered, their breasts as 'objects'. The following narratives emerged from the interviews with these women, some of whom spoke of the wonder that their bodies were able to nourish an infant. Those women who had become technically proficient at breastfeeding

exemplified the concept of 'ready-to-hand': the lactating 'breast' as an object became invisible, and what emerged as the focus for these women was that their breasts represented the nurturing or comforting of their baby.

Kay reported that the first time she breastfed the midwives put the baby to her breast and she was unable to remember the experience properly. Her body, her breast, was providing the milk to her baby without her being aware. Her breasts were 'ready-to-hand'.

> *I mean they put him on my breast, but I don't really remember it properly the first time because there's just so much emotions and everything happening so I really don't remember the couple of hours afterwards because you're on a high so to speak.*
> *(Kay. Int. 8. Para. 22).*

Kate spoke of how she could not comprehend that her body could produce milk that would nourish an infant. After she had given birth she saw visibly the effect that putting her infant on the breast had on her son; however, she denied any active involvement on her part.

> *It was outside my realms of comprehension, that I could even produce something that was going to feed the baby... but just putting him on the breast - that whole reflex action where he latched on... and here he was - instant calm and it was an instinct and it was right... it was totally passive on my part.*
> *(Kate. Int. 3. Para. 6).*

Liz discussed the fact that a woman's body will naturally produce milk after giving birth. As breasts are a 'ready-to-hand' part of a woman's body, she believed it encouraged being physically close to her baby, as much time was spent providing nourishment when her baby was very young.

> *Well it is something that your body simply does unless you stop it. I mean your milk does come in, it is a natural part of it [having a baby] especially in the initial days it's really the only contact that you have with your baby apart from cuddling her. Having the baby on the breast is really the time when you're sitting there, you're close to her, you're looking at her, and she's getting nourishment from you.*

(Liz. Int. 9. Para 50).

Liz also spoke of how she could just 'pop' out her 'ready-to-hand' breasts and feed her daughter. She commented how simple breastfeeding was in contrast to feeding an infant with formula, because the breast was 'ready-to-hand'.

> *It's so much easier when you just have the breast and you can be at somebody's place and just pop them out and away you go, whereas having to carry formula, boiled water and sterile bottles and [having to] shake them up, it's a fiddle.*
> *(Liz. Int. 9. Para. 18).*

7.2.4 'Unready-to-hand'

The 'unready-to-hand' mode of equipment is exhibited when an object ceases to work, or becomes problematic in a functional sense, and thus the transparent nature of the equipment that exists in the 'ready-to-hand' mode is suspended. The equipment becomes the focus, not the outcome (Heidegger, 1962; Plager, 1984). The concept of the breast being 'unready-to-hand' was illustrated numerous times during the participants' interviews. Prior to their breastfeeding experiences, many of the women had only encountered their breasts as sexual equipment; when their sexual breast became also a lactating breast, they experienced their breasts in a new and different manner. Many described how their breasts were 'unready-to-hand' in their new mothering role. They discussed how they had to become technically proficient at 'using' their functional breasts, and thus their focus was the breast, and becoming proficient at breastfeeding, not the outcome of breastfeeding. This mode of 'unready-to-hand' was especially dominant when a woman was struggling with the technical skill of handling the 'breastfeeding breast', which commonly occurred when the baby was less than three months of age.

Liz described how she had previously-held understandings of how the breastfeeding breast would be, and had expected her breasts to be 'ready-at-hand' when her infant was born. She was astonished that this was not the case, finding instead that her breasts were 'unready-to-hand', as her nipples were cracked and sore. She mused at her former naiveté.

> *I just always had the expectation that it would work and that it would be fine. And I was quite surprised by having these problems, they weren't little at the time, with the cracked nipple and the sore nipples, I really didn't expect them at all. I just expected him to start feeding and everything to be wonderful (laugh).*
> *(Liz. Int. 9. Para. 4).*

Eva wanted to latch her daughter on to her breast but struggled with 'unready-to-hand' nipples. She came to understand that breastfeeding is a skill both she and her baby had to learn. Through exposure to differing latching techniques, and information about nipple care and proper diets to ensure adequate supply, she gained knowledge on how to breastfeed. Eva had to purposefully practice a technique that would enable her baby to suckle and acquire milk from the breast.

> *I was faced with the situation where the baby was born and I wanted her to latch on but she couldn't really because my nipples weren't sticking out as much as they should have, it took quite a lot of work to get the technique right and to get the baby sucking them out... The first one and a half weeks we were learning about breastfeeding. The first thing I realised is that it doesn't come naturally at all. It's actually a skill that the baby has to learn and it's a skill that you have to learn. There are all sorts of different techniques that you get shown and different things work for different people, and then there's nipple management, how often and how long, your diet and all those sorts of things. It's tricky and it's really hard and you have to work at it and practice and practice and practice lots. It's only now, three months down the track, that I feel confident that we're doing it right, that she's getting enough, that she feels happy and I feel happy we're on demand feeding and it's really good.*
> *(Eva. Int. 19. Para. 6 & 7).*

Sam struggled to get her son latched onto her breast, trying many different techniques suggested by her midwife. She discussed how both she and her son struggled with breasts that were 'unready-to-hand', but two weeks after the birth they managed to make breastfeeding work.

> *We were doing all sorts of tricks like, expressing a little bit first and we were even dribbling water into his mouth so that he was getting*

> *something to kind-of keep him satisfied. Every trick in the book we were using and then that morning, for some reason, he latched on fine and then continued to and he's been fine ever since... kind-of, I mean that we've both got better at it.*
> *(Sam. Int. 12. Para. 8).*

The first time that Lee fed her son she was completely focused on the technique rather than on the outcome of breastfeeding. She felt that she 'obsessed' over acquiring this new skill so that, in the first week of her son's life, the mechanism for feeding her son, her breasts, were 'unready-to-hand'. However, Lee went on to describe how, once she had mastered the act of breastfeeding, she ceased to think about the mechanical and was able to focus on those entities that lay beyond the need to provide her son with essential nutrition.

> *I was thinking the whole time really about the mechanics of it and whether I was breastfeeding properly, and that was probably the first week that he was alive. They became sort of obsessive thoughts – 'are you holding him properly, are the lips right, is the nipple drawn right back' you know all those things because it's all new to you... In the beginning, whenever you start a new job or task you start thinking about the mechanics and whether you're doing it right, and your mind gets fixed on all those sorts of things and you don't see outside of that but once you master it then you start thinking about other things.*
> *(Lee. Int. 10. Para. 18 & 19).*

7.2.5 'Present-at-hand'

'Present-at-hand' describes entities that we experience by going through entities that we have proximally encountered (Heidegger, 1962). "Things that are 'present-at-hand' only become visible when those entities that are 'ready-to-hand' become transparent" (Inwood, 1999, p. 214). Once the women had become proficient in managing their 'functional breast' and 'breastfeeding', they were able to navigate their way through the proximally-encountered equipment and focus on those things that lay beyond. The women's focus dwelt with those entities that were more metaphysical in nature: the comforting nature of breastfeeding breasts for their infant, and being able to visibly see the infant's body grow.

Lee spoke of how enjoyable breastfeeding became for her once she became confident in providing for her baby's nutritional needs through breastfeeding. What emerged as 'present-at-hand' through breastfeeding was the chance to sit and be close to her infant. Breastfeeding afforded her the opportunity to develop her relationship with her son, a relationship that brought her satisfaction.

> *Once I was very confident with breastfeeding him, probably by the time he was about six weeks old, then I started to really enjoy it as a lovely time when you're holding your baby really close. Having a chance to sit down for a while and hold him and talk to him. You know [it is] a really pleasurable experience.*
> *(Lee. Int. 10. Para. 20).*

Liz reinforced the idea that, when she was not anxious about the technical act of using breasts to feed, she gained access to the 'present-at-hand' experience of breastfeeding as pleasurable. She spoke of how she enjoyed meeting her daughter's nutritional needs, whilst providing a relational connection between both mother and daughter through the physical touch involved with breastfeeding.

> *You are her [the baby's] source of nourishment. You're giving her the best food that she can have and you're giving her that contact with you, which is so lovely. To be at the breast is lovely for both her and me.*
> *(Liz. Int. 9. Para. 52).*

Eva spoke of how pleasurable it was to see the benefits of breastfeeding. The breast in its 'present-at-hand' mode became physical growth and health for her daughter, a mode that emerged only as Eva became proficient at breastfeeding.

> *Just looking at her [my daughter] growing and looking so healthy, she hasn't been sick at all, almost all the weight she's put on has been from me and it's such a satisfactory feeling.*
> *(Eva. Int. 19. Para. 11).*

These narratives have examined how the body has been interpreted as *res extensa*, or extended thing, by the participants. This way of interpreting the body has been inherited and is exhibited through the language available in the

subject-object discourse. It has had a significant influence on the way in which we understand the human body, including breasts. Exploring the women's narratives through Heidegger's (1962) understanding of how people interpret objects has offered a depiction of how women can come to know their breasts and breastfeeding.

7.3 Summary

Concepts of how people understand and access equipment are useful when exploring women's narratives about breastfeeding. Because we have inherited an understanding of the body as an object, Heidegger's (1962) thesis on how humans approach objects has offered some insights into the being of a breastfeeding woman. However, this approach fails to take into account embodied[24] understandings of experience, and continues to relegate bodily-based intelligence as inferior to that of the mind. If women's experience of breastfeeding is to be more fully explored, a different perspective on how we experience our bodies is needed. Therefore, the following chapter explores how an embodied interpretation of women's breastfeeding experience allows the emergence of a meaningful understanding of the being of a breastfeeding woman.

[24] Embodiment describes how we exist and understand existence through a lived body capable of both physical movements and non-physical reasoning, through which we gain meaning (Merleau-Ponty, 1981). See Chapter Four, Section 4.4.3 for additional information.

Chapter Eight

The Embodied Experience of Breastfeeding

8.1 Introduction

The concept of Cartesian Dualism provides a lens through which to interpret the body as an object. As described in Chapter Seven, this way of understanding the body has informed women's understandings of their breastfeeding experience. However, breastfeeding is undeniably an embodied experience and, as such, the language embedded in the subject-object tradition is inadequate to describe its depth. When attending to embodied narratives, women's experience of breastfeeding becomes an experience of embarrassment, pain and tiredness. It becomes an experience with the fear of failing, and feelings of guilt if women perceive that they have 'failed' at breastfeeding. The experience of breastfeeding can ultimately leave a woman feeling emotionally crippled.

This chapter describes the embodied experience of breastfeeding, centering on the process of establishing breastfeeding. It begins by highlighting the philosophical basis for the concept of embodiment, and then proceeds to explore how embodied breastfeeding experiences are silenced in the everyday language available to describe breastfeeding. Women's initial breastfeeding experiences are then explored through narratives that describe breastfeeding as a painful and tiring process. Exploration of the narratives highlights how the women participating in this study were anxious about being successful at breastfeeding, and how they struggled with feelings of guilt if they were unable to successfully establish breastfeeding. This chapter concludes with the participants' discussions about the emotional impact of not being able to breastfeed.

8.2 Philosophical Underpinnings

It can be argued that interpreting women's experience through an object-subject lens is a superficial way of dealing with the depth of their experience of breastfeeding, as only some specific facets of the experience can be explored, thereby limiting the discussion and prohibiting the emergence of a fuller understanding of what it is to be a breastfeeding woman. Any interpretation that is limited by the subject-object lens neglects to expound on the experience of existence; in consequence, such interpretations close down upon the opportunity to gain a full understanding of the lifeworld. It is this failure that led philosophers such as Heidegger (1962), Gadamer (1989) and Merleau-Ponty (1981) to argue that the Cartesian approach to explaining existence inadequately articulates and describes the lifeworld, as it is from our embodiment that we experience the lifeworld (Robertson-Malt, 1999).

Heidegger desired to "reverse the Cartesian tradition by making the individual subject somehow dependent upon shared social practices" (Dreyfus, 1991, p. 14). Heidegger (1962) claimed that 'subject' and 'object' can only exist and be experienced through the contextualisation of 'being-in-the-world' and therefore it is only in acknowledging this ontological position that anything is capable of being understood. He further argued that being is existence, and that the source of meaning, or significance for being, replaces the individual subject (Dreyfus, 1991; Heidegger, 1962; Inwood, 1999). The Cartesian tradition claims that the source of meaning is always the mind; however, this belief is still grounded in subjective experience, and ultimately cannot be sustained in the light of the development of this ontological perspective (Dreyfus, 1991).

Gadamer (1996) argued that any objectification of our bodies "demands of all of us a violent estrangement from ourselves" (p.70). He claims that all the kinaesthetic phenomena that are experienced by the body require attention, as this is an essential task of our 'being-in-the-world'.

Merleau-Ponty (1981) argued for an embodied interpretation of human beings, espousing that he could not "understand the function of the living body except by enacting it myself, and except in so far as I am a body which rises towards the world" (Merleau-Ponty, 1981, p. 75). He believed that the body was not an 'amalgamation' of the subject and object; instead, the union is a constantly-

present part of existence. In the *Phenomenology of Perception* (Merleau-Ponty, 1981) he wrote: "We need to reawaken our experience of the world as it appears to us in so far as we are in the world through our body, and as far as we perceive the world with our body" (p. 206).

For Merleau-Ponty (1962), the lifeworld is a world that we have access to through our bodies. He stated that "it is through my body I go into the world" (Merleau-Ponty, 1962, p. 316), thus espousing that we do not have a body that can be utilised as an object; instead, we are a body. Because we have inherited a historical way of interpreting our body as an object, understanding the embodied body is a difficult undertaking (Dahlberg et al., 2001). To fully understand the lifeworld, it must be interpreted from an embodied perspective, because "we cannot step outside the body, instead, we experience it from both inside and outside simultaneously" (Dahlberg et al., 2001, p. 51). It is the body that is constantly perceived, always present, and moves towards the world in a meaningful manner (Merleau-Ponty, 1962, p. 92). The body grasps the world through intentionally navigating its way within the world, and thus the body gains access to the meaningful (Leder, 1984; Leonard, 1994). The embodied person dwells in a "culture and particular lifeworld that enable the cultural meanings to be inscribed on the body" (Benner, 2000, p. 8), and thus we come to understand the world.

As stated previously, the women who participated in this study began narrating their breastfeeding experience by employing the language embedded in the subject-object discourse. However, as they sought to explore and articulate the effects of their breastfeeding experience, it became evident that the subject-object language was inadequate to describe the depth of that experience. Instead, their descriptions turned to that of an embodied experience of lived breastfeeding. The examination of this embodied experience begins with an exploration of the hidden nature of the phenomenon.

8.3 A Hidden Story

Mothering is an experience often veiled in secrecy; neither the positive nor negative aspects of what it is to be a mother are often discussed between women who have given birth (Maushart, 1999; Swigart, 1998). Furthermore,

embodied knowledge of what it is to be a mother is not extended to women who are pregnant with their first child. The women who participated in this study commented that the embodied experience of breastfeeding, which can be viewed as an integral part of mothering, was also silenced. The embodied experience of breastfeeding is therefore a hidden experience as described by Mel in the following narrative. Prior to breastfeeding she had perceived that breastfeeding was an easy aspect of mothering; however, once she engaged in the act of breastfeeding she discovered that her assumptions had led to unrealistic expectations.

> *When you breastfeed you just assume 'I'm breastfeeding, what could go wrong?' They don't tell you that it's so hard... You couldn't even get them [the baby] latched on and no one tells you that you can experience that. No one prepares you.*
> *(Mel. Int. 17. Para. 24).*

Sue struggled with what she described as a lack of milk, which she could not resolve no matter how many hours she let her son 'graze' at the breast. She spoke passionately of the hidden stories about breastfeeding, and the associated pitfalls, which led her to believe she was, in some respects, inadequate.

> *I'm angry in some respects that the downfalls of breastfeeding are not told to you at all. It's a real slap in the face, you think that there's something wrong with you because it's [breastfeeding] not happening for you.*
> *(Sue. Int. 6. Para. 80).*

Later in the interview, Sue further reflected on the lack of information about the difficulties of breastfeeding, articulating how this can negatively affect one's experience with breastfeeding and limit opportunities to overcome complications that one may encounter.

> *There's no information to tell you what to do if it [breastfeeding] doesn't work. If it isn't for your mother or a friend who's had a similar problem you'd be totally at sea really. It's not fair.*
> *(Sue. Int. 6. Para. 100).*

Eva contemplated why the experience of breastfeeding was hidden from the public domain. She spoke about how women do not wish to disclose their experiences due to a 'stigma' that surrounds the topic of birth and breastfeeding, and that the only acceptable place to voice one's experience with breastfeeding difficulties is with those who have already lived the experiences of birth and breastfeeding.

> *The question is really why don't people talk about the difficulty of breastfeeding? There is definitely a stigma attached to that and I only discuss those things with a very elite circle of people who are in exactly the same situation as I am, like other young mothers... I think of all the people that I know that have had babies not one of them talked about the pain of birth, not one of them, or of breastfeeding difficulties. I would have been a perfect candidate for listening but no one chose to share that information. I'm still trying to figure out why.*
> *(Eva. Int. 19. Para. 23).*

This statement might reflect the difficulty women have in articulating their embodied experiences due to such things as a fear of being perceived as a failure. It might also be indicative of life experiences that are beyond our capacity to articulate because the language we possess is inadequate for portraying the essence of the phenomenon. Also, breastfeeding could be considered to be a rite of passage, which is similar to the manner in which giving birth is sometimes perceived (Maushart, 1999; Swigart, 1998). It is hoped that, through the thoughtful analysis of these women's experiences, insight might be gained into the lifeworld of a mother who chooses to breastfeed.

For the women who participated in this study, the embodied experience of breastfeeding involved encountering embarrassment, pain, and fatigue. The fear of failing to breastfeed was also a re-occurring theme in the women's narratives – if a woman weaned her infant prematurely, she experienced feelings of guilt, described by one participant as emotionally crippling. The embodied experience of breastfeeding begins when a woman gives birth and begins to breastfeed her infant, and is revealed in the participants' narratives about their first breastfeeding experiences.

8.4 First Pictures

The arrival of a newborn marks the beginning of a new era of embodied experience for a woman. It makes no difference whether this is her first or seventh child – each experience is unique. Therefore, her embodied experiences that result from her relationship with this new infant will provide her with new understandings of the lifeworld.

For many, a part of mothering a new baby is breastfeeding, and the first time a woman puts her baby to her breast is an experience that is often vividly remembered. These encounters are *embodied experiences.* The following interpretative account starts at the beginning and explores the participants' experiences as they emerge from this first picture of what it is to be a woman who breastfeeds. These first pictures provide a glimpse of the complex fabric that makes up the complete experience of breastfeeding. These first breastfeeds offered by women to their newborns provided the participants with an initial understanding of what it is to be a breastfeeding woman, but are not necessarily an indication of the path upon which their decision to breastfeed would take them.

Sue's first breastfeeding experience was an experience with newness. She managed, with some difficulty, to get her newborn son latched on to her newly lactating breast, and spoke of how the midwife made the experience positive for her as a new mother. This first picture reflects how, as a new mother, Sue struggled to acquire the embodied knowledge that enabled her to establish breastfeeding; however, she marvelled that her new baby appeared to have embodied knowledge about how to breastfeed.

> *It was just after he [my son] was born. The midwife at the hospital was delightful, she was great. And she handed my baby and I said 'Oh yes so we're supposed to feed him aren't we' and she said 'yes' and she showed me how, she was good. And she [the midwife] tried to show me lying down, which I found really difficult. She decided that I had floppy boobs so I had to hold my boob (laugh), which was really hard to. You know, you've got this newborn baby, you're a new mother and you're trying to hold your breast as well, and that whole process it was tricky but we succeeded and he latched on really well and the comment then*

was that he [my son] was going to be a really good feeder because he was straight into it, he latched on and was aware.
(Sue. Int. 6. Para. 42).

In contrast to Sue's experience, Emma felt uncomfortable about her first breastfeeding experience. She was aware of being with a number of people and was concerned about her body being exposed. Emma was also mindful of being touched; although she understood that the midwife was trying to help, she wanted to reclaim her body before attempting to breastfeed her son.

My first memory would be - having a whole lot of people in the room and I was thinking how am I meant to hide it (laugh), I didn't want to flash it all off to my father. That was my biggest thing. Then having the midwife poking and prodding your breasts while you're trying to, you know [start to breastfeed]. That whole night was horrible. She [the midwife] was making sure that you were doing it right and stuff, which was really good, but you've been poked and prodded everywhere else then you've got to put up with that as well.
(Emma. Int. 14. Para. 10).

Sam's initial experience of breastfeeding involved a great deal of input from the hospital staff, some of which made her uncomfortable. She spoke of one particular event in which a midwife attempted to force her infant onto her breast, despite both Sam and her infant being upset at the time. Over the subsequent two-week period, Sam struggled to get her son to feed from her breast and was only successful after significant input from other health care professionals, and the use of multiple 'tricks'. At the end of the interview, Sam returned to her initial experience and spoke once again of how negative it had been for her as a new mother. She attended to the vulnerability of a new mother who might not know what was best, nor have the power to speak up against the actions of a health care professional.

We had quite a long labour and the midwife put him [my son] to the breast pretty much straight afterwards but he wasn't interested. Then we stayed in the hospital for the night and had no luck breastfeeding there either. And had actually had a fairly awful experience during the night with a midwife who was determined to get him to the breast, and he was screaming and I was really upset. I could tell, even though I'd

never done it before that this was not going to work… He [the baby] was just too upset to be able to latch on. She was grabbing his head and forcing him and he just screamed more and I just got more and more upset and she was getting really impatient with us. That was our first experience, which didn't really bode well for the future.

While we're speaking about health care professionals I do still blame almost that first awful midwife at the hospital because I think that made our first experience of breastfeeding so hellish. I will never know but I wouldn't be surprised if it scared him off it for the first little while, the first two weeks. It certainly had a hugely negative impact on me. If that one thing had never happened I wonder how much more smoothly the process might have gone… which is a shame because I wonder how many other women she has done that to and is still doing that to. Given that that was my first time I didn't know that it wasn't supposed to be like that.
(Sam. Int. 12. Para. 2, 4 & 122).

During her interview, Jan initially provided a very objective, medically-oriented summary account of her experience with breastfeeding, after which she offered the following description of her first night as a mother.

I had my son in the evening and went up to the ward and saw a nurse when we got there but then didn't see another nurse until six am. I didn't know whether I was supposed to wake him to feed him, when he's crying am I supposed to feed him? Am I supposed to feed or settle him or whatever? And if you pushed the buzzer no one came, and the same in the morning, I waited about an hour for someone to come. And again I didn't know…I assumed that you're supposed to breastfeed, but didn't really know how to go about it and so just tried, and didn't really get on very well. I thought 'Oh well I'll do this later I 'spose.'… [It was] terrible, terrible. I thought I was the hardest done by person in the whole world really, just because you want to get it right, it's just so new and you're very nervous, really, really nervous, and frightened that you're going to do something wrong, something that may affect your child. I found it awful.
(Jan. Int. 13. Paragraphs 18 & 20).

Prior to giving birth, Jan was employed as a regional manager of a large company, a position she described as being both very time intensive and stressful; hence, she is a woman well-placed to handle stressful circumstances. However, in the above narrative she clearly articulates the anxiety she experienced in her new role as a mother, her main concern being to provide the best for her son. Being unsure of what the 'best' was, she attempted to refer to those who would know best – the midwives. Instead of receiving the guidance she desired, her avenue for gaining support was closed down upon. Jan described her anxiety at being unable to gain support from health care professionals by calling on the words *terrible*, *nervous*, *frightened* and *awful*. Later in the interview, she offered the following statement reflecting on the embodied knowledge she had gained through her initial experiences as a breastfeeding mother.

> *So it's very hard for a new breastfeeding person... because you don't know which is the right way, or the best way, the best way for you. That's your first lesson with little people is that they're unpredictable and that there is no best way for lots of things. It's very hard for someone who has been in control before because it's so out of control and you don't have a yes or a no, or a right or a wrong.*
> *(Jan. Int. 13. Para. 65).*

In contrast to Jan's struggle to gain confidence in mothering, Mai had her first child more than a decade before the arrival of her second. Mai was working as a registered nurse and was comfortable in her knowledge of caring for infants. However, this knowledge could not have prepared her for the birth of her young daughter at 25 weeks gestation because of intrauterine growth retardation. Her daughter weighed one pound at birth. Mai was determined that everything possible should be done to ensure her daughter's survival, and resolved to express breastmilk for her even though initially she was only being fed through a nasogastric tube. She spoke about the first time she sat down to use a pump to express her breastmilk.

> *I felt sad. I said to myself "this isn't how it's [breastfeeding] meant to be." Especially when my first baby, I managed to breastfeed straight away in the hospital. I wanted to put her [my daughter] straight onto my breast.*
> *(Mai. Int. 4. Para. 88).*

Sometime later Mai had the opportunity to feed her daughter the way she intended to when she gave birth. In the following narrative, she describes how it was for her to finally be able to put her little girl to her breast for the first time.

> *I had been told by the doctors and the paediatrician told me that she [my daughter] is not going to make it. There we were all stacking these containers of breastmilk. For the first few days they had to hold off the breastmilk, glucose was basically what she was having for the first few days before they started feeding her with the nasogastric feedings. And finally I get the chance, I get to latch her onto my breasts... She was a tiny little thing, I was overwhelmed (laugh). My breast was larger than this little thing sucking away on them. It was such a lovely feeling from then on. The nurses didn't believe that she would be able to suck like that. We were encouraged not to have her too long on the breast because she had to conserve her energy to grow. It's hard work sucking away, you know this tiny little thing so... She wasn't even a kilo when we came there, but then I think she was just over a kilo when I thought I'll give you a go... Like what I was saying my breasts were bigger than her (laugh), from then on I just kept it [breastfeeding] up. They kept saying that she had to conserve her energy as much as possible in order to grow but I couldn't help it. I couldn't help it I just thought this was the best way to bond with my baby, to put her on the breast.*
>
> *Well - first of all it was quite emotional. It was quite emotional, not only that, I was quite emotional thinking that 'Oh she [my daughter] is so young, so small but look at her sucking away.' She knew, she's tasted it, and [she thought] 'this is different from what I'm getting through my nostrils, through my nasogastric, it tastes the same, but it's a different way.' I was just amazed actually just looking at her, and also emotional as well looking at that tiny little thing sucking away. Mixed emotions actually. Well I was quite emotional and they [the nurses] said 'you'd better stop now' but I still wanted to carry on breastfeeding. It was lovely, it [was] hard to start off with but it was the best experience about (laugh).*
> *(Mai. Int. 4. Para. 8, 10-12 & 90).*

Mai had previously experienced breastfeeding, and understood it as starting immediately following birth. Having to wait to breastfeed meant setting aside

her previously-held understandings about how breastfeeding should be established. However, once she was able to bring her tiny daughter to her breast, Mai was overcome with emotion, in part due to of her daughter's strength and determination. Her initial experience of breastfeeding her daughter was a defining moment in her life; Mai understood and experienced breastfeeding as a powerful embodied experience that underpins the coming-together of a mother and her infant both physically and relationally. It was, for Mai, an experience forged through perseverance, which she described as the 'best' of embodied experiences – a moment when her potential for being was revealed and experienced as full and rich.

Although women's initial embodied breastfeeding experiences are varied in nature, they all hold significance and meaning when attempting to understand what it is to be a breastfeeding woman. New experiences offer access to a world that will be forevermore differentiated; 'being' is revealed at the point at which one acquires access to new experiences. For the participants in this study, the birthing of a new type of 'differentiated being', attained through breastfeeding, meant that they felt uncomfortable and struggled with feelings of embarrassment.

8.5 Breastfeeding as an Experience with Embarrassment

A common theme in the participants' narratives is the struggle, at least initially, with embarrassment at breastfeeding in the presence of others. Having a health care professional touching their breasts in such an invasive manner, whilst being watched by family members or friends, was both daunting and distressing for these new mothers. Breastfeeding required women to behave in a way that was foreign, as their chosen way of being-in-the-world had not previously included exposing their breasts in such a public manner. During their initial breastfeeding experiences, women were exposed to different-ways-of-being that left them feeling uncomfortable and vulnerable. These feelings of embarrassment negatively coloured their breastfeeding experience, hindering their ability to initiate breastfeeding.

Emma spoke of being conscious of her body after giving birth, and in the presence of others she felt concerned about what was being exposed; her

chosen way of being-in-the-world precluded her from accepting 'other' touching and viewing her in a close and intimate way. Attempting to breastfeed a young infant for the first time, her concern was a calling to focus on nurturing her infant; instead, she felt called to attend to people who could potentially observe her body in a manner that was unfamiliar to her. She likened this experience to being on stage naked – she felt exposed and vulnerable whilst trying to master a new skill. This feeling extended beyond that initial experience in the hospital, through the first month of her baby's life.

> *Just getting cleaned up would have been nice. You're conscious of your body… whether you're still bleeding all over the show and what parts of you are hidden or what's covered. While you're giving birth you don't care what you're showing but, once the [baby is] out the modesty starts kicking in… You've never had to sit there completely topless in front of everyone before and try and carry on as normal. When you start , you can't, you've got to flop everything out and it's a major mission to get it in the baby's mouth, it's hardly discrete…*
>
> *It [breastfeeding] just made me uncomfortable but I'm finding now that most people realise that and they'll turn away while you're trying to get yourself sorted… Especially that first month when you're trying to get to know how to do it and it's horrible to have someone sitting there watching you, it's like being on stage naked… I find men will walk out of the room, but other women will watch especially if they've had babies. (Emma. Int. 14. Para. 21-31).*

This experience of breastfeeding exposure was also shared by Debbie, who spoke of how difficult it was to be observed while struggling to breastfeed. She believed that having another bear witness to her struggle allowed others insight into her inability to cope with breastfeeding. Her way of being-in-the-world did not allow her to have others witness her struggling, because it meant she was not achieving what she perceived to be an appropriate standard of parenting. Debbie wanted to veil from others her experience of breastfeeding her son as her struggle spoke of failure as a parent.

> *It was really embarrassing because he wouldn't latch on so it was taking me five to ten minutes to get him on each time. He'd always go on but that time, especially when you had someone there, which you do when*

you first have them because there's all these visitors, and you're trying to latch him on and hide yourself as well and he's screaming... My dad's wife, came in and helped me latch him on which was really good and I had a girlfriend there, who's a good friend, but it was hard having her watch me struggle so much especially because I didn't know what I was doing either, my baby and I didn't know what we were doing. So I found that really hard... I wanted everyone to go away because I was not coping. Everyone would just sit and watch you and even if I went to the bedroom I would have people follow me in and it was like 'go away' cause it was such a struggle... But not the struggling part. I guess it's the whole good parenting stigma - you can cope and that sort of thing. I wasn't coping at all because I burst into tears every time I latched him on, it was so sore because he had made such a mess of them. Each time I'd put him on I'd just about scream and it's hard to keep a smiley face in front of your visitors when you're doing that.
(Debbie. Int. 15. Para. 33-39 & 46).

Debbie described her embodied experience with breastfeeding as involving not only embarrassment but also pain. The experience of breastfeeding as painful was a recurring theme throughout the participants' narratives.

8.6 Breastfeeding as an Experience with Pain

In a world without pain we feel light, and participation in life is effortless (Gadamer, 1996); however, for the majority of women who participated in this study, breastfeeding was an experience with pain in the form of engorgement, as well as sore and cracked nipples. According to Gadamer (1996, p. 75) pain alienates one from him/herself: "pain causes us to withdraw from all external experience of the world and turn us back upon ourselves". Breastfeeding pain meant that the women turned back in upon themselves, withdrawing from external social experiences as a result. Sometimes, because of the severity of the pain experienced, some women brought their breastfeeding experience to an end. For others, breastfeeding pain became something to conquer and overcome. Irrespective of the outcome, pain is always an embodied experience that has meaning, that forms the basis of interpretations offered by the women.

For some of the participants in this study, their first experience of breastfeeding pain was associated with engorgement, a process that most commonly occurs in the initial few days of breastfeeding. The breasts swell due to increased blood supply and the production of milk (Lawrence & Lawrence, 1999; Renfrew, Woolridge, & Ross-McGill, 2000). It is reported that engorgement is a time-limited event that is manageable by frequent infant feeding, manual expression of breastmilk and the application of ice packs (Lawrence & Lawrence, 1999). However, these descriptions of engorgement do not relay how it is to be the woman undergoing the embodied experience of engorgement. The following narratives provide some insight into this experience.

For Cathy, engorgement was described using the words *blown-up*, *balloon*, *uncomfortable*, *sore* and *awful.* She also spoke of how being engorged made latching her daughter onto her breast extremely difficult.

> *The third day was absolutely awful because you're blown up like a balloon (laugh) and they're underneath your arms, and they're meeting together in the middle, and they're just so sore and uncomfortable and you just feel awful. And, because they were so engorged she couldn't latch on. The Lactation Consultant came in and spoke to me for a while and showed me what to do but that was very painful because I was so engorged.*
> *(Cathy. Int. 18. Para. 8).*

Kate described her experience attempting to feed her infant when her breasts were engorged with the following narrative, in which she explains why her embodied experience of engorgement was the lowest moment of breastfeeding her son.

> *Trying to get a baby latched on an engorged breast - for god's sake - I heard someone say it's like trying to get your lips around a brick wall.*

> *My milk kicked in when I got home [from hospital], now I was not at all prepared, I thought I was getting mastitis. I knew I would come home and you'd be all blown up but I wasn't prepared for the lumps or for it to be so sore. The first night home with the baby he was up all night basically. I must've been up just about every hour. He [my son] was suckling at one end and just pouring out the other, which apparently*

does happen sometimes when the [breastmilk] goes from colostrum to milk. I didn't realise that, and the next morning I just thought I don't want to do this, I can't. I was staring down the next 20 years of looking after this child and it was just going to leave me feeling like I felt that next morning. I thought well why couldn't they keep me in hospital just one more night so I could just have someone there to say that this is normal, don't worry about this.
(Kate. Int. 3. Para. 44 & 50).

Pain was also a part of Kay's experience with breastfeeding. She relayed how on the fourth day after giving birth she wanted to stop breastfeeding, but then learned the best way of reducing the pain related to engorgement and blocked ducts was to feed her infant. She realised that not only was she responsible for feeding her baby, she was also responsible for healing herself.

I was in pain. I was in agony. I had blocked ducts as well and that's quite painful. And the best way to get rid of it is to get the baby to feed or by expressing, but it was so painful, expressing really hurt me. The baby actually made it better but you had to help yourself, the ducts are all backed up and you have to massage to try and clear them out, and it was really hard. But I was lucky, I didn't go through what a lot of women go through with cracked, sore, red, ripped nipples… I was lucky on that side of it.
(Kay. Int. 8. Para. 10).

Later in the interview, Kay returned to the pain she was experiencing on that fourth day post-delivery because of being engorged, and spoke of how difficult it was at the time to see past the moment, because her embodied experience was that of being emotionally overwhelmed, weary and in agony.

At that time all I could think about was the pain in myself. You [are] not thinking rationally, because everything that you've gone through it all catches up to you... all you can think about is right there and the pain and the agony... deep down I really didn't want to put him on the bottle. He didn't go on formula in the end and I'm really glad he didn't.
(Kay. Int. 8. Para. 34).

In western society we have come to understand that pain can be managed and resolved by accessing medical assistance. However, the pain associated with breastfeeding is not always easily resolved, and primarily requires a woman to take action to heal herself as highlighted in the above narrative from Kay. Unfortunately, this knowledge is not always available to women; instead, they turn to that which they have previously understood to provide a solution – treatment by health care professionals. Gadamer (1996) points out that uncertainty about the duration of pain results in suffering, eventually leading to a change in character as a person attempts to cope. This is a concept that is revealed in women's narratives about pain that persists over time.

The nipple is the most sensitive part of the breast, and therefore is more susceptible to producing painful stimulus when the integrity of the skin is impaired (Lawrence & Lawrence, 1999). When a woman initiates breastfeeding it is not unusual to experience pain, especially if the infant's positioning at the breast is less than optimal (Page et al., 2003; Renfrew et al., 2000). All the women who participated in this study spoke of how, at some point, they experienced pain associated with breastfeeding, most commonly associated with sore and cracked nipples.

Lee had attended antenatal breastfeeding classes prior to giving birth, so that she would not have difficulty breastfeeding. She had gained an understanding that positioning was intimately linked with cracked nipples and the pain associated with breastfeeding; however, the first time she fed, she discovered that the information she had received was not correct, and thus she felt betrayed by her educators and friends. This was the first step in beginning to understand that she had to take ownership of healing herself.

Despite her cautious positioning, Lee developed significant cracks in her left nipple, leaving her stunned that her efforts at prevention had failed. She employed nipple shields to reduce the pain associated with latching, but was castigated by her midwife for this. Lee spoke of how she withdrew from the advice offered by the midwife, choosing instead to inwardly endure the pain using the only thing that gave her relief – a nipple shield. She discovered that she was capable of persevering through breastfeeding pain; when the cracks finally healed, she was able to enjoy the experience of breastfeeding her son, which she continued for 15 months.

I felt that I was quite well prepared but the first feed was very, very uncomfortable, and my nipples were really sore. I was really surprised how hard he [my son] sucked and how sore it was. I was surprised by that because I thought if you had the baby properly positioned it didn't hurt... From what I'd heard painful feeding only came through bad positioning. I had my friend and the midwife helping with the positioning and checking it and everything like that. They both said that the positioning was fine so I felt slightly cheated that it [breastfeeding] was sore.

My left nipple got really cracked really badly. I'd tried so hard to get good positioning and gone to the class and learnt all about it. Every time I fed him [my son], I thought all the things that they tell you; chest to chest, chin to breast and checked it so carefully. I think it [the nipple] got cracked through him being latched on and pulling away and shaking his head at the same time. The crack was really bad; it was about half way around the nipple, and a couple of millimetres in and it was weepy and horrible and so when he was about a week old I went and got some breast shields. And I found that I was feeding well with them again. I guess it was a combination of the breast shields, it wasn't so painful because it was really painful with him latching on with the cracked nipple, and also the milk sort of settling down to a normal supply after being engorged. So then I fed through the breast shield on the left side for about four weeks. I remember one day the midwife came around and I was feeding with the breast shield and she said "that has to go, the baby won't be getting enough milk". And I just looked at her and I just thought 'you are mad!' (Laugh). There was no way I was giving it away, it was just so painful feeding without it. I thought 'I can't cope without it and he was feeding fine with it and I feel fine and he was thriving, he wasn't losing weight or anything, so I'm not going to worry about it'.

Well gradually the crack healed. I remember the first time that I fed without the shield, it had healed up quite a bit but it gaped open that very first time. I looked at it and I was so disappointed, you know, because I thought it was healing really nicely and that I was going to be able to feed without the shield. The only hassle feeding with the shields is that it's a real pain putting them on because you have to use K-Y Jelly and

> *you've got to boil them after every feed. The baby would wake up and he'd be crying and all of a sudden you've got all this fiddle, so that was a pain. So I was really glad when the crack healed up and the soreness stopped. Even on the right side that wasn't cracked I found the nipple really tender especially the first, sort of, ten sucks of the feed would be very uncomfortable. I'd be, sort of, sitting there gritting my teeth. But as soon as that all settled down I was really happy with feeding.*
> *(Lee. Int. 10. Para. 12, 22 & 24).*

Gadamer (1996) describes pain as an oppressive weight that forces us down, dragging us under. This sense of being dragged down by breastfeeding pain prevented some of the participants from continuing with breastfeeding their infant. Liz experienced a great deal of pain due to cracked nipples after a few days of feeding her new daughter. She spoke of pain and bleeding at each feed, and even her mother's coaching did not help her cope.

> *The nipples were still incredibly sore, both of them, and the left one in particular bled quite a lot, and that was horrible. [My daughter would] start to feed and I'd be in agony. Mum would say "Count to twenty" and I'd be up to 30, going "31, 32, 33" and then you'd look down and there'd be blood all through it [the breastmilk]. That was all a bit horrendous.*
> *(Liz. Int. 9. Para. 16).*

As described above, feeding her daughter was a painful feat for Liz, made especially difficult because she had flat nipples and her daughter would not latch properly. Liz spoke of how fearful she was of the pain associated with latching. Breastfeeding pain was a deterrent to breastfeeding; it meant that life ceased to be the light and effortless experience it had previously been, and stopped her from enjoying contact with her new daughter. Liz struggled to overcome the pain by using nipple shields, and was eventually able to feed her daughter without them.

> *[The breasts] they're so hard. She [my daughter] just wasn't having a bar of it. And the [midwives] said it was a combination of my [flat] nipples and her latching. And if she'd been a better latcher it would have pulled it [the nipples] out and it would've been fine but the combination of the two meant that it was really an uphill battle... I was scared of pain, and it is, a slight barrier to [breastfeeding]. I found that latching on every*

time I would be tense because I was prepared for a lot of pain. It was an ordeal, especially in the initial minute. You'd be sort of thinking 'Oh my god, oh my god this hurts' so I didn't really have a chance to enjoy the skin-to-skin contact. I was thrilled that I'd passed that hurdle because when I left the hospital I thought I would never be able to feed, and well I'd be expressing and it would be bottles and expressing and trauma. So there was a series of steps and another step was getting rid of the nipple shields and wow, fantastic, I've got rid of them and it's such a big leap forward and it's only been two weeks.
(Liz. Int. 9. Para. 16 & 18).

Cathy had weaned her previous child early and was determined to breastfeed her new daughter; however, she described her embodied experience of breastfeeding her daughter as excruciating – more painful than having mastitis. She came to understand breastfeeding as intolerable, but felt trapped by her desperation to breastfeed.

For Cathy, life with breastfeeding meant being forced to carry an oppressive weight that she was unable to cope with, and eventually her embodied experience of pain overwhelmed her desire to continue. When she felt she could no longer cope, she spoke about weaning to her husband, who suggested that she just needed to persevere. In the face of what she had already struggled through, her husband's response was crippling; Cathy's breastfeeding experience had stripped her of hope and undermined her ability to mother.

She [my daughter] was quite unsettled and I was in excruciating pain and I would have to have anything, a toy, or my clothes to bite on to try and stop, dull the pain before I would latch her on again... The day that I got it, mastitis is very, very painful but the thought of having to have her latched on to me was even more upsetting, more painful than the mastitis. So it was probably the third or fourth week I finally talked to my husband, you don't talk much in the first four weeks (laugh). And I finally talked to my husband I was just in tears about having to carry on feeding because I was in so much pain from her not latching on and coming off all the time. He wasn't too supportive. He really wanted me to feed her since I hadn't really fed our son. He thought maybe if I could keep going, because what's what he would do - be a brave hero - he was

> *saying that he'd be able to carry on feeding. So that was really hard not having that support from him. I [would] just like for him to say "Well look if it's too sore maybe you can stop." I didn't want to stop, I would have loved to carry on feeding but I wanted to know that I had that support from him if I did. By the fifth week I was still in so much pain... (Cathy. Int. 18. Para. 8).*

Eva was an educated and articulate woman, who held a Master Degree and was a valued professional in the firm in which she was employed. Giving birth to her daughter was a completely new experience for her, and she read widely to gain knowledge about all aspects of mothering. Breastfeeding was an important issue for Eva, and she was committed to breastfeeding her baby; unfortunately, her reading did not prepare her for what was to come.

Eva's experience with breastfeeding was an embodied experience of pain. Her daughter was three months old at the time of the interview and Eva was still experiencing significant pain every time she fed her infant. Thus, she was able to describe her pain in great detail. Eva shared that she had flat nipples prior to breastfeeding, which made latching her daughter onto her breast difficult, but in persevering she managed to start breastfeeding her infant. However, she soon developed cracks in her nipples, followed by mastitis one week post-delivery, ending up in hospital on intravenous antibiotics.

Eva likened breastfeeding pain to the pain of giving birth and called on techniques normally associated with birthing to cope. She experienced pain as described by Gadamer (1996) – pain that caused her to feel alienated from herself; despite this, she found the strength to continue. Eva relays her experience of the pain associated with breastfeeding in the following paragraphs.

> *I got terrible cracks, terrible cracks [in my nipples], and that led to an infection, which led to a mastitis, which led to me going back into hospital after a week with huge engorgement, a huge infection and horrible, like really bad cracks. The whole thing was nightmarish and extremely painful, there would be days when she [my daughter] would latch on and I would be crying with pain, it was so bad and the midwives didn't really know what to do. Because they were really keen for me to breastfeed, they kept saying "breast is best and blah, blah, blah..." but*

then they also had me, their client, sitting there in tears saying "it's so painful, I don't know if I can do it anymore." It was a dilemma for them how to deal with me and it was a dilemma for me as to whether to continue feeding or not. Except that right throughout I felt that I wanted to continue unless it got excruciatingly bad, which it almost did, but I kept going. It's a story of triumph over pain in a sense.

The first eight weeks were really, really, really hard. It [breastfeeding] takes practice and time, and I was in great pain as well. It was an interesting thing because once the pain of the previous feed wore off, it was a little bit like the pain of birth, it fades very quickly, so that by the time the next feed came around I was ready to feed again because I'd almost forgotten the pain from the last time. It is quite an interesting phenomenon for me. But it was never so painful that I didn't want to feed her the next time.

It [breastfeeding] felt like a really personal thing between the two of us that I wanted to work at, and sure it was painful... I just so badly, so badly wanted to be able do it for the baby, that I was able to work through the pain. I had techniques to get through it. I have a crystal here that a friend gave me and every time before I would latch her on I would take a moment to look at the crystal and take a big deep breath and then I'd pop the baby on and I'd breath through the pain, and that was every feed. And, imagine that you're feeding six times a day, that's quite a lot of feeding and crystal watching (laugh). I guess it's like giving birth, the benefit that you get at the end of the process outweighs the pain that you have during it.

There was one day, when it was a turning point, where I almost gave up but I had a fabulous midwife. She, [the baby], was about four weeks old. And I was in tears sitting here feeding, it was dreadful and she [the midwife] could see that I was mentally and physically exhausted, I had lost quite a bit of weight and she goes "Right, you have a choice here. Whatever choice you make you just have to be happy with it, and have to go with it and don't look back. You can choose to feed and put up with the pain or just accept that there is going to be some pain and be happy with that - or start weaning her off and go onto the bottle and

being happy with that." She gave me the weekend to think about it. She also gave me a mid-way option, which was to feed a little bit then after a certain time stop feeding, and give her a bottle to top her up. So therefore, I could have a rest and the baby could have as much food as she needed to feel not hungry, that was quite good. We did that for a week and I started to feel much better, a lot stronger, I'd had a rest and my nipples were healing slightly. I really appreciated the fact that she [midwife] didn't say "you have to do this." She gave me some options and wasn't judgmental about it, which is important because there's quite a lot of pressure on women to breastfeed and if they don't they're considered a failure. So what this woman was saying was "it's OK not to breastfeed, it's OK to bottle-feed, breast is ideal but it's OK to bottle-feed and you're not going to be damaging the child." Just somehow the lifting of that pressure at that very crucial time made me stop and think and made me realise that I did want to continue breastfeeding but that there was an option, if it did get ever too painful I could bottle-feed her. I got better, the nipples got a little bit better - they're still a little bit painful now, but everything took a turn for good.

The other thing that the midwife said on that day was if you're breastfeeding and not enjoying it, and you're not happy with it, it's like having someone over for dinner and not actually wanting them to be there. I thought that was a very good analogy because when you go to someone's house and you don't feel quite welcome it's a bit edgy and there's tension, you know that there's something under the surface and you don't feel happy and comfortable. I imagine that was what it must have been like for my daughter, latching on but feeling all that tension, because I was in agony. So she [the midwife] said if you do decide to breastfeed you have to be happy about it and go with it and that's what I decided to do. I decided I wanted to try and continue.
(Eva. Int. 19. Para. 6, 7, 9 & 12).

Eva persevered and was still exclusively breastfeeding her daughter when she was six months of age. She chose to attend a post-natal depression group and counselling as a result of her experience, and commented that these interventions greatly assisted her in dealing with her unresolved, negative feelings about the pain she experienced as a result of breastfeeding.

"Merleau-Ponty shows how any sensing already recognises a set of meanings, in so far as part of the perceptual field leaps to the foreground as the centre of significance" (Leder, 1984, p. 31). The experience of breastfeeding for the majority of women is an experience with pain (Blair et al., 2003; Hill et al., 1994; Page et al., 2003; Salmon, 1994). However, many of the participants in this study were disconcerted by their pain; it leapt to the foreground, alerting them that their experience was incongruous with their previously-held understandings about breastfeeding as a natural and easy process.

According to Merleau-Ponty (1981), pain always has an embodied origin that invariably has meaning and signifies an attitudinal position towards the world. For those participants who spoke of breastfeeding pain, it meant unexpected injury and assault – something to be endured so they could offer their infants the best available nutrition. Their narratives speak of the great lengths to which a woman will go, and the sacrifices she will make, for her infant. However, there comes a time when, for some women, the pain becomes too much to bear: "pain makes me give way... We all know the moment at which we decide no longer to endure pain... and when pain becomes intolerable" (Merleau-Ponty, 1981, p.441).

In addition to experiencing pain when they breastfed, many of the women in this study also experienced tiredness. Both their pain and their fatigue were significant deterrents to breastfeeding, at times undermining their determination to continue.

8.7 Breastfeeding as an Experience with Tiredness

New mothers frequently relay how tired they are. New babies have differing nutritional requirements from adults, which often results in an infant needing to be fed overnight. This is especially true for breastfed infants, as breastmilk is digested easily, usually being fully digested in one and a half hours (Lawrence & Lawrence, 1999). This means that an infant may wake to feed several times during the night, leading to a disruptive sleep pattern that can be viewed negatively by breastfeeding women. Tired, weary, and fatigued were words that the majority of participants used to describe their embodied experience of being a breastfeeding mother. Debbie struggled to survive the initial period of being a

new mother, and spoke of how sleeping was intrinsically linked to coping with her new role.

> *Yes, I think 95% of my entire problems were due to lack of sleep. I didn't sleep after he [my son] was born for about three days and at the end of that I'd just sleep for an hour or so and then I'd be up again. I think a lot of my problems were due to a lack of sleep with breastfeeding, because I wasn't coping when he wouldn't go straight on, I'd just burst into tears. Whereas if I'd had a good night's sleep I probably would've coped a lot better with it.*
> *(Debbie. Int. 15. Para. 84).*

At the time of the interview, Kate's baby was seven months old and, although she had recovered from the engorgement and resolved her transient feelings about the daunting nature of mothering, she went on to speak of how physically demanding breastfeeding is in terms of the embodied effort of making enough milk to feed a healthy infant.

> *[Breastfeeding] is demanding... he [my son] sleeps really well but there's an incredible sense of tiredness the whole time and all I can put it down to is the breastfeeding. By the end of the day I'm still really tired and I think it must be producing [breastmilk], he's growing and growing like a weed, just that whole production must take it out of you. It would be nice to have some energy back but it's such a drop in the ocean in the scheme of things. It's [breastfeeding] just so worth it... I think that a lot of people would not want the expense of formulas and mucking around with mixing them up and heating them up in the middle of the night where everything's the right temperature - it's all ready to go.*
> *(Kate. Int. 3. Para. 74 & 76).*

Sally was breastfeeding her fourteen month old son at the time of the interview, and spoke of how family and friends had tried to convince her to cease breastfeeding to ease her tiredness. Despite her fatigue, breastfeeding helped to keep her going when she was feeling emotionally and physically drained. Sally was able to continue breastfeeding, as it was the one thing that kept her going through the tiredness.

Just before Christmas I got really tired, really, really tired. I've had glandular fever and I think it was a bit of a relapse. My mum was really concerned and she tried to convince me to wean him then for me, for my sake. There have been times when I've been exhausted, you get exhausted as a mother anyway, but I think I have been more exhausted breastfeeding because of the physical making of the milk – [friends and family] they've been concerned for me to stop. But when I'm really tired and down the only thing that keeps me going is actually breastfeeding. I need to breastfeed to buoy me up. So it would be a vicious circle if, I stopped breastfeeding I wouldn't be able to buoy myself up. It's kind-of a balancing game.
(Sally. Int. 11. Para. 104).

Just as pain has its origin within a person, and expresses an attitude about the world, so too does fatigue; thus, fatigue reveals its significance to the person experiencing weariness (Merleau-Ponty, 1981). For some of the women who participated in this study, tiredness forced a pause in their breastfeeding journey, mirroring Merleau-Ponty's (1981) comment that fatigue makes one break one's journey. It may be that for a moment a woman is so weary that she decides that breastfeeding is not for her, only to take up breastfeeding a moment later. For others fatigue spells the end of the road.

When Mel's son was ill she weaned him because she was so tired from constantly getting up and feeding him two times during the night. She described her unease about night-time when she desperately longed to sleep but knew it was not possible. She spoke knowingly about what it was to be mother-tired, relaying how important it is to know that other women experience similar feelings.

When he [my son] got strep throat, at nine months, I gave it [breastfeeding] up because I was getting up twice in the night and I was so tired, at least if I gave him a bottle I could get up once and my husband could get up the second time.

When you're a mother you can cope during the day, and the day is fine, but... when the night starts coming in you get butterflies in your stomach because you know it's your sleep time and this is when you want your baby to sleep. It would be so much nicer if a mother could stay awake

> *for forty eight hours, but it doesn't work that way. It was really nice to talk [to my friend] about it and it made her feel more relaxed and it made me realise that other people went through the same thing but you don't discuss those sorts of feelings with other people.*
> *(Mel. Int. 17. Para. 40 & 44).*

There comes a moment when a woman decides she can no longer withstand the fatigue, and as with pain, it becomes overpowering. "Tiredness does not halt my companion, because he likes the clamminess of his body, the heat of the road and sun, in short, because he likes to feel himself in the midst of things, to feel their rays converging upon him, to be the cynose of all this light, and an object of touch for the earth's crust. My own fatigue brings me to a halt because I dislike it, because I have chosen differently my manner of being in the world... I am free in relation to fatigue to precisely the extent I am free in relation to my being in the world, free to make my way by transforming it" (Merleau-Ponty, 1981, p. 441).

Being tired was a part of the embodied experience of breastfeeding, at times deterring women from continuing to breastfeed their babies. Another aspect of the embodied experience of breastfeeding that held significant meaning for the participants was that of being anxious.

8.8 Being Anxious

We exist as a body 'within-the-lifeworld'; therefore, all experiences are embodied (Dahlberg, et al., 2001; Merleau-Ponty, 1962). For Merleau-Ponty (1962) the lifeworld is that which we have access to through our bodies; all experience and sensing that occurs as a result of our bodies being in the lifeworld, such as anxiousness[25], as well as inauthentic[26] fear and guilt, are embodied experiences. The following section explores how women experience anxiety ontologically, as well as inauthentic fear and guilt on the ontic level. Prior to returning to the participants' narratives, it is worth exploring the

[25] Anxiety and anxiousness are used interchangeable in the following sections.

[26] Refer to Chapter Four, Section 4.4.1 for a discussion of Heidegger's (1962) understanding of *dasein's* experience of authentic and inauthentic states.

philosophical and theoretical understanding of how *dasein* exists as 'being anxious'.

Dasein exists in its primordial state in nothingness; in this state, *dasein* may not have formed any interpretations, but it does always exist as interpreting. To flee the anxiety caused by the nothingness, *dasein* inauthentically embraces the interpretations that already exist within the lifeworld into which it is 'thrown'. If *dasein* does not embrace these pre-existing interpretations, it experiences anxiety, which Heidegger describes as the fear of nothingness (Heidegger, 1962; Gadamer, 1996). "Anxiety is intimately connected with an oppressive sense of constriction, with sudden exposure to the vastness and strangeness of the world" (Gadamer, 1996, p.153). *Dasein* desires to be free of anxiety, and therefore flees into inauthenticity, to a place of familiarity, a place where it feels at home, that is 'within-the-world' or within the lifeworld. However, *dasein* is cognisant that the interpretations 'within-the-world' are not true to *dasein's* essential nature; in consequence, *dasein* also becomes anxious because it does not feel at ease with these interpretations.

Thus, *dasein* experiences anxiety in a state of nothingness, and also when accepting the interpretations present in the lifeworld. Therefore, one of the fundamental ontological modes of *dasein* is anxiousness (Heidegger, 1962; Inwood, 1997; Inwood, 1999). As a result, when anxiety emerges, *dasein's* 'thrownness' and existence are disclosed (Heidegger, 1962; Inwood, 1997).

Anxiety is always anxiety about something (Gadamer, 1995). The women who heeded the call to explore their anxiousness questioned their existence as women, and mothers, as they examined the roles the world stated they should adhere to. The women in this study also experienced inauthentic anxiety, in the form of fear about their ability or inability to breastfeed their infants. When *dasein* dwells in this inauthentic 'within-the-world' mode, *dasein* becomes mindful of failing to live up to the perfect ideal, and therefore experiences guilt. Terms such as emotionally crippled were employed by the participants to describe their anxiousness and guilt in relation to the issue of breastfeeding.

Fear is fear of something 'within-the-world', within the realm of our thrownness; fear is always an intra-world experience (Heidegger, 1962; Inwood, 1999). As fear stems from something that resides 'within-the-lifeworld', Heidegger refers to fear as the inauthentic counterpart of anxiety (Heidegger, 1962; Inwood, 1997).

"Fear is not just an inner feeling; it opens up a world of potential threats" (Inwood, 1999, p. 16); *dasein* fears consequences. For the women in this study, fear was produced in anticipation of being unable to breastfeed.

8.8.1 Anxiety and the Fear of Failing

In New Zealand society, breastfeeding holds a privileged position above other forms of infant feeding, with breastmilk portrayed by 'the they'[27] as easily produced and delivered. Therefore, fear of failure is experienced when faced with not being able to produce breastmilk. As the infant is most important to a mother, not being able to satisfy the infant's needs is interpreted as failure. Women interpret failing at breastfeeding to mean they are not good mothers, and as a result their infants will no longer need or want them.

For Cathy, breastfeeding was an integral part of being a mother, but she only managed to breastfeed her son for nine weeks. She attributed her difficulty breastfeeding her son to the early introduction of a bottle, following which her son always struggled with latching onto her breast. After giving birth to her second child, a daughter, the attending midwife had managed to facilitate a successful breastfeed, which left Cathy greatly relieved and hoping for a more successful breastfeeding experience. However, the day after that first feed, Cathy was in pain from feeding, her daughter would not settle, and the midwife suggested giving her a bottle. Because of her previous experience with her son, Cathy was hesitant to follow the midwife's advice. Cathy faced a difficult decision as her fear was not pain from breastfeeding; rather, it was fear that her daughter would reject her breastmilk, and reject her as a mother, if she was given a bottle.

> *I had heard her [my daughter] screaming for hours, she had hardly slept, and I was already bleeding [from my nipples] after that first one and a half days because she was feeding so much and there probably wasn't that much [breastmilk] there for her. Also she had [managed to] latch on [to my breast]; just that fear that if she had a bottle maybe she wouldn't want me [my breast] again, she wouldn't want me either.*
> *(Cathy. Int. 18. Para. 41).*

[27] Refer to Chapter Six for a description of 'the they'.

Eva questioned her very existence when her daughter was three weeks old and she was struggling with the decision whether or not to continue breastfeeding. She spoke of how her extreme fatigue prevented her from thinking clearly, and thus she was more susceptible to feelings of failure and guilt.

> *When I was having that crisis about whether to stop breastfeeding and go onto the bottle or not, I was in tears at the idea of having to give up because I so badly wanted to do it. I also went through a time when I thought if I can't breastfeed her I'm not being a very good mother, I remember that quite clearly, and feeling really terrible about that. In fact it is not true, and I realise now, there's heaps of things I can do for her as a mother and no one's going to replace me whether I breastfeed or not. But, at the time feelings were heightened so much, and I was exhausted and a bit sick as well so it was like 'what's the point in my being here if I can't breastfeed?'*
> *(Eva. Int. 19. Para. 73).*

For Sam, fear emerged in the experience of being at home alone for the first time with her newborn son following their discharge from hospital. Due to a family history of milk allergies, she did not believe that formula was an option for her infant; however, she struggled to breastfeed, and in her desperation sought help from sources, such as La Leche League, that she considered she would not normally have resorted to.

> *So we were on our own for the first time completely, it was so daunting. I think it got to about 8.30 at night and we [my husband and I] couldn't get him [our son] on [to my breast] and I just didn't know what to do. At that stage we hadn't used any formula because I had a history of milk allergy in my family and so I was scared to even try formula in case he reacted badly to that... I thought 'My god, I can't feed my baby at all, what's going to happen?' I didn't know what to do, who to ring - I was looking in the phone book under the La Leche League, and things like that, to try to get someone to help.*
> *(Sam. Int. 12. Para. 16).*

Mel clearly articulated how she felt during the time leading up to the transition from breastfeeding to formula feeding her daughter. She was desperate in her attempt to continue breastfeeding because she was afraid that otherwise her

daughter might die from cot death, likening having to stop breastfeeding to a train coming towards her in a tunnel. She spoke of how she just wanted someone to let her know her baby would be safe on formula. Three years after giving birth, she still recalled vividly how it was to be in her metaphorical tunnel.

> *In your mind you really want to breastfeed, you really want to breastfeed. It's like the light at the end of the tunnel, when you can see that you might not be able to do it you're panicking - you try everything, you're grasping at straws, and you get quite emotional. It's like you can see the light coming towards you and you know that you're going to have to stop. And people are saying "try this, don't give up, we will support you either way." But, oh god why don't you just tell me "it is alright, it is ok to go to the bottle." You hear people say "cot death" and "the baby's a lot better if you breastfeed them", all this stuff is wiggling around in your head. It would be nice if someone said "look don't worry your baby will be fine, there's nothing wrong with formula, it's perfect," nobody told me that. I remember I was so emotional even now I can feel quite hyped because I can feel all the emotions that whiz through you.*
>
> *With my daughter I wanted to keep going, I'd feed her in the morning and then give her a top up or I wouldn't give her a top up [of formula] because I wanted to have fed her properly myself. I'd know that she might be waking a bit earlier and I kept trying to do it myself, I really wanted to keep going [with breastfeeding], but it was overwhelming. I knew that I'd have to give up, I really wanted to keep going but in the back of your mind is someone saying 'it's not working, it's not working.' It's horrible.*
> *(Mel. Int. 17. Para. 16 & 52).*

These narratives demonstrate women's fear that they will fail to breastfeed their infants. Some of the participants managed to overcome their initial breastfeeding difficulties, leaving their fear behind; but for some women, their fear of being unable to continue breastfeeding their infant became a reality. For these women, breastfeeding became an experience of guilt because they could no longer provide their infants with what they believed was best.

8.8.2 Guilt

Just as *dasein* exists as essentially anxious, *dasein* also exists as essentially guilty, meaning that *dasein* is unable to achieve infinite possibilities of being; therefore, because of guilt, *dasein* exists in a deficient state (Heidegger, 1962). To escape the unsettledness of essential guilt, *dasein* withdraws into the inauthenticity of everyday guilt (Dreyfus, 1991; Heidegger, 1962). Heidegger defines everyday guilt as a "lacking in some way... this kind of lacking is a failure to satisfy some requirement which applies to one's existent Being-with-Others" (Heidegger, 1962, p. 328). Inauthentic *dasein* falls under 'the they's' influence, adopts its interpretations, and thus experiences guilt in accordance with what *dasein* is told to feel guilt about (Heidegger, 1962; Inwood, 1999). This is analogous to *dasein* fleeing essential anxiety and submerging itself under the influence of 'the they', leading to inauthentic anxiety. Those women who participated in this study and were unable to continue breastfeeding experienced everyday guilt because they were influenced by 'the they', which advocates breastfeeding as the infant feeding method of choice. Their inability to breastfeed was interpreted as a failure to live up to 'the they's' expectations, leading to guilt.

Mel struggled through prolonged engorgement and continuous mastitis during the six weeks she tried to breastfeed her son. During that time in her life, she had similar experiences to other mothers who struggled with the decision of whether or not to continue breastfeeding. Mel questioned her ability to be a good mother if she ceased to breastfeed, but in the end the decision was made for her, as she lay in a hospital bed receiving intravenous antibiotics for severe mastitis.

> *People kept saying "just keep going [with breastfeeding] and it will go OK" but we should have stopped heaps earlier. We shouldn't have got to such a state where I couldn't stand up, I couldn't eat - I couldn't do anything. I was useless to everyone including my son. I felt terribly, terribly guilty about not being able to breastfeed. And you know you get all this stuff shoved at you all the time about how breastfeeding is best and you almost feel like you're not a good parent if you can't. There's all that baggage and I kept thinking he's doing this to me and I'm trying my best, and we're not, we're not getting it.*
> *(Mel. Int. 13. Para. 8).*

Mel went on to describe her embodied experience of guilt at having stopped breastfeeding. She spoke of the great difficulty she had had with her son, and how she did not like him because of the disturbance he had caused in her life, which caused her to suffer from additional guilt. Meanwhile, she was so worn out from her experience that she was unable to think clearly about the situation, and she concluded that she was not a good mother.

> *My midwife was great; she sent me along to the Plunket Family Centre and they were fantastic in their support. Like they talked a lot about bonding and I told them that I felt guilty. I was very emotional, incredibly tearful all the time about feeling inadequate. And so they [the Family Centre staff] were really good setting me up with baby massage classes earlier than I probably would normally have gone. I could go to the Family Centre at anytime. My son was very unsettled as well [because of] being on antibiotics, which didn't help me. So they would take him for the day, probably once a fortnight, for quite some time and that was great. But the guilt lasted a long time probably about six months. I also felt guilty that I didn't like him [my son] that much, because I really didn't. He caused a lot of hassle, my husband was off work for six weeks and there was always a drama. I was so tired and I just couldn't cope. I was used to being someone completely in control and it was out of control, and this thing cries all the time and I can't comfort it. And then you're not a good mother... Your perception is that you're not a good mother on top of that.*
> *(Mel. Int. 13. Para. 24).*

Sue spoke of how she had let her son feed at the breast for long periods of time, and yet despite this she did not have any evidence that he was receiving any breastmilk. She did not understand why the health care professionals did not heed her concerns about her infant's health; therefore, her ability to listen to her embodied knowledge, and use it to nurture her infant, were undermined. Out of concern for her infant, she finally fed him formula, but subsequently suffered from feelings of guilt. Because she had provided her infant food that did not come from her body, she felt that she was not providing the 'best'. This feeling of guilt for inadequately providing for her son was reinforced by the health care professionals, who she believed were supposed to be there supporting her in her mothering role. So, to avoid being exposed to additional emotional 'hammering', she chose to not disclose the use of formula.

All day Friday he was feeding, feeding, feeding and I could hear his stomach rumbling. He didn't have a wet nappy all that day, and when I rang someone and said "this is really strange" they said "oh no that's fine". But I thought 'no, I don't think it is, he's dehydrating, he's not having any fluids go through him.' So I fed him formula on the Saturday. I had the guilts for a week about the formula. I was still breastfeeding him because I had the midwives coming in and they kept on saying "no everything's fine" and trying to get me to wean him off the formula but I just felt that he needed it.

They [the midwives] would come in and you almost felt like you had to hide the bottles and the formula, because they would ask how you were feeding him [my son] and you'd had it drummed into you that 'breast is best'. Then they'd watch you breastfeed, and everything was going well, he was latching on very well, but the moment you suggested that you were topping him up with formula they were sort of like: 'Yes well that's alright' but each time they came in they were like 'you're feeding him less formula aren't you?' That was practically their first question. So in the end I found it easier to say "yeah, yeah we've got him off the formula totally," which wasn't the truth but it was just easier. At home with a newborn baby, first time around and the last thing that you need is to be hammered from that quarter as well.
(Sue. Int. 6. Para. 20 & 22).

After deciding to stop breastfeeding her infant, Debbie's breasts, although permanently scarred, were able to heal. However, as a result of her decision to wean her son, she traded her physical suffering for the suffering of guilt. The cause of this guilt was the inability to provide her infant with milk that, in her perception, meant thriving and health. Debbie acknowledged that another foundational cause of the guilt she experienced was the concern that her son would no longer love her.

I'm quite happy not to be breastfeeding now, for a long time I felt really guilty about it because everyone else was. I felt really guilty for quite a while. For probably about another two months after I stopped I felt really guilty that I wasn't breastfeeding, but now I've seen that he can go so well on the formula that I'm OK with it. Whereas I thought 'he's going to get all these health problems and he's not going to thrive as well' and

he's been fine... You do feel guilty for a long time after you stop. Which you shouldn't do. If you can't do it it's OK, it's not bad to stop, your baby's not going to love you any less or anything...
(Debbie. Int. 15. Para. 119 & 123).

In the narratives discussed in this, and the previous sub-section, the participants expressed both fear and guilt when describing their breastfeeding experience. The inauthentic modes of anxiety and guilt were expressed in the form of a fear of failing their infants if they were unable to breastfeed, and guilt if they either failed to breastfeed, prematurely weaned their infants, or introduced artificial formula feeds. If they were unable to resolve the unsettledness resulting from their experience with breastfeeding, they felt emotionally crippled.

8.8.3 Emotionally Crippling

Some of the women who were subject to the embodied experiences of fear, failure and guilt in relation to their experience with breastfeeding were no longer able to cope with the strength of their emotions. This led them to employ such terms as *emotionally crippling* to ultimately describe their embodied experience of breastfeeding.

As previously mentioned, Mel's daughter suffered from severe reflux, which caused Mel to struggle to breastfeed for the first five weeks after giving birth, at which point she started to feed her infant expressed breastmilk. Due to a reducing breastmilk supply, Mel could no longer sustain her daughter's nutritional requirements by expressing, and by the time her daughter was ten weeks of age she was being fully formula fed. Mel's effort to continue breastfeeding was fuelled by a strong desire to provide her daughter with the ultimate source of nutrition, and she spoke of the emotionally crippling experience she had during the weaning process; of how her thoughts and decision making were influenced by others, and how she longed desperately for support from those around her. During the interview, Mel returned to this novella many times.

She [the baby] was on the Zantac for six months and Prepulsid till seven months and that was fine, perfect, we never had any feeding problems after that. She would sit up and she'd drink her bottle cause I could feed

her that way and that was it, wonderful. I don't know why somebody didn't tell me in the beginning to give up. It's really horrible because people are saying to you "breastfeeding is the best thing for your baby", but it's emotionally crippling for you to have to give it up. Or with the Plunket nurse saying 'I'll support you no matter what', that's really nice but I didn't want that, I wanted someone to say "it's not working, go to formula it's a lot easier, don't berate yourself over this and just don't worry about it", but they don't. They try and convince you to do otherwise. It's really hard, it's hard because you're trying to do it and you need their... they're supportive but they're on the edge, they're not in there helping you with your problem, not helping you deal with it, not telling you "well look if it's not working then give it up." Being a new mother you've got so many people giving you assistance and advice, without anyone saying 'look at it this way'. But I suppose they don't want to, they don't want you to give up so they have to let it be your choice. But it was crappy with my first daughter... When I went to the Family Centre for help they said to me "it won't make any difference if you give your child a bottle than if you breastfeed her." Why were they getting her to sit on my knees and breastfeed her upwards? To me that's an unnatural position. They should have been telling me that "you might have to give up breastfeeding", getting me prepared for the worst. You don't want to give up but you have to. If someone had prepared me maybe for having to give it up it would have been a lot easier, I wouldn't have persevered so much with express breastfeeding.

There are heaps of people out there with worse problems but you're absorbed in yourself and it was tough. I know it didn't last very long but those five weeks were definitely a long time in my life...
(Mel. Int. 17. Para. 2, 4, 18).

Sam's experience of breastfeeding her son was extremely distressing. She dreaded every feed and doubted her ability to resolve the breastfeeding difficulties she was encountering. Like many other mothers, she desperately wanted to continue for the sake of her son, but struggled to rise above her tiredness and find the strength she needed. Although her partner provided crucial support, she battled to overcome feelings of inadequacy in relation to her ability to mother because she could not fully breastfeed her son.

> *It [breastfeeding] was so hard and so stressful. Like every time he'd wake for a feed I'd think 'oh, here we go again'. There was nothing, nothing pleasurable about it at all. I wanted to make it work for all the reasons that you're taught; that you know, that breastfeeding is good for you and for your baby primarily. So I wanted to try and make it work, but as I said, there were several times when I was willing to flag it away, but I have a really supportive partner, he just was great. If it wasn't for him I think we would've given it away at two weeks... Even now at ten weeks if we get slightly out of that routine, if I try to do too much, then it becomes really difficult again. About once a week, if I can't get my son to settle I still give him 50 mls of formula just to get him down. I still kind-of have an issue with that. I don't know if it's a threat to your sense of womanliness or your ability as a mother because you like to be able to feed your baby yourself completely. Sometimes it still does upset me if I can't, if I need to give him a top up with formula. But on the other hand I get worried if I don't think he's gaining enough weight. So it's kind-of a no-win situation really. (Participant has tears in her eyes while talking). (Sam. Int. 12. Para. 12 & 20).*

Throughout the interview, Sam repeatedly returned to her inability to resolve her feelings of inadequacy as a mother because of the difficulties she had in breastfeeding. She talked of the constant worry about being unable to satisfy her young son's nutritional needs. However, Sam demonstrated how her definition of successful breastfeeding changed with every positive breakthrough she achieved, and thus she constantly doubted her embodied capabilities as a breastfeeding woman.

> *Sometimes I wonder if it [breastfeeding] was really worth it. (Participant was crying). I know that it is in terms of the nutritional value and all of that kind of thing, but the stress that I put myself through, I don't know whether it was worth it really... With the constant nagging, worry of whether my milk supply is adequate and whether he's doing OK, but it's fine. (Participant is crying). The more we progress though, the older he gets and the better his weight becomes the more secure I get in the knowledge that things are OK. We used to be giving him a comp [of formula] about three or four times a week, and now we're giving it to him once a week. Sometimes I think that I'll feel like I've finally succeeded when we get through say two weeks without having to give him a comp.*

> *I don't know why that will be a milestone for me but it probably will, and that will be when I want to start (laugh) giving him a bottle anyway I suppose.*
> *(Sam. Int. 12. Para. 56 & 58).*

Emma vigorously questioned her ability to mother during the first month after she gave birth to her son. Despite her previous experience with young infants, she believed she was unable to care for her own. She laboured to breastfeed her son, letting him feed for hours on end, but believed he was only receiving insignificant amounts. For Emma, concerns arose with breastfeeding when she recognised her infant son was not gaining weight. She spoke to her midwife about her concerns only to have them dismissed and, therefore, silenced. Over a period of four weeks Emma had the growing realisation that all was not well, and despite attempting to get her concerns validated, became increasingly alarmed by her son's distress. Her son required constant vigilance because of his distress, which, combined with concerns that were not validated by health care professionals, resulted in Emma self-diagnosing depression. This depression resulted in her rejecting her son at four weeks postpartum, which she described as the worst month of her life.

> *I didn't have the problems with latching [my son] on or anything, we latched on perfectly not a problem. It was just the whole amount of time that he was on me. I didn't know that I wasn't producing enough milk for him. He would be on me for like three hours then off for half an hour screaming then back on again for three hours continuously. No body pointed out to me "hey he's not getting enough." He had blood in his nappy and the midwife said "Oh no its OK, keep going" but I know now not to listen and to do what I feel is right. I actually said to her "I'm not producing enough am I?" and she was like "yes you are, yes you are just keep going."... He was losing a lot [of weight]. I actually resent the midwife for letting him go through that for so long and not doing anything about it. [It occurred over] four weeks. [My son] he would just scream continuously, I didn't have a break, I was just a mess by the end of it. Absolutely beside myself... [I was thinking] 'What the hell have I done?' I used to work at a kindergarten, in a day care centre, and I had heaps to do with babies so I was really confident about having him. I thought I knew what I was doing but when I couldn't stop him crying and I did not know why, I absolutely lost it. [I was thinking:] 'Why have I done this? I*

> *shouldn't have brought a baby into the world if I didn't know how to look after it.' But, it's a lot better now because he sleeps and feeds properly. But no, that first month was just horrible. The worst experience of my life at that point, the first month.*
> *(Emma. Int. 14. Para. 71-77, 81 & 83).*

Jan suffered with a tremendous amount of guilt associated with weaning her son at three weeks, following her hospitalisation and surgery for severe mastitis. She spoke of how she was burdened with feelings of failure because of her inability to breastfeed, comfort, or be what she perceived to be a good mother. She questioned, four years after the experience, whether she was suffering from postnatal depression because of feelings of complete despair brought on by her experience with breastfeeding.

> *I was so tired and I just couldn't cope. I was used to being someone completely in control and it [the baby] was out of control, and this thing cries all the time and I can't comfort it. And then you're not a good mother... Your perception is that you're not a good mother on top of that... I may have been going to have PND (postnatal depression) anyway but I was never treated for it, but I had this... complete despair about breastfeeding.*
> *(Jan. Int. 13. Para. 24 & 28).*

The first time a woman breastfeeds her way of 'being-in-the-world' is transformed, because she begins a process of being-in-the-world in a different, as-yet un-experienced way. According to Gadamer (1975, p.111)

> "transformation means that something is suddenly and as a whole something else, that this other transformed thing that it has become is its true being, in comparison with which its earlier being is nil. When we find someone transformed, we mean precisely this, that he [or she] has become another person as it were".

Following this transformation, previously-held meanings provide women with neither the interpretive framework nor the understandings they need to navigate their way through the embodied experience of breastfeeding. Thus, women find themselves in a place of unsettledness, and it is in this state that they encounter authentic anxiousness. In an attempt to be at ease 'within-the-world' in which

they are 'thrown', women flee to the world of 'the they'; to provide themselves with an interpretive framework, women choose to accept 'the they's' interpretations of what it is to be a mother, and the edict that all mothers can, and must, breastfeed[28]. In accepting 'the they's' interpretations, women embrace the very ideals that produce the fear of failure, and feelings of guilt, and thus they become 'emotionally crippled'. This closes down on the possibilities that 'being-in-the-world' holds for a breastfeeding women.

Merleau-Ponty (1981, p. 441) points out that "our attitude towards the world, when it has received frequent confirmation, acquires a favoured status for us" (Merleau-Ponty, 1981, p. 441). The women in this study were free to adopt a certain embodied way of being in the lifeworld. They had a choice to either develop their own interpretations or accept 'the they's' interpretations of what it is to be a breastfeeding woman. The consequences of accepting the interpretations as offered by 'the they' meant they experienced inauthentic anxiety in relation to their breastfeeding experience.

The way in which a woman chooses to exist 'within-the-world' will come to the fore when she breastfeeds. Either she will adhere to inauthenticity and remain involved in the public world, or she will free herself from their interpretations and understandings, and attend to dasein's authentic anxiety. In the mode of authentic anxiousness, *dasein* sees that the meanings provided by 'the they' are just an illusion, and so the rules the world espouses are no longer seen as essential because they become meaningless (Dreyfus, 1991). Thus, one is returned to *dasein's* authentic ownmost, and the interpretative possibilities of being and associated embodiment are freed to emerge (Heidegger, 1962; Dreyfus, 1991).

8.9 Conclusion

When women initially discussed their experiences of breastfeeding they employed language embedded in notions of Cartesian dualism, an orientation inherited from centuries of approaching the body as an object. However, as

[28] See Chapter Six for a full discussion about participants' understandings of 'the they's' influence over breastfeeding interpretation.

they continued to relay their experience with breastfeeding, the language embedded in the subject-object discourse lost its relevance and they turned instead to a language that spoke of an embodied way of 'being-in-the-world'. This embodied experience of breastfeeding was a hidden experience.

For the women who participated in this study, breastfeeding was an experience with embarrassment, pain and fatigue. It was also about feeling inauthentic anxiousness in the form of fear of failing with breastfeeding. If a woman did fail to adhere to the average breastfeeding norm, as espoused by 'the they', she experienced guilt. If a woman was unable to resolve her feelings of guilt, she became emotionally crippled, and thus the possibilities of being were closed down upon. However, if women attend to their authentic embodied experiences, they gain access to a multitude of interpretive possibilities through which being is opened up. The opening up of being occurs because women respond to the call to care through breastfeeding, and it this experience that will be explored in the following chapter. This opening up of being through breastfeeding is explored in the following chapter, within the context of women's experience of solicitude.

Chapter Nine

Breastfeeding as Concernful Solicitude

9.1 Introduction

This chapter explores how women are called to care for their infants, and begins by attending to an exploration of Heidegger's concept of care. It goes on to highlight how women decide to breastfeed because they care deeply about their infants, eventually coming to more fully know and understand their infant's needs through breastfeeding. This chapter demonstrates that, as the relationship between a woman and her infant matures, women come to recognise that breastfeeding offers their infants comfort. The women's narratives also reveal that the relationship formed as a result of breastfeeding is close, exclusive and intimate; therefore, this relationship is privileged. This privileged relationship offers women insight into their embodied capabilities, whilst providing health and well-being for their infants. Ultimately, the relationship offered through breastfeeding opens up women's potential for being.

9.2 Ontological Understanding of Care

Dasein exists in the world 'with-other', and one of the fundamental or essential modes of being-with-other is that of care (Heidegger, 1962). Care can be defined as 'concern-for', or 'care-for'. The things or 'others' that call out to *dasein* capture its concern or care. *Dasein's* attention is focused on that which it is concerned with, and as a result, *dasein* comes to understand both 'other' and being, through the everyday things that capture its focus or care (Heidegger, 1962; Inwood, 1999).

Because of the importance of care in *dasein's* ability to come to know and understand the world, Heidegger considers that the primordial being of *dasein* is itself care (Heidegger, 1962); therefore, care is *dasein's* basic mode of 'being-

in-the-world'. "Care, as a primordial structural totality, lies before every factical[29] 'attitude' and 'situation' of Dasein, and it does so existentially *a priori*" (Heidegger, 1962, p. 238). Care provides the ontological basis for approaching entities, such as objects and 'others', within-the-world. Because care is an essential part of being, it is not possible to exist without care, and according to Inwood (1999, p.2) "no one is wholly carefree, careless or uncaring". Everyone is fundamentally careful and navigates their way in the world accordingly (Heidegger, 1962; Inwood, 1999)[30]. It is possible to encounter 'happiness', 'sadness' and 'anger' only because *dasein* exists as care (Dreyfus, 1991; Heidegger, 1962). In the everydayness of life we experience emotions, such as 'gladness' or 'dismay', only because we care; therefore, being can be made visible through the comportment that is care (Heidegger, 1962).

Dasein's structure of care provides the basis for everyday connection with entities 'within-the-world'. There are two types of care that are employed by *dasein*, one mode of care for objects and another one for 'others'. Heidegger employs the term *concern* to describe the care that is exhibited when one attends to objects that are encountered 'within-the-world'. Concern is that which manipulates items and puts them to use (Heidegger, 1962). However, this type of care does not accurately portray the care with which we attend to others; instead, Heidegger (1962) employs the word *solicitude*[31] to describe this type of care. Therefore, care 'within-the-world' is always exhibited through either concern or solicitude (Heidegger, 1962).

Care or solicitude is expressed towards 'others' through two distinct modes (Heidegger, 1962). One can be described as a deficient mode of care, which typically characterises the "everyday, average Being-with-one-another" with whom we have no familiar relationship (Heidegger 1962, p. 158). Heidegger (1962, p. 158) describes this as "being for, against, or without one another, passing one another by, not 'mattering' to one another". Therefore, care

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[29] According to Inwood (1997, p. 124) "factical, facticity; similar to factual, factuality except that they are applied only to *dasein*, e.g. the sheer fact that one exists."

[30] It is important to note that care does not describe the ontic ways of 'being-in-the-world' but purely the ontological-existential manner (Dreyfus, 1991; Heidegger, 1962).

[31] In this context, solicitude is an attempt to translate the German word *fursorge*, defined by the translators of Heidegger's (1962) work, Macquarrie and Robinson, as "the kind of care which we find in 'prenatal care' or 'taking care of the children'" (p. 157).

towards other can be deficient, in which case 'inconsiderateness', 'indifference' and 'perfunctoriness' result (Heidegger, 1962). The other distinct mode of care or solicitude is described as proper, or authentic care, and is expressed by 'considerateness' and 'forbearance'.

Authentic care is exhibited by either '*leaping in*' or '*leaping-ahead*' (Heidegger, 1962). *Dasein* can exercise care by *leaping in* for the other and taking away care, which describes how *dasein* essentially 'takes over' another's care. Heidegger (1962), however, warns that this type of care can result in the domination and dependence of the individual whose care is taken away. An example of this as it appears for a breastfeeding woman might occur when a well-meaning health care professional 'leaps in' and latches an infant on to a woman's breast. In this case, the health care professional has taken away the care of the breastfeeding woman, because she has prevented the women from gaining the skills she needs, resulting in the woman's prolonged dependence on an outsider for assistance with breastfeeding.

The second type of authentic solicitude is the type that *leaps ahead* of the 'other' "not in order to take away his 'care' but rather to give it back to him authentically as such for the first time" (Heidegger, 1962, p. 159). Solicitude in this mode desires to facilitate independence, not dependence (Heidegger, 1962; Inwood, 1999). In doing so, the other becomes 'free' to care for himself or herself. Heidegger (1926) talks about how, when two individuals devote themselves to the same task, each taking hold of their *dasein*, they become authentically bound together, thus freeing each other into their ownmost Being. Therefore, through authentic solicitude, *dasein* can be brought into its ownmost being (Heidegger, 1962).

9.3 Responding to the Call to Care: Coming to Know and Understand Other

As one dwells 'with-Other' through the authentic mode of care or solicitude, one comes to understand the Other (Heidegger, 1962). Heidegger (1962) claims that we understand others because of things or entities that concern us within-the-world. From this it follows that we can engage in concernful interactions while being-with another on an everyday basis, thus forming the basis of our

understandings of others. The women who participated in this study expressed concernful solicitude for their infants. This was evidenced by narratives that expressed how they had come to care whilst pregnant; the call to care became even louder following the birth of their infants, facilitating the women coming to know, and ultimately to understand, their infants.

9.3.1 The Call to Care

The care that is expressed towards 'other' is that of solicitude; however in everydayness the mode of solicitude that is most commonly expressed is deficient because it fails to attend to other with authentic solicitude. To express an authentic mode of solicitude it is important to be open to 'being-with-one-another'. The example of a woman who has just given birth provides the backdrop for an interesting interpretation, and explanation, of this idea.

When one is first introduced to a new individual it is customary to greet and converse: two people become both linguistically and sensorally acquainted, and both verbal and non-verbal communication is assessed. This pattern of communication normally occurs prior to the development of a trusting and intimate relationship. However, for a woman who has just given birth, current practice is to introduce the newly arrived infant to the breast as soon as possible. Breastfeeding requires that a mother be close to her child, that their bodies touch, and that a mother embraces her infant to her. Some women initially struggled with coming-to-know their infant in such an intimate manner prior to becoming 'acquainted', and as a result a woman could come to 'mistrust' or confuse her infant's signals.

Emma provided a narrative that relays how she wanted to know the child she had just given birth to before putting him to her breast to feed. To be forced to be 'close' to someone whom she had just met was a difficult experience for her.

> *You're still trying to get over what you're holding, having the baby there, then to have to be launched into feeding him so soon - I would have preferred to get used to having him and be able to do it [breastfeed]. I know you can't because they're hungry but it would have been a lot nicer... During the night, that first night, he was just shocking. I read that babies sometimes can go without a breastfeed for 24 hours when they're*

> *first born but he was just on me continuously that whole night and it was horrible… I just wanted to look at him not have him on me.*
> *(Emma. Int. 14. Para. 13-19).*

Newborn infants communicate primarily through non-verbal communication and crying, while a mother expresses solicitude towards her infant by striving to understand these unfamiliar communications. A crying, inconsolable infant speaks to a mother of a distressed baby. Equally, an infant that smiles in response to his or her mother's care portrays a satisfied, fulfilled child. It is important to remember that infants typically do not smile for the first six weeks (Muscari, 2001); however, the participants in this study engaged in a process of coming-to-know their newborn infants, and actively sought positive responses from their infants, as such responses provided a visible measurement of the effectiveness of their caring. At times, their interpretations of their infant's responses to the breast and breastfeeding influenced their decisions whether or not to continue to breastfeed.

Sue had completely weaned her son when he was three months old. She believed she had insufficient milk to satisfy her son's needs despite letting him feed for hours on end. For Sue, the most difficult aspect of her breastfeeding experience was having her young son inconsolable despite frequent feeding. As she deeply cared for her infant, watching him suffer was devastating for her.

> *[My son] he wasn't sleeping. He was a newborn baby and, particularly during the day, even from one or two days old we couldn't get him to settle during the day at all. He just wasn't contented at all - that was the most soul-destroying thing. You could see this poor little so-and-so was just really unhappy and there was nothing I could do. I thought I was doing the right thing by trying to breastfeed him and it still didn't settle him because he wasn't getting anything as we found out later. It was awful.*
> *(Sue. Int. 6. Para. 34).*

Lee questioned whether she should stop breastfeeding her son as she was in pain due to cracked nipples. Her doubt was reinforced by the perception that her son was not enjoying breastfeeding as he would constantly come on and off the nipple during a breastfeed. However, once her son was about six weeks old, he displayed behaviours that indicated to Lee that he was also enjoying the

experience of breastfeeding, and Lee's decision to continue to breastfeed was validated. Lee breastfed her son until he was 15 months of age.

> *I thought I could really easily have given up [breastfeeding] because it was such a hassle and so painful and my son didn't even seem to enjoy it that much in the first six weeks. But then he definitely settled to enjoying it and being happy... He probably wasn't not enjoying it, it's just that a baby under six weeks old is less responsive. I remember, after he was six weeks old he used to do this really cute thing. That you'd fed him and he was full, he would pull his lips away from the nipple and give you a huge grin, [he would] look up at you and "ooh" (laugh) and sort of smile and then he'd return to feeding. That was really sweet. (Lee. Int. 10. Para. 30 & 32).*

Debbie decided to wean her son due to the severity of the pain associated with cracked nipples. Her perception was that she was being harmed by breastfeeding her son, and her resentment towards him for harming her negatively affected their relationship. In her narrative, Debbie provides an example of how difficult it can be to express authentic solicitude when 'other' is causing you pain. For Debbie, the pain resulted in the end of the breastfeeding relationship. She believed that if she had not made the decision to wean her son their relationship would not have improved.

> *Because of the pain that I was having from [breastfeeding], because I was cracked and bleeding, it was just horrible. I resented my son a lot for that. If I hadn't made the decision to bottle-feed we still wouldn't be getting along.*
> *(Debbie. Int. 15. Para. 50).*

Jan expressed how she dealt with her son with solicitude, sharing that, through her relationship with her son, she came to understand breastfeeding as painful. She provides an example of a woman who felt forced to care through breastfeeding, believing she had no choice. The call to care through breastfeeding was strong; however, Jan's experience of breastfeeding pain drowned out the call and provided her with an overwhelming message she could not ignore. With graphic language she images how it was to breastfeed her son, describing the effect that her experience had on her expectations for breastfeeding her second child.

> *[My son] he was really aggressive so it wasn't even that it was a nice experience once he got on [the breast]. He was chomping even though he had no teeth, he was like a barracuda it was awful. He was really horrible. So when I got pregnant again with my second child I was terrified of breastfeeding.*
> *(Jan. Int. 13. Para. 8).*

The experience of breastfeeding her second child, a daughter, was a very positive one for Jan. She spoke in depth about how breastfeeding facilitated authentic solicitude, leading to a close connection with her daughter. Jan was also cognisant of how her relationship with her daughter was adversely affected by her first breastfeeding experience.

> *[Breastfeeding] it's made a big difference [with my daughter]. Which is pretty hard for my son, but our relationship is fine now, it just got off to a rough start. I'm so pleased it's changed, I was so relieved because for a long time I thought I was never going to like him. That sounds awful doesn't it? It's very true, very honest when I say that I didn't like him at all. I can remember sitting in the bathroom, cause I used to have to use a breast pump initially too and that didn't work either, thinking if something happened to him I would never have had another child. That kind of whole thing like: 'if you were taken away tomorrow, I really wouldn't be that upset.' That is awful. It's a horrible, awful, awful feeling and thing to think. But thank goodness I only thought that once. (laugh). I would never have harmed him, it was not a harming thing, just if I was given the opportunity I would never go through this again.*
> *(Jan. Int. 13. Para. 52).*

Jan spoke of how she had to resolve her feelings of guilt for not continuing to breastfeed and for not enjoying her son before she could have another child. In the following narrative, she describes how she came to the position of wanting to have another baby.

> *I think I knew that I had a choice and that I was right over that guilt thing. That I knew that if we had another baby that I didn't have to breastfeed, that I had a choice and that if things could actually go OK and I could get on top of it. If I had to bottle-feed from day one then that's what I'd do and they'll still be a healthy and happy child, and that they wouldn't be*

deprived or be so negatively affected. I wouldn't feel so completely guilty about that.
(Jan. Int. 13. Para. 54).

According to Inwood (1997, p. 52) to "will, wish or strive for anything whatsoever one must in advance already be care" (Inwood, 1997, p. 52). Women approached their infants with a stance of concernful care, and as a result wished and strove to breastfeed them. Through breastfeeding, women expressed their care; however, an important part of caring for a new infant is learning what it is that they require to be happy. This presents a significant challenge for most women. Some of the participants decided that breastfeeding did not satisfy their infants or work for them, but those women who persevered discovered that breastfeeding was the best way to comfort their baby.

9.3.2 Understanding Breastfeeding as Comforting

According to Gadamer (1996, p. 112), a comforted person is one who is "open to new things, ready to embark on new enterprises and, forgetful of ourselves, scarcely notices the demands and strains which are put on us... This is what health is". The participants in this study understood that an aspect of coming to know and understand a new infant is being able to console and offer them comfort when they are crying. In this context, comfort meant more than just a lack of crying; it was the ability to offer their infants a passage by which they could be readied to embark on life, and give themselves over to all that life had to offer. For the women it represented health for their infants.

For these women, breastfeeding became the tool with which they could sooth and comfort their infants. The relationships they forged through breastfeeding developed because of the solicitude a mother feels for her infant, was facilitated by time spent, being constantly present, and working together. As the relationship matured, the women came to understand that breastfeeding meant comfort, and ultimately, a sense of health for their infants, which in turn meant it facilitated their own sense of well-being.

In the following narrative, Kay shares how breastfeeding her son comforted him like nothing else would, offering him a sense of safety, security and reassurance

that he would be taken care of. Breastfeeding represented more than nutritional health – it also enabled Kay to offer her son embodied well-being.

> *It just sort of happens, if my son wants a feed he gets a feed. Sometimes at night he might want an extra one before he goes to bed, he might've had a bad dream or something - it comforts him as well. Two nights ago he woke up crying for some reason, I think he must have had a bad dream or the wind was howling, it could have rattled the windows, and he wanted a comfort feed. It wasn't a feed, more of a comfort thing for him. There's no way of comforting him like a comfort feed. I used to do that when he was little too, just feed and feed but not really feeding.*
> *(Kay. Int. 8. Para. 82).*

Jan had the opportunity to bottle feed her son and to breastfeed her daughter, and she noticed marked differences in her ability to comfort her two children. In the following narratives, she contrasts her experiences in relation to comforting her son and daughter. Breastfeeding became the ultimate source of consolation for Jan's daughter when she was upset, unlike her brother, who was considerably more difficult to console. Jan discussed why she believed that being at the breast furnished her daughter with a safe, secure haven, noting that breastfeeding seemed to "take away" the pain. The pain, which held her daughter back from engaging actively in life, was removed through breastfeeding. She spoke of how fulfilling it was, as a mother, to be able to offer her daughter life through comfort, and satisfy her child so completely.

> *I liked bottle-feeding him [my son], I didn't think there was much difference. But I would say that when he was beside himself, you know if he got himself really upset about something or you know, when he'd had his immunizations, or something like that, to breastfeed and to really snuggle with them, and to give them a breastfeed, they're almost completely satisfied. You know you can put them completely at ease and they're much happier. The bottle's not quite the same in my perception. I can snuggle close and give him his bottle but we're not quite as close and all encompassing as breastfeeding in those situations.*

Sometimes if she's [my daughter's] been distraught she's not drinking at all. She's just, you know, snuggling. She pacifies herself with my breast really, rather than having something to drink. It's not the milk, it's the being close. With my son there were a couple of occasions when I had wished I could, I would even bring out my breast and think 'Well even if you can just get close to it would that make you feel better?' But he was long gone past that stage then. Whereas, [my daughter] she'll always come to it but then she could just be a breasty girl, you know she just might be that kind of baby anyway... Initially with my daughter I felt like a bit of a milking machine, you know. I didn't enjoy it at all, it was just a function. Now that she has two bottles a day it is more of a comfort than having a lot of milk and it's nice. I quite like it. It's quite snuggly. It's usually first thing in the morning, you know very early in the morning, and it's just her and I and it's very quiet and she's having a lovely snuggle and something to eat and that's very nice. It's not just a function, it's a nice cuddly time.

I can almost feel it mentally as well as physically, I can feel my daughter wanting to be close. It's almost like when you snuggle in with your husband or partner, you know, and you can feel that real closeness. It's like having a really nice hug... Sometimes you snuggle that little bit closer and it just feels really nice. It feels as if you're cocooned. And, in that crying, I'm hurt or frightened or something that's what she does, she snuggles right in. She doesn't want her head out at all, she wants your arms right around her, she wants to be cocooned. And my son doesn't do that at all and he never has snuggled like that. He wants to be over your shoulder, held that way... [To be able to comfort like that is] satisfying, really satisfying, almost like you're taking away all the pain or the fright or the hurt and you can do it so quickly. You can soothe fears and all kinds of things almost immediately... It's great, fantastic. You can sometimes do it just by holding, but she responds so much faster and relaxes with breastfeeding, often they're tense when they've hurt themselves, and she just relaxes straight away.
(Jan. Int. 13. Para. 46, 48-50 & 84-92).

One participant, Eva, spoke of how she experienced a sense of well-being because she could completely comfort her infant through breastfeeding. It was a method of comforting that Eva, due to the positive solicitude she felt for her

daughter, was pleased to be able to provide. Breastfeeding supplied comfort and facilitated the health of both mother and child, releasing them both to engage in new enterprises and give themselves over to what life had to offer.

> *It's a really lovely feeling because you have the baby in your arms, which is a lovely feeling in itself, and you're satisfying her needs using your own body, which is a very satisfying feeling as well. If comfort is defined by having a sense of well being while doing it then yes, absolutely. There definitely has been times when the only way we could calm her down, if she's worked herself into a frenzy, is to pop her on my breast and immediately she'll stop crying and she'll calm down completely whether she's hungry or not, she receives comfort, and I'm really happy to provide that.*
> *(Eva. Int. 19. Para. 66).*

Breastfeeding also provided Sally with a great deal of pleasure. She especially enjoyed breastfeeding at night. Not being subjected to external pressures such as outside employment afforded Sally the freedom to focus on her relationship with her son, and a part of this relationship was breastfeeding. She spoke of how breastfeeding also offered her health by providing her with energy for all that life holds.

> *I really love it [breastfeeding]. I really love it. It's just great. Especially the middle of the night feeds. I wasn't pressured to go to work, I didn't have outside commitments. If I was really tired I'd sit down for an hour and have a feed and we're both going to get revived. I got a really strong letdown, but you also get an emotional response with that and I really did. I don't so much anymore, it still relaxes me and I enjoy it, but in the early days I used to really get a feeling of total contentment within a minute of him latching on. There is a hormone response to my understanding but it was all tied up with that.*
> *(Sally. Int. 11. Para. 32).*

As the women who participated in this study came to understand the ways in which their individual infants communicated, they came to understand that breastfeeding offers the ultimate source of comfort. The comfort and health that breastfeeding offered meant that both the women and infants were able to actively return to exploring and engaging with their existence. Breastfeeding

offered comfort, born through relational closeness, which enabled the return to life.

9.4 Being Close

Dasein exists as 'being-with-other'; knowing oneself is possible as a result of 'being-with-others', as *dasein* understands 'other' in relation to understanding itself (Heidegger, 1962). Heidegger (1962, p. 161) claims that "solicitous concern is understood in terms of what we are concerned with, along with our understanding of it". To express solicitude for 'other' we must come to understand and know ourselves. Heidegger (1962) also describes how we normally express the deficient modes of solicitude, such as indifference or passing each other by. In these deficient modes, it's impossible to come close to others, or know oneself, as one must come close to the 'other' to understand oneself. If *dasein* remains 'aloof' and 'hides away', it cannot come to know others, or even itself.

According to Heidegger (1962, p. 161), "being-with-one-another must follow special routes of its own in order to come close to 'others'". However, if one dwells closely and chooses to open up to 'other', authentic solicitude can grow out of this closeness. As one dwells with-other in a 'proximal' or close manner, he or she comes to understand the 'other', and also understands how to 'be' with 'other'. Being in close proximity makes 'being-toward-other' and thus, closeness, possible (Heidegger, 1962, p. 161).

Breastfeeding requires that a woman and her infant be physically close; it also requires emotional openness to the infant, otherwise a woman will feel "tense, unhappy and uncomfortable" (Eva. Int. 19. Para. 12). By dwelling closely with their infants through breastfeeding, the women in this study were 'being-toward' their infants, which allowed them to understand their infants; thus, authentic solicitude for their infants grew. Those women who persevered with breastfeeding spoke of how it facilitated closeness between them, and through this closeness they came to understand and know themselves, as well as their infant.

Sally spoke of how she expressed solicitude in breastfeeding her son. She enjoyed breastfeeding because it was an act that excluded others, even those who were relationally close to her son, such as his father and grandparents. She relayed how she did not want to lose this privileged relationship, as it was through being close that Sally came to understand fulfilment in a different and special way.

> *[Breastfeeding] it's just something else that no one else can share with my son; my husband can't and my parents can't. I think it just makes us really, really close to each other because it's something that only ever the two of us can share... I really enjoy the fact that he needs me and I really don't want to give that up. That's part of the reason that I'm breastfeeding, you know a small part of it but it is definitely there, because as soon as I stop he's not going to need me the same... I don't want to lose that.*
> *(Sally. Int. 11. Para. 88 & 90).*

Breastfeeding facilitated a time where Lee's son focused solely on her, not on any other. Breastfeeding provided the time to be relationally involved and thereby solidify their attachment through being close.

> *[Breastfeeding] it's one of the times when you have a really nice time with your baby just responding to you, not to everything else as well. And it's a lovely time to talk to them, to hold them and cuddle them and all that kind of thing.*
> *(Lee. Int. 10. Para. 60).*

The understanding that Emma came to was that breastfeeding her infant gave her a sense of purpose and a belief that she was needed. The 'always-nearness' of her infant meant that there was a depth to their relationship, facilitated by solicitude, that was expressed through breastfeeding. This close relationship made Emma feel special, and weaning her child off breastmilk onto the bottle meant that she would no longer have exclusivity within their relationship. Emma's relationship with her baby was valued, unique and distinct from other relationships because of the authentic solicitude and closeness that breastfeeding created.

> *When you're pregnant you know that you're the one that's keeping them alive, and keeping them well and breastfeeding them and you've got them all the time, but once they're on the bottle they can be separated from you... You're no longer special.*
> *(Emma. Int. 14. Para. 105).*

Abby spoke of the closeness that she felt for her children as a result of breastfeeding. She had breastfed her first child, a daughter, for five months before conceiving her second child, at which point she could no longer maintain her milk supply and subsequently weaned her daughter. She went on to breastfeed her second child for 18 months. At the time of the interview, Abby was breastfeeding her third child, a boy, who was five and a half months of age. She spoke about the differences in her relationships with her daughter and her two sons, attributing these to the closeness of breastfeeding. Solicitude allowed Abby to build a close relationship with her sons. The closeness experienced through this relationship taught Abby's sons about authentic solicitude, which was expressed through their reciprocal closeness and learned ability to express solicitude for Abby.

> *I fed my son longer and I'm closer to him than I am to my daughter who I didn't feed for very long at all... I think it's because you've spent so much time together. They're latching onto you, you're sharing a little bit more, more than you would just sticking a bottle into their mouth. My other son is quite clingy, this one [the youngest child] is fine but the other one gets quite jealous. He's forgotten what breastfeeding was but he knew that closeness.*
> *(Abby. Int. 2. Para. 38 & 41).*

For Kate, breastfeeding meant a physical closeness to her young son. She talked about how she enjoyed the quiet and stillness of feeding at night, and enjoyed having the time to focus on her son away from the busy-ness of the day's routine. She discussed how seven months after her son's birth she was still amazed by the miracle of his life and how he was growing and developing as an individual. Breastfeeding him facilitated the relationship between mother and son and also provided Kate with time to learn about his personality.

> *I get lots more cuddles because that's all part of the breastfeeding. That tummy on tummy stuff and in the middle of the night it's just you and him*

and it's like you and the baby are the only ones in the whole world that are up at that time of the morning. I'm sure if you were to phone around there are a hundred thousand other women doing the same thing... We just had a light on in the room and the radio playing quietly in his room for a while and it's a really calm sort of experience. I love to sleep so I was really thinking it was going to be torture, but I found you're a zombie, but when you see them it's far more pleasant than I thought it would be... I suppose because you're getting to know this little person. [My partner and I] we sit here at night and go 'Oh my god - we made him', that whole new parent cliché where you are stunned that you've done something like this ... you set this thing in action when you conceived and it's happening to you and all you've got to do is eat properly through the pregnancy and the rest takes over and then just one thing after they're born, you're doing it.

It's a bond. [The baby,] it's now a separate entity, he's not a part of you anymore, he's not reliant on you, he's becoming more so as his personality is developing. There's a real feeling of doing that bonding... And I think breastfeeding helped all of that. I still love it sometimes if he sleeps too long I want to go and get him up. You actually miss him because there's almost an unnatural bond I suppose. I'm just so pleased that breastfeeding worked because I don't have to boil bottles and mix formula and the cost of it. All we've had to do is look after me. (Kate. Int. 3. Para. 14, 16, 18 & 20).

Eva shared that mothering a child irrevocably changes the way in which a woman understands herself. A woman who has mothered will always have an enduring link with her offspring. In part, this link is due to the responsibility or solicitude a woman feels towards her child. Eva recognised the unique nature of this relationship and acknowledged that her relationship with her daughter is different to any other relationship she will ever have.

There's something really special about being a mother and no matter what happens to your children you're always going to feel a special bond. It's tied into a quote I heard 'husbands and partners can actually come and go but if you don't have children you'll always be childless, but if you have children you'll always be a mother'. You're always going to have your children... It's special, special, they're your full responsibility.

(Eva. Int. 19. Para. 79).

Breastfeeding had opened up the opportunity for Eva to experience closeness with her daughter. She spoke about how the relationship and closeness between them existed in part because they had both worked at it together.

> *Certainly breastfeeding has made me feel closer to my baby. I'm pleased that we've been able to make it happen together. I would emphasize that it's a two-way thing, you have to learn your part but the baby also has to learn to do her part, the fact that we've managed to do that together I think makes me feel closer to her. I think I would, especially in the first few months, have felt that I'd let her down if I hadn't been able to do it.*
> *(Eva. Int. 19. Para. 116).*

Eva had experienced a great deal of difficulty during the process of establishing breastfeeding, and had to persevere through a significant amount of pain to continue. At the time of the interview, she was still breastfeeding her daughter, who was three months of age. Eva understood the embodied experience of breastfeeding pain; however, she referred to breastfeeding as 'easy', and stated that "it just happens". She expressed a stance of openness toward her daughter. This led to relational closeness with her daughter, which gave her the strength to stay-the-course required of her to breastfeed, thereby overcoming her embodied experience of pain. During the interview, Eva breastfed her daughter, and in the following narrative, which emerged at the end of the breastfeed, Eva expressed authentic solicitude:

> *(Laugh). You just had a lovely time didn't you? (Comment is directed to the baby). I must say this is the best moment when she comes off and her face is all pink and she can hardly hold her head up and she looks all pleased, and fat cheeked... It's not deliberate, it just happens, you feel such wonderful feelings towards her and then she's so cute and it's just easy to do it. It just happens. You could say I don't have a choice, because I'm her sole caregiver but there's ways you could look after your baby if you didn't want to. It's just such a natural, easy thing. And, she's just so cute I can't keep my hands off her (laugh).*
> *(Eva. Int. 19. Para. 140-142).*

For Amy, breastfeeding facilitated mutual growth for both mother and son. Amy points out that she had to make the commitment to be there through breastfeeding, requiring her to dwell with openness with other. Initially, their relational growth developed because of the consistency of contact associated with breastfeeding a young infant. As time went on, the frequency of breastfeeds diminished, but the foundational bond formed through their constant contact paved the way for a secure relationship. Openness to being close through breastfeeding facilitated authentic solicitude, and thus their relationship flourished.

> *It was just a process, a continuum, something that grew. Initially when my son was born you connected to him through the consistency of feeding him. You knew that you were going to have to feed him in a couple of hours and that was it, you were just constantly feeding him. It never really felt like it at the time and gradually as he gets older it becomes more of a pattern, there's more of a routine to it. You grow with it and he grows with it and to me it became more and more a part of the lifestyle. As he grew I was growing too. We both grew physically and mentally.*
>
> *In terms of my relationship with my son I believe it was truly enhanced by breastfeeding. For his first year of life and even now I suppose I have spent so much time with him and have been there for him through breastfeeding. I've had to be there for him and making a commitment to breastfeed, I've had to be there for him. In that way our relationship is now so strong and so solid because of the foundation of that first year, and even now has been built on that knowing that I'm always going to be there for him, to feed him when he needs it. In terms of our relationship I believe that's really grown and been really strong as a result of that. (Amy. Int. 1. Para. 32 & 34).*

Kay also spoke about the closeness that exists between a mother and her baby when engaged in a relationship that incorporates breastfeeding. Kay was a solo mother who did not share custody with her son's father. She relayed an incident in which her young son responded to her, and discussed how breastfeeding was more than just physically providing nutrition. Breastfeeding provides many cherished intimate moments for a mother and her infant. The relationship a mother has with her child when breastfeeding is reciprocal and

facilitates the development of authentic solicitude. It is this mode of solicitude that cements the relationship between them.

> *Not that long ago I was sitting on the couch there feeding him and my girlfriend was sitting in here, and my son was feeding then he stopped and he was looking up at me and I was just looking at him and he went like this with his hand to my face and just touched me. My friend said 'Oh look at that that's so neat'. It was just a neat feeling, like a real bond. I guess that's what you can see when you're feeding them all the time. It's a special moment, I guess that's the only way I can really explain it was through that moment. It's like the way he just looks up at you and gives a smile and touches your face like that, it's really neat. It's really hard to explain. Breastmilk is the best thing for the baby but it's also something else as well, not just feeding the baby, it's a bond.*
>
> *Sometimes I look at my son and I think 'I haven't only just given birth to him, but I'm making him into who he is now. You're giving him the best possible start to life. They say if you breastfeed it offers the best start in life. Sometimes you feel so much love for him when you're feeding him, I don't know why. Sometimes it makes you really happy. Sometimes you get tears in your eyes, it's happiness, not sadness. One day he's going to grow too big for this (laugh).*
>
> *It's a special time while I'm breastfeeding my son. And at night before he goes to bed he knows, he sometimes looks at you and grins from ear to ear. It's for me only. No one else can share in that. Which may sound a bit selfish, but I carried him for nine months, I gave birth to him, I've looked after him and no one has helped me right from day one. Right from the day I was pregnant I've had no help. So the way I see it I deserve that (laugh).*
> *(Kay. Int. 8. Para. 58, 64 & 119).*

Women come to understand other, as well as themselves, through breastfeeding. They also come to experience authentic care in different ways because of their experience of breastfeeding. As previously mentioned, Heidegger (1962) highlighted that authentic solicitude is exhibited through two positive, but different, modes, described as 'leaping-in' and 'leaping-ahead'.

Both examples of authentic solicitude provide insight into the being of a woman that breastfeeds.

9.4.1 'Leaping-In'

Authentic solicitude is exhibited when one 'leaps-in', to take-away, or take-up, the care of another (Heidegger (1962). This type of solicitude is typified by the dependency of 'other', and can result in 'other' being dominated. When considering the relationship of a woman and her infant, the infant is by necessity dependent upon his or her mother, which offers the opportunity to explore Heidegger's concept of solicitude as expressed when 'leaping-in'.

The women who participated in this study expressed authentic solicitude through the mode of 'leaping-in'; however, it was not because of a wish to dominate, but rather because breastfeeding meant that their infants were dependent on them. Mel shared her enthusiastic perceptions of what the breastfeeding relationship meant for her, reveling in the idea of being able to completely and exclusively care for her baby.

> *How wonderful is breastfeeding – you put your baby on and you're looking after your baby completely. There doesn't have to be anybody around at all, and it's just you and your baby. As long as you eat and drink you're taking care of every single one of its needs and that to me was wonderful.*
> *(Mel. Int. 17. Para. 24).*

Sally expressed authentic solicitude for her infant through 'leaping-in' and providing for her infant, which meant she took away her infant's care or concern. She also spoke of how she believed she was closer to her son because of breastfeeding him. She spoke about how her companions could leave their infants at home, but to her that was inconceivable because of the dependent nature of breastfeeding, and the resultant bond this relationship created.

> *One mother at coffee group the other day said her husband had taken her child away for the weekend to see his parents and it was the first weekend without her child and I just couldn't even comprehend that. I'm breastfeeding so physically I couldn't do it but emotionally I couldn't*

imagine being away from my son for that period of time. I mean I go to work for 3 1/2 hours, and the first thing I do when I come in is go and check him in his cot and make sure he's alright because it seems like so long since I've seen him... I mean my son needs me, like really needs me, whereas perhaps these other babies don't need their mothers quite the same, yea it's tricky. It's really hard not being able to talk about it cause I can't say "I think you're not as good a mother" cause it's not that they're not good mothers it's just... the closeness.
(Sally. Int. 11. Para. 50).

Sally's narrative highlights how solicitude is 'leaping-in', and within this context means accepting the dependent nature of the relationship between mother and infant, which is especially evident when a woman chooses to breastfeed. The other type of solicitude the participants expressed was exhibited through the mode of 'leaping-ahead'.

9.4.2 Leaping-Ahead

Authentic solicitude also *'leaps ahead'* and desires to provide the other with authentic care and independence (Heidegger, 1962; Inwood, 1999). Liz provided an excellent example of solicitude that 'leaps ahead'. She had struggled to establish breastfeeding, and it had taken commitment to reach the point where she enjoyed breastfeeding her daughter. The solicitude she felt for her daughter was expressed in Liz's desire to be very close to her daughter. During this time of being close, Liz was able to silently watch her daughter and dream about her daughter's future. For Liz, this type of solicitude was expressed in "doing the right things", which meant that she could ensure a positive future for her daughter. Liz was actively anticipating the day when her young daughter would secure her own independence.

It's amazing watching my daughter and trying to imagine what she's thinking because often she'll be lying there and her eyes are flicking side-to-side looking or looking at my chest (laugh). I just often sit there and stare at her looking at me. But I also do watch BBC World News in the middle of the night (laugh). So I'm not always just sitting gazing totally at my daughter but... (laugh). You're looking at this beautiful child that you've nurtured and that you're continuing to nurture and my

> *mind often wanders. You wonder what is she going to be like when she grows up and, you know, are you doing the right things - yes I am, obviously she's happy - that lovely sense of being very close to your baby.*
> *(Liz. Int. 9. Para. 62).*

Kate offered authentic solicitude as expressed by 'leaping-ahead' to facilitate her son's health and wellness. For Kate, breastfeeding was more than providing physical nourishment, it was a way to gift her son the best she was capable of giving. Through the provision of breastmilk, Kate endowed security, comfort, health and love on her young son.

> *Very early on when he was newborn I really felt like I could visualize, I could just imagine him taking all that from me as well as the milk, all the love, nurturing, security, all the things you want your baby to have. I wanted him to feel like he was in this huge big cocoon of love and security so that he would always feel content and never feel all that sort of stuff. And you can actually visualize that, leaving your body with the milk and going into him. And you'd sit there at night and that's what I could do and I can still do it sometimes. Even today when I'm sick, I visualize all these little antibodies so that he doesn't get it from me.*
> *(Kate. Int. 3. Para. 66).*

A woman who breastfeeds must be open to being close to her infant, to achieve which her solicitude must be authentic. Authentic solicitude is needed because a woman must possess the willingness to alter her life and embrace her infant in such a close and intimate manner. If her solicitude is authentic, then through this closeness she is able to concernfully nurture her infant. Authentic solicitude also offers a woman the opportunity to come to know herself in a new and increasingly authentic manner as "knowing oneself is grounded in 'being-with'" (Heidegger, 1962, p. 161). As women learn more about themselves and their infants through 'being-with' in a close manner, the breastfeeding relationship becomes privileged.

9.5 Breastfeeding as a Privileged Relationship

When two individuals dedicate themselves to the same activity, "they become authentically bound together... which frees the other in his freedom for himself" (Heidegger, 1962, p. 159). The type of authenticity with which one is released into their ownmost possibilities for being is the solicitude that 'leaps-ahead' of the other to promote independence. A woman breastfeeds because she desires that her infant have the best she can offer, by way of the physical benefits breastfeeding offers, as well as the relationship that is developed through such intimate nurturing. The desired result of this authentic solicitude is an infant that will eventually gain his or her independence and take hold of that which is his or her ownmost potentiality for being. The breastfeeding relationship that is forged through authentic solicitude facilitates an exclusive, close, and intimate connection seldom experienced in other relationships; therefore, the breastfeeding women in this study considered that the relationships they shared with their infants were privileged.

For some women, breastfeeding is intrinsically linked to the mothering role. Abby shared how she had come to understand the relationship that breastfeeding fosters between a woman and her infant. Abby was a young Maori mother who had three children, and believed that breastfeeding was an integral aspect of mothering. She spoke of how breastmilk was a gift a mother could provide for her baby, claiming that, despite the pain a woman might go through to breastfeed, breastfeeding was special and the best food source for her baby.

> *I think it's something special for the mother to go through to breastfeed her baby. The fact that you know it is your child and you're giving it what you can. If you really want to be a mother I guess that's part of it. (Abby. Int. 2. Para. 116).*

Abby believed it was important to facilitate the relationship with her infant through breastfeeding, by being focused on breastfeeding when it was time to feed her babies. She believed that to breastfeed she needed to relinquish her previously-held sense of self, and embrace the mutual dependency required to breastfeed, a process that could only occur if she was open to expressing authentic solicitude. She believed it was imperative to relax and think about the baby, otherwise the baby would perceive this and fail to settle and feed. Abby

recognised that breastfeeding represented more than nutrition; it was about a relationship that required being 'wholly' present. If she was not focused on their relationship then breastfeeding would not work.

> *Just sitting and relaxing - that's what you're really doing, is thinking about breastfeeding the baby. If you're thinking of other things you can't be feeding the baby. If you're tense and feeding your baby the baby feels it and he's going to carry on crying, no matter what he's not going to eat... Bottle-feeding you just stick it in their mouth and they're quiet. No matter what kind of mood you're in as long as the bottle's in their mouth they're not worried about it...*
> *(Abby. Int. 2. Para. 94 & 96).*

Abby was disappointed to wean her first daughter at five months of age. Because she became pregnant with her second child, her milk supply was greatly diminished and she could no longer continue. She mourned the loss of breastfeeding her daughter and spoke about how it affected the closeness of their relationship. She spoke of how breastfeeding facilitated closeness and trust between a mother and her child, thus making the relationship a privileged one.

> *Since I've been able to experience both [breastfeeding and bottle-feeding]. That's where you are bonding with your child is different. I've found that with my daughter it's definitely different. As far as closeness is concerned she's not as close to me as my sons are... With communication it is time and because you're breastfeeding them they know that you're giving them time and they know that you will have time for them... I've always been told and read quite a bit about it, that the touching thing is a bonding thing so I guess that that would be part of it that skin-to-skin contact... A lot of times when he wants to be breastfed its not because he's hungry, it's just because he wants his time.*
> *(Abby. Int. 2. Para. 98-100 & 104-106).*

For Abby, breastfeeding involved both her own mother and her mother-in-law. Abby's extended family valued the relationship forged through breastfeeding and supported Abby to breastfeed, thereby assisting her to develop the relationship with her children. By providing certain foods to nourish Abby's milk supply, the grandmothers provided their grandchildren with a gift for their life

and nourishment. In the following narrative, Abby explains how her mother-in-law supported the privileged relationship that Abby had with her children through breastfeeding.

> *My mother-in-law had a few children herself and she's looked after all my nieces and nephews, they've got quite a big extended family. She helped out with my breastfeeding. When my babies were first born she would always bring over a meal for me at lunchtime and dinnertime so that she knew that her grandchildren were having something decent to eat. Not just feeding me but more for the babies.*
> *(Abby. Int. 2. Para. 74).*

Breastfeeding afforded the opportunity for Kate to be close to her young son and thus she was coming to know and appreciate him in a very special manner. She rejoiced in the way his life had started and reflected on how he was growing, developing, and responding to her as he aged. Breastfeeding meant being close, and establishing a warm nurturing relationship together. Kate and her son had come to know each other through breastfeeding, experiencing and expressing this relational closeness by giving themselves over to being playful and delighting in the process. As a result, their breastfeeding relationship was privileged.

> *My son's head has just been of fascination to me since the time he was born and he's had, he's got that scar on the side - that's a forceps scar - so he was sort of wrenched into this world unceremoniously in the end and his head has just fascinated me ever since. I don't know if it's to do with that or it's just to do with the fact you always love babies, you know yourself that, when you hold babies the smell of their head is always lovely. The top of their head and their hair. They're so incredibly warm and soft and his heartbeat too, you know with the fontanelle. He often now holds hands with me. If he's not tired and he's just feeding he'll put his foot up on my shoulder or he does some real boy things like his feet are going the whole time. It's a lovely time. It's very seldom that I've done it but it's really nice if I feed him when I'm just in a dressing-gown, to have tummy-on-tummy is really lovely as well. There's lots of handholding at the moment, as he's got older. There used to be lots of touching his head - I think that's what wore all the hair off for a while. I'm a fiddler, if he's got any sort of thing, you're doing the ear touching,*

touching his hair, give him the once over while he's still for five minutes as well. See whether his fingernails need cutting and all that sort of thing. It's a relaxing time now. If I'm hyped he picks it up really easily now. If there's someone else here or something better that he might want to look at. He'll do the flirty thing now when he's on the boob too, look over backwards and you know, even with his dad. So it's obviously a place where he feels really secure too. I've had such a positive experience with it. I wish a lot more people did.
(Kate. Int. 3. Para. 74).

Eva offered a poignant example of a woman who authentically cared for her daughter. In her solicitude, Eva desired that her daughter be healthy, happy and thriving, and theoretically '*leapt ahead*', doing her best to ensure that her daughter would achieve all she hoped. Therefore, Eva chose to breastfeed despite cracked nipples and severe mastitis. She spoke passionately of how thrilled she was to see her little daughter thriving as a result of her persistence with breastfeeding. Eva posited that watching her daughter growing and developing successfully gave breastfeeding a purpose beyond the pain. She believed that being able to succeed through the pain and continue breastfeeding was one of her greatest achievements. It was through this achievement that Eva felt privileged: not only had she succeeded at breastfeeding, she was also providing her daughter with everything she needed for life. As a result of this privileged relationship Eva gained insight, as her possibilities of, and potential for, 'being' were revealed.

It's the best feeling in the world. People will say how healthy and beautiful she looks and I think I'm actually growing her myself. She's thrived on breastmilk and those times of discomfort you don't even remember them anymore. I'm not, you know, delighted with the pain but knowing that there's a higher purpose.

I actually feel, personally, that it's one of my greatest achievements to have got through that really difficult time and to have breastfed the baby thus far. I'm really proud of myself (laugh)... I felt special that I was a breastfeeding mother. Even when I was walking around without the baby there was something special about me because I was breastfeeding. I'm actually someone else's food source. I felt superior in a way... but maybe I'm a bit more special because I'm a breastfeeding

> *mum. I know that that will actually go away once I'm not breastfeeding anymore and I'll move into a different stage of life. At the moment I'm certainly enjoying it. I enjoy the feeling that I have achieved that.*
> *(Eva. Int. 19. Para. 11,19 & 27).*

As one comes to know another in an authentically-caring manner, one also comes to know himself or herself, and thus one's ownmost potentiality for Being is realised (Heidegger, 1962; Paley, 2000). Eva discussed how privileging the breastfeeding relationship she had with her young daughter had altered her perspective and changed her as a person. She spoke about the deep sadness she felt at possibly failing her infant because she was not coping with the pain she was experiencing in relation to breastfeeding. Eva provided another example of solicitude that '*leaps in*', conceding that being responsible for providing another life with the nourishment needed was a daunting task; however, what emerged as significant from *leaping-in* and taking away the care of another was what she had personally gained from having privileged the relationship. For Eva, succeeding at this important role had changed her perspective on life significantly.

> *The idea of having a person fully dependent on me to provide them with milk from my own body, has certainly changed me because I've found that concept pretty daunting, especially with my nipples being so sore and having mastitis. I really wanted to rise to that challenge, but I struggled physically to do that and that was awful, I got very depressed because I wasn't doing it very well. The idea that I was the milk source for someone else did change me quite a lot, it's again hard to describe exactly why or in what aspects. It probably softened me, and made me calm down and made me look after myself a little bit more because my daughter is dependent on me to be healthy so that she could get what she needed.*
> *(Eva. Int. 19. Para. 118).*

Kate spoke of how privileging the breastfeeding relationship with her son meant having her ownmost potential opened up to her, and as a result she considered herself enriched. She was able to extend her horizons through further understanding the cyclical nature of life. In the following narrative, Kate explains how she came to this extended understanding, relaying how coming-to-understand her embodied ability had been an awakening experience, and

how she reveled in this new knowledge. Through her privileged journey with breastfeeding, she had learned to celebrate the life-giving power women possess.

> *My Nana died a couple of weeks ago. They [the hospice staff] thought she was going to pass away and the hospice [staff] said we could stay up there for the night if we wanted to so my husband stayed here [at home] with the baby and I went into the hospice and I stayed there till about two o'clock in the morning and mum said to me you've got a little boy to feed so go home. I was just going to go straight home in the morning to feed him but the whole time that you're there you're aware that - what's my milk going to be like in the morning? I'd been up all night and it was a fairly sort of emotional time so I came home about two am and then got up to feed him at seven, but driving home was so neat, to be coming home from that situation, it was that whole cyclical thing where someone's dying but you're going home to this new life. Breastfeeding's such a positive - it's a new life thing, as opposed to the end of a life. It's one of the few times that you'll ever do anything like that I suppose. So it was really good to come out of that atmosphere and come home to something quite positive. It's still with you, you're coming home to this little dude that needed you to be there for him. That was a really positive time as well to happen. It certainly brought out a part of me that I probably didn't know that I had. The whole function, when I was pregnant it was probably the same. I used to have this analogy that I used to tell everybody, that it was like when you're born you're given, 34 years ago I got given this Porsche, and I've just been driving it around town and all of a sudden by getting pregnant I'm actually taking it out on the open-road and seeing exactly what it can do. Like I've not been using my body to anywhere near its capabilities and all of sudden I've got this prestige car that I've been driving as a supermarket trolley just around town, and all of a sudden it's out on the open-road and it's amazing what we can do. We're awesome. Women are amazing and I think any man that goes through it with his wife or lady would be in awe of them. Even right up to the breastfeeding and including that. It's just a fact, we're machines designed to, and it's not saying that that's what your whole life's all about but it's bloody amazing to know that that's what your body can do.*

(Kate. Int. 3. Para. 70).

At the close of her interview, Kay offered the following narrative as a summative reflection on what she had gained through her breastfeeding experience. She concurred with Kate's understanding that breastfeeding had opened up her possibilities for being, which she attributed to privileging the relationship she had developed with her son through breastfeeding. She relays how her relationship with her son had completely altered her life; she speaks of a relationship 'with-other' that supports and strengthens life, a relationship that released both her son and herself to achieve their ownmost potential.

> *I haven't changed my life for my son, it's [that] he and I are building a life together. We're building a new life. He's changed my life but we're changing it together, for the better, so I don't feel tied down.*
> *(Kay. Int. 8. Para. 156).*

A breastfeeding relationship is often forged through hard work, pain and perseverance. However, it is also through this privileged relationship that a woman comes to know her child and establishes a trusting relationship. Paley (2000) asserts that, if *dasein* maintains itself primarily in deficient modes of solicitude, then successful attainment of positive modes of solicitude "may count as an attainment, a successful realisation of what one truly is" (p. 69). A successful breastfeeding relationship offers an example of the successful attainment of a positive mode of solicitude. It also highlights how women can come to know who they truly are, and what they are truly capable of, as reflected in Kate's (Int. 3. Para. 70) narrative about the embodied knowledge that she had gained through her experience of breastfeeding.

A woman who provides her infant with authentic solicitude is concerned with the care of her infant. This infant is not influenced by, or familiar with, their ways of 'being-in-the-world'; therefore, the relationship a woman has with her infant is a relationship that is isolated from the tensions that exist in being with 'the they'. Instead, the infant chooses to communicate in ways that are not sullied by such things as the call to averageness. If a woman can authentically attend to her infant, then the relationship is freed to be what it is, and all that matters is what is passing between her and her infant. This unique and privileged relationship provides a woman with enhanced understanding of what it is to be a woman in a way she would not otherwise have access to. She may possess fulfilment

because she has experienced this relationship; she may also fathom in greater depth the purpose of life. As a result of these enhanced understandings of womanhood, she is released into her ownmost potential for being.

The mode of authentic solicitude expressed by a mother through breastfeeding is the solicitude that both 'leaps-in' and 'leaps-ahead'; it is solicitude that aims to open up the path by which the 'other' can be freed to care. The relationship built through breastfeeding, through 'being-with' in the mode of authentic solicitude, may be the closest relationship that infants have in their first year of life. When a woman is willing to express authentic solicitude through a privileging of the breastfeeding relationship, her infant will experience closeness 'with-other'. In doing so, the infant will also be exposed to authentic solicitude, and thus, the infant will learn about both care and themselves through 'being-with-other', and ultimately be freed to secure their future independence.

9.6 Summary

The primordial mode of Being is that of care – we care for 'others' with solicitude. A woman expresses solicitude for her infant when she chooses to breastfeed. Initially it can be difficult to understand the cues that a new infant offers, and out of her concern, along with difficulties associated with the establishment of breastfeeding, a mother may decide to wean her infant. However, if she continues to breastfeed her infant, then she comes to understand that breastfeeding provides comfort and closeness. In consequence, breastfeeding becomes a privileged relationship through which a woman provides her infant with authentic solicitude, by both 'leaping-in' and 'leaping-ahead', thus providing a way for her infant to ultimately gain independence through health and happiness. Through this experience with authentic solicitude, both mother and infant are freed to attain their ownmost potentiality of being: "Authenticity involves taking responsibility for who I am and who I will become, recognising that at every moment I am in the process of building a life – a life that is 'my' life, not merely in the sense that I am the one living it, but in the sense that I have created it" (Paley, 2000, p. 73).

This marks the end of a sequence of chapters that have explored the findings of this research, focussed on the rich narratives provided by the women who

participated in this study. The following chapter offers an interpretive discussion of these findings, from the viewpoint of the researcher rather than the participants.

Chapter Ten

Discussion

10.1 Introduction

Statistics published by the Ministry of Health (1999b) indicate that, within New Zealand, breastfeeding initiation and duration rates have remained static for some time, despite national strategies to achieve the WHO's (2002) goal that women exclusively breastfeed their infants for the first six months and continue to breastfeed for two years (Ministry of Health, 1999b; Ministry of Health, 2001; Ministry of Health, 2002). I have argued that, unless researchers and policy authors pay attention to the experiences of breastfeeding women, current breastfeeding rates are unlikely to change. With that in mind, this research study has explored women's experience of breastfeeding in New Zealand. Its findings reveal that breastfeeding occurs within the context of historically-mediated societal interpretations, and breastfeeding is understood by women to be an embodied practice that ultimately facilitates their authentic care of their infant. To fully explore the meaning of the participants' experiences of breastfeeding, this chapter offers the researcher's interpretations of these findings and explores the implications for health care professionals. The limitations of this study, along with the areas that would benefit from additional research, are also discussed.

10.2 Revisiting the Aim and Methodology of the Study

The aim of this study as articulated in Chapter One has been to explore women's experience of breastfeeding in New Zealand. The thesis that emerged from adherence to this aim is that breastfeeding women experience society, embodiment and concernful solicitude in ways that were previously hidden from them, and would have remained so without the experience of breastfeeding. These new experiences provide a woman with a wealth of knowledge about intuitive embodied listening, as well as societal interpretations of breastfeeding.

This study has employed a reflective lifeworld research methodology, based on the philosophical work of Heidegger (1962), Gadamer (1989) and Merleau-Ponty (1981), which has guided me to approach my research with a stance of openness, whilst being aware of the impact of historicity on current understandings of breastfeeding. It also provided the research's foundation on the hermeneutic circle, which is integral to calling forth of meaning from the participants' narratives.

Breastfeeding is an issue that has been written about at great length (see Chapters Two and Three for a review of the relevant literature); however, commonly-held understandings based on this literature frequently ignore the meaning that breastfeeding has for women, and the literature that does focus on meaning has little sway in the public health policy arena. Addressing the issue required a methodology that enabled a return to a well-researched phenomenon to re-examine it for the meaning that breastfeeding has for women in New Zealand. Reflective lifeworld research allowed me to re-examine what it means to be a breastfeeding woman in New Zealand, unconstrained by previously-developed theoretical frameworks.

The need to respond to the participants' narratives, valuing them for their inherent meaning, was of particular importance to me. It was my desire not to infuse their account with the language that currently exists around breastfeeding, but rather to enable these women to use language that reflected their experience of the lifeworld as it appeared to them. In doing so, women can take ownership of their knowledge and facilitate a language that supports, rather than undermines, their experience. Reflective lifeworld research allowed me to embrace women's language, rather than excluding or altering it to fit a pre-determined framework. To that end, I have included extensive passages from the women themselves.

The following discussion renders my interpretations of the narratives offered by the breastfeeding women who participated in this study. The various sections highlight specific issues that have emerged, and that need to be explored and resolved if health care professionals are to provide support to breastfeeding women in accordance with their needs.

10.3 Coming-to-Know: Creating Breastfeeding Knowledge

Giving birth to, and breastfeeding, children is the domain of women. These acts are understood to belong intrinsically to women, and they represent and constitute aspects that are integral to mothering. Women who become mothers may have the opportunity to use their bodies to engage in the process of nurturing and growing infants and children, and in doing so, embrace a significant amount of responsibility and accept a challenging task.

The women who participated in this study articulated a strong desire to breastfeed their infants, because it represented to them the ultimate source of nutrition. Other research studies also highlight that women choose to breastfeed because of a deep desire to provide their children the very best they can offer (Arora et al., 2000; Earle, 2002). This desire provides strong motivation to initiate breastfeeding, deeply affecting the decision-making process of women who breastfeed.

First-time mothers who choose to breastfeed engage in a process of 'coming to know self' as women capable of breastfeeding, a process that for some begins at a young age when girls become aware that women feed their infants at the breast. The culture women have grown up in provides them with a backdrop from which to interpret breastfeeding, which affects their own decisions about infant feeding and ultimately mediates their approach to breastfeeding. However, before a woman begins to breastfeed she must know that her body is capable of producing milk and feeding an infant. The knowledge that an infant can thrive on the milk she provides requires confidence and awareness of her body's ability.

Ryan (1999a) demonstrated that women have the ability to embrace a variety of differing perspectives that enable them to interpret breastfeeding and their experiences with it. Prior to ever bringing a baby to her breast, a woman will have gathered a wealth of information that will form the basis from which to interpret her experience. This groundwork comes to the fore as a woman contemplates being a woman who breastfeeds, and the decisions she makes prior to breastfeeding pave the way for the experience she will have of breastfeeding. For example, a woman may establish a desire to be discrete

when feeding her infant around others, or she may embrace the concept of demand feeding, which will affect her experience once breastfeeding begins. By making these determinations, a woman defines who she will be as a breastfeeding mother. This process of coming to know oneself as capable of breastfeeding takes time, and will occur even if a woman does not engage in a premeditated examination of her beliefs.

First-time mothers must come to know their bodies in a different way. Beginning with pregnancy, they must navigate their way through new territory, coming to understand their breasts as functional and capable of sustaining another life. This process is intrinsically linked to coming to know that their infants are enjoying breastfeeding (see Chapter Nine, Section 9.3.1). Each infant will respond differently at the breast, and learning to interpret their infant's cues and behaviour provides women with the confidence that they can care for their baby's needs through breastfeeding. This is evidenced by the participants who discussed at length how they came to understand breastfeeding as the ultimate source of comfort for their infants. These issues have also been highlighted in another New Zealand study (Dignam, 2001).

Understanding the breast as functional necessitates an understanding of the 'always-thereness' of breastmilk, and requires that women learn to manage the unpredictability of breasts that make milk. Women by necessity must embrace and accept their altered sense of self, or they will continually be uneasy with the re-configuration of their bodily boundaries and purpose. The inability to reconcile their bodily breastfeeding experiences can ultimately mean the end of breastfeeding for some women, especially in a culture that values independence and freedom (Beasley & Heritage, 1998/1999).

Unachievable ideals of motherhood, including breastfeeding practices, result in women interpreting themselves as failures (Maushart, 1999; Rubenstein, 1998; Swigart, 1998). This study has clearly demonstrated how women strongly desire to mirror the perfect breastfeeding mother, defined by having a thriving healthy infant who is settled in a routine. Such ideals can shroud the reality of breastfeeding, which follows a complex path of coming-to-know self as well as the infant. A lack of understanding of the process of establishing and maintaining breastfeeding can lead women to believe that they have failed at breastfeeding, either wholly or in part. Unfortunately, this study highlights that

many women find themselves in this circumstance, due in large part to the silencing of the more difficult aspects of breastfeeding.

10.4 The Shrouding of Breastfeeding in Silence

Once a woman conceives, she will at some point birth a baby, even if the infant has not fully matured – she has no control over this. And although a woman's body will initially produce milk for a newly birthed infant, women do have a choice whether to initiate and continue to breastfeed their babies. The reasons women give for not continuing to breastfeed have been well documented (Gunn, 1984; Mozingo et al., 2000; Scott et al., 2001; Vogel & Mitchell, 1998b). Despite this, the women who participated in this study discussed how a realistic picture of breastfeeding was unavailable from their social networks, antenatal education, or the various types of media. While the silence that exists around giving birth, and the overwhelming nature of becoming a mother, is well recognised in the literature (Maushart, 1999; Rubenstein, 1998; Swigart, 1998), the silence that exists around the realities of breastfeeding is not.

This silence undermines women's confidence when facing unexpected breastfeeding difficulties, and may lead to feelings of isolation in women struggling to establish breastfeeding, especially when peers seem to have 'perfect' infants. The belief that they are not measuring up to the ideal mother further silences them, the end result being an inability to seek the help they need. The participants in this study who struggled to breastfeed continued to do so in silence, and shared how they did not want to discuss their experience with others in case they were perceived to be failures, or somehow contributed to breastfeeding difficulties for other women who would at some point in the future initiate breastfeeding.

Breastfeeding is both a process and an art – it is a skill that takes time for both women and infants to learn, requiring both technical and embodied knowledge to become a transparent aspect of mothering. To gain this knowledge a woman must spend time 'doing' breastfeeding, which means navigating the pitfalls, a process that can be greatly facilitated by the sharing of experience through communities that are knowledgeable and supportive of breastfeeding.

The silencing of knowledge about the realities of establishing breastfeeding creates a vicious circle. If a woman struggles to breastfeed and subsequently weans earlier than planned, it is very likely that, to avoid being perceived as a failure, she will not discuss her embodied experience with others. Thus the embodied knowledge she has gained about the difficulties of establishing breastfeeding is effectively lost, being of no benefit to others because of her silence. By hiding the reality that breastfeeding is often difficult, the silence that shrouds breastfeeding fuels the propagation and reinforcement of unrealistic ideals of mothering. It is important therefore, to examine women's embodied experience of breastfeeding, regardless of its duration. This examination begins through addressing how our society has come to understand the breast as an object.

10.5 Re-conceptualising the Objectification of Breasts and Embodiment

Despite being strongly critiqued by philosophers such as Kant and Wittgenstein, Descartes' concept of the mind-matter split has endured in Western thinking (Kenny, 1998). We have come to accept and understand our bodies as objects, which has significance for breastfeeding women because they have inherited a language to describe breasts and breastfeeding that objectifies the experience. This dominant language silences the language that offers embodied understandings of breastfeeding, affecting women's ability to articulate their experiences of breastfeeding. The following discussion highlights the impact that objectification has on breastfeeding, beginning with the influence of biomedical technology.

It has been argued that breastfeeding does not comply with scientific technology, as breastfeeding can never be completely understood in reductionist terms, unlike artificial formula supplied to an infant in a bottle (Van Esterik, 1994). The inability to quantify breastmilk does not fit comfortably with objectified measurement, which complies with the ordered, and time-structured manner valued in our society (McBride, 1999). This need to quantify affects the manner in which health care practitioners, who work alongside women with young infants, approach breastfeeding; historically, artificial formula has been

the preferred means of infant feeding as it complies with the values of the medical community (Ryan & Grace, 2001).

These understandings also inform women's interpretations of breastmilk, and can negatively impact upon their confidence if their infants are unsettled, or do not grow in a way that mirrors the norm. If women are insecure about their infant's intake, they begin to doubt their embodied ability to respond to their infant's need. It takes time for women to feel comfortable with breastfeeding, as their previously-held values about objective measurement undermine their ability to trust themselves. Sam (Int. 12) provided a poignant example of a woman who struggled to trust her embodied capabilities. She concernfully monitored her infant's weight and provided complementary artificial formula, constantly questioning her ability to breastfeed her son fully. She struggled with overwhelming feelings of doubt and guilt about her ability to mother. The immeasurable nature of breastfeeding is meaningful for women who are struggling to breastfeed, and can ultimately undermine its establishment.

Another consequence of the objectification of bodies and breasts is that women have come to understand their bodies as something to be managed and tamed, something they have control over, and that the object-body can be manipulated into behaving in a manner acceptable to them. It is interesting to note that women tend to objectify their breasts when they are struggling to breastfeed (Schmied & Barclay, 1999). The meaning that this context holds is that breasts are something to be fought and managed with tools such as pumps, shields, and medications.

The interpretation of breasts as objects and the subsequent impact on the breastfeeding process silences the strong messages that come from embodied knowledge. For breastfeeding to continue over time, women must force themselves to pay attention to their embodied knowledge and respond to it. This study has highlighted how a woman's embodied knowledge rises to the fore as she dwells with breastfeeding. It is this embodied knowledge that is meaningful for breastfeeding women, rather than knowledge based on the breast as object, and therefore it holds sway over women's decisions about breastfeeding.

During the interview process women began to peel away the layers of language that described breastfeeding as a reductionist, objectified, medicalised process

that represented singly a source of nutrition, turning instead to a language that described breastfeeding as an embodied act. The knowledge that they gained through breastfeeding was turned into a language that saw the emergence of rich narratives to describe what it was, for them, to breastfeed.

What emerged from the participants' narratives about the embodied act of breastfeeding was that, for the majority of them, it was painful. This is consistent with the literature, which documents that breastfeeding pain is common (Blair et al., 2003; Blyth et al., 2002; Chapman et al., 1985; Hill et al., 1994; Page et al., 2003). Breastfeeding pain disrupts the establishment of a satisfying breastfeeding relationship. Some of the participants discussed how the pain of breastfeeding caused them to resent their infants, undermining their confidence in their ability to mother effectively. Women discussed how the pain resulted in a failure to form positive attachments with their infants; this was in itself a different source of embodied pain, which sometimes meant that women regretted those first weeks, months, and occasionally years spent with their children.

Despite experiencing breastfeeding pain, it became evident that a woman's interpretation of her embodied experiences can hinder or enhance her breastfeeding. For example, Eva encountered numerous difficulties that resulted in a great deal of pain for months, but because she believed breastfeeding difficulties would in time be overcome, she had the perseverance to continue (see Chapter 7 page 38, Eva. Int. 19. Para. 6,7,9&12). In contrast, Jan interpreted breastfeeding, and the pain she experienced as a result, as an entity over which she had no control, and she struggled to accept her body as breastfeeding (see Chapter Seven page 23 Int. 13 para. 65).

Ultimately, this research demonstrates that women are capable of generating their own embodied knowledge. Bartlett (2002) postulated that women's breasts are knowledgeable and supply women with invaluable information about breastfeeding; however, women need to learn to listen to this knowledge, which comes initially through just being aware of the messages being sent. As a woman dwells listening to her embodied knowledge, she can learn to interpret the messages from her breasts. This research has highlighted that, when a woman listens to her embodied knowledge, she is able to interpret, respond, and alter her breastfeeding practices accordingly, facilitating a positive

breastfeeding experience. However, women need the ability and resolve to persevere with the establishment of breastfeeding.

10.6 Breastfeeding Requires Perseverance

Many of the participants were not prepared for how challenging their breastfeeding experience was. For some, their belief that breastfeeding is an intrinsic part of mothering, and that it represents more than simply a source of nutrition, provided the motivation to persevere despite the difficulties they encountered. The manner in which women spoke about this was reminiscent of how Bottoroff (1990) described women's motivation to breastfeed as a test of perseverance. However, it was evident that for some of the participants in this study, breastfeeding was challenging because it was a direct affront to their conceptions of bodily boundaries. For these women, enfolding another being intimately required courage and a great deal of commitment, without which they could not have successfully established breastfeeding. This was especially true if they were struggling with feelings of embarrassment or pain.

Chapter Seven focused on how women choose a certain way of 'being-in-the-world' which, according to Merleau-Ponty (1981), will be favoured above other ways of being. This way of 'being-in-the-world' dictates how women will respond to breastfeeding. A woman may not have breastfed an infant before, but her understandings of breasts, breastfeeding and artificial formula, developed over a lifetime, will direct the path she will take as a breastfeeding mother. A definitive example of this emerges when considering the issue of perseverance in the face of breastfeeding difficulty. What makes one woman continue to breastfeed when it's painful, while another would stop? It's my contention that women choose how much they are willing to go through to breastfeed, a choice that is directly influenced by their way of 'being-in-the-world'.

This research has offered a number of examples of women who have chosen to continue with breastfeeding despite difficulties. These women all discussed similar experiences with pain associated with breastfeeding; however, women's interpretations of their experience were directly related to the meaning that breastfeeding held for them. Women for whom breastfeeding was extremely

painful, and whose way of 'being-in-the-world' allowed them to persevere, found that the relationship with their infant that breastfeeding was facilitating made the pain worthwhile. Women need to believe that the benefits of breastfeeding far outweigh the difficulties experienced whilst breastfeeding if they are to persevere and prolong the duration of the breastfeeding relationship.

10.7 Prolonging Breastfeeding: Breastfeeding as Relationship

Breastfeeding does not occur in a vacuum; it must, by necessity, involve at least two people, typically a mother and her baby. Breastfeeding is a relationship. The participants in this study discussed how a part of forging a breastfeeding relationship was learning how to respond to their infant's cues and behaviours, facilitating a positive reaction from their infants. These initial interactions provided the basis for the establishment of their breastfeeding relationship.

This is particularly evident during the initial postnatal period when women dwell closely with their infants. A newborn consumes so much of a woman's time, and the focus of her thought and attention is directed accordingly. This 'being-with' an infant enables women to be concerned with, and focused on, their infant. Being-with means that the two come to know each other, defining a dynamic relationship between mother and child, which is essential if breastfeeding is to continue.

During the initial breastfeeding period, women were typically concerned with the technical function of breastfeeding; however, those women who were able to persevere with breastfeeding came to know breastfeeding as comfort for their infants. They described this comfort as 'all encompassing', illustrating the potential power of the breastfeeding act, especially in a society that values settled infants (see: Beasley & Heritage, 1998/1999; Beasley, 2002; McBride, 1999). As women breastfeed over time, it becomes less about the technical act or function of breastfeeding, and increasingly about the relationship between themselves and their infants. Ultimately, the physical act of breastfeeding becomes transparent, as women came to know and understand breastfeeding as relationship. This is reminiscent of Heidegger's (1962) description of a

skilled carpenter using a hammer; the hammer ceases to exist in his hand and the 'becoming' of the wood is what emerges as significant.

Benner, a noted nursing researcher, has focused on understanding how nurses develop their nursing skills, which has implications when examining the issue of women gaining breastfeeding knowledge. She describes how acquiring the skills to nurse involves "learning to inhabit a familiar differentiated world through the development of concerns, perceptive skills and skilful comportment" (Benner & Wrubel, 1992, p. 8). Nurses progress through stages from novice to expert as they gain the experience and skill base needed to become proficient at nursing. Benner's understanding also helps to explain how women acquire the skills to breastfeed. Women need to learn to inhabit a differentiated world, and this is achieved through the development of concerns along with intuitive knowledge, which is developed by 'being-with' their infants through breastfeeding.

The women in this study described how they experienced a closeness with their infants as a result of breastfeeding them. It was a closeness born from mutual physical dependence on each other – the mother for the physical comfort of releasing milk, and the infant to have their hunger satisfied. Breastfeeding closeness came from spending significant amounts of time together, which facilitated coming to know in an intimate manner. This feeling in turn strengthened the relationship between them, and the women in this study believed that the work of breastfeeding assisted in forging a relationship whose closeness extended beyond the duration of the breastfeeding period. This relationship had a transforming effect on these women. Through breastfeeding, they developed embodied knowledge that increased their confidence in their ability to mother, and experienced relational closeness in a unique way.

As women dwell with breastfeeding they come to form their own interpretations of their experience. However, the influence of 'the they' on women's interpretations affects both their understanding of breastfeeding and how they experience their culture whilst breastfeeding.

10.8 'The They's' Influence on Breastfeeding Behaviour

Women's breastfeeding behaviour is mediated by history and current social and cultural understandings of breastfeeding. This concept has been demonstrated through the narratives that have emerged in this study, and support the findings of Ryan's (1999a) study into women's narratives in post-World War II New Zealand. These influences inescapably inform women's understandings and interpretations of their breastfeeding experience.

Prior to breastfeeding, women understand their breasts in accordance with their culture, and in New Zealand culture the breast is primarily interpreted as sexual (see Chapter Six, Section 6.2.3). Women feel pressured to conform to externally-prescribed body types, central to which is the concept of the breast as sexual rather than functional; therefore, women struggle with the changes that breastfeeding imposes on their bodies. The sexualized breast heightens women's anxiety in relation to breastfeeding. Women must come to understand their breasts as being more than sexual, and that they are capable of growing a thriving infant. This is a significant adjustment that can result in an uncomfortable struggle for women to reconcile their altered sense of self. Ultimately, breastfeeding must conform to standards of social behaviour. Unfortunately, these understandings can interfere with women's breastfeeding, interrupting a seamless transition to being a breastfeeding woman.

Another of 'the they's' major influences on breastfeeding is the conceptualisation of breasts as belonging to the private sphere; similarly, breastfeeding as a derivative is relegated to the same private domain. In consequence, women do not see other women breastfeeding. If they do, breastfeeding etiquette dictates that the breastfeeding woman will make it look effortless, discrete and ultimately an easy activity; if a woman cannot achieve this, she will not breastfeed around others (Kennedy, 2000; McLeod et al., 1998; Sheeshka et al., 2001). Thus 'the they' imposes silence on the experience of establishing breastfeeding, hiding it from the public domain and precluding women from understanding ahead of time that breastfeeding can be difficult.

This study has determined that women strongly desire to mirror the perfect breastfeeding mother as espoused by 'the they', which can be extremely difficult if they are struggling with feeding their infants. However, because of

breastfeeding's relegation to the private sphere, women must navigate society's rules about breastfeeding through engaging in the act of breastfeeding, and learning to reconcile the responses of others. Research has indicated that women are particularly receptive to the responses of those around them when breastfeeding (Benson, 2000; Dignam, 1998; Heath et al., 2002; McLeod et al., 1998; Murphy, 1999). This taking up of meaning occurs only whilst breastfeeding, and significantly influences decisions about how and when a woman will breastfeed.

The influence of 'the they' on breastfeeding also emerged from the women's narratives in discussions about prolonged breastfeeding being unacceptable. This unwritten rule was enforced by 'the they' through disapproving looks, and women generally understanding that it was not acceptable. Morse (1987) discussed the coercive nature of society in relation to prolonged breastfeeding, noting that previously-supportive networks began to undermine breastfeeding once the infant reached one year of age; as a result, women would either withdraw from publicly breastfeeding or wean their infant. The women participating in this study also echoed the narratives that emerged from both Morse's (1987) and Murphy's (1999) study into socially-prescribed weaning practices.

It is interesting to note that, when this research was presented in 2003 to postgraduate midwifery students enrolled in a paper on breastfeeding, the narratives on breastfeeding as care (see Chapter Nine) prompted much discussion about prolonged breastfeeding. Although "prolonged" was not defined for the students, the longest period for which a woman participating in this study breastfed was two years. In response to the shared narratives, the overwhelming message from the midwives was that breastfeeding that long was deviant. They espoused that women who engage in such prolonged breastfeeding are potentially abusive and needy co-dependents, who continue to breastfeed to their child's detriment. That health care professionals, who are supportive of breastfeeding, openly conceive of women and their breastfeeding relationships with their children in this manner, demonstrates the strength of the bias that exists around breastfeeding in New Zealand culture.

It is important to remember that 'the they' is neither good nor bad – it simply provides a framework by which being is interpreted. 'The they' provide prescribed, everyday ways of being-in-the-world, which offer particular

interpretations of being a woman who breastfeeds. Ultimately, this study has shown that the possibilities of being as breastfeeding women are closed down upon through being with 'the they'. However, if new societal understandings, and interpretations, of breastfeeding were to emerge, women would be offered different types of language through which they could interpret their breastfeeding experiences.

10.9 Alternative Interpretations for Women's Breastfeeding Experiences

Once women have given birth they become privy to a new world of knowledge and understandings about birthing (Maushart, 1999), and this is also true of breastfeeding. The women who participated in this study discussed how, prior to breastfeeding, they understood it to be an effortless and natural process that takes place between a mother and her infant. Once they had attempted to breastfeed, they came to understand it as problematic. This view is becoming increasingly common amongst women who are mothers, as evidenced by popular press articles discussing how difficult women are finding breastfeeding (see Sarney, 2003/2004). However, such narratives tend not to discuss breastfeeding relationships that last longer than three months. While acknowledging that breastfeeding requires considerable time and perseverance to become comfortable (Blair et al., 2003; Page et al., 2003), there needs to be room for interpretations of breastfeeding as pleasurable, not just problematic. If women's interpretations of breastfeeding experiences are mediated by the narratives available to them, as demonstrated in this study and in Ryan (1999a), there is a need for access to an interpretation that accepts the pleasurable aspects of breastfeeding.

The participants in this study who espoused an interpretation of breastfeeding as pleasurable talked about the exclusive nature of their breastfeeding relationship with their children. It is a relationship they did not wish to share. Dignam (2001) discusses how, for intimacy to occur between a woman and her baby during breastfeeding, a significant amount of time needs to be invested in the relationship. She also reports that women who experience intimacy with their infants value the exclusive nature of the relationship. It is something no one else shares. The women in this study chose to use the word 'closeness' to

describe their relationship with their baby; however, there were distinct parallels between Dignam's work on intimacy and breastfeeding and the narratives that emerged in this study. Ultimately, it takes time and commitment to the exclusivity of the relationship for a woman to come to know her baby in a close or intimate way. The closeness that some women experience in their breastfeeding relationship does not occur in a hurried manner. Breastfeeding closeness emerges through the maturing breastfeeding relationship.

The concept that both a woman and her baby can flourish because of their relationship has been discussed by Traina (2000). An infant's need for affection can also be enjoyed by its mother, which in turn facilitates the flourishing of being. Within the context of this research topic, it emerged that women flourish because of their relationship with their infants. Through breastfeeding, both women and their infants are enabled to progress towards their 'ownmost' potential; however, breastfeeding success requires that women exhibit authentic care for their infant through their commitment to breastfeeding. This commitment is exemplified by those participants who breastfed their infants longer than normal[32], and felt that they were perceived as deviant by society because of it. Because of the strength and confidence these women gained from the closeness of their relationships with their infants, they continued to breastfeed despite intense social pressure to wean.

Women who participated in this study described breastfeeding their infants using the following language: it's all about the closeness, touching, cocooning, all-encompassing, exclusivity. Over time, women who breastfeed come to understand breastfeeding as more than nutrition, and the participants employed language that reflected this; it's about a relationship, a physical relationship that provides for both the women's and infant's wellbeing. The relationship is, therefore, privileged.

There is also a need to address issues of maternal sensuality and sexuality when discussing breastfeeding. Breastfeeding as an intrinsic part of motherhood is unavoidably sensual; unfortunately, the interpretation of it being

[32] In New Zealand, 19-21 percent of European-descent, 13-14 percent of Maori, and 17-18 percent of Pacific Island babies are fully breastfed at six months (Ministry of Health, 2002). Fully breastfed means that the infant is having no other liquids or solids except water or medicine.

a sensual experience is silenced in the public domain because it is considered to be a deviant aspect of womanly experience. However, the language used by those women in this study who successfully established breastfeeding reflects that breastfeeding is sensual and can be linked to women's experience of sexuality. Some of these women would fall into the 'significant minority' referred to by Traina (2002, p. 373), who asserts that "a significant minority adhere to the more sensual description of motherhood because it makes more sense of their embodied experience."

This research reveals that women can transcend 'the they's' critiques of breastfeeding as singularly functional. Indeed, some participants opted for an interpretation of breastfeeding that embraced it as a sensual act. Society needs to accept that women can and do derive sensual pleasure from breastfeeding – it is a reward for offering themselves to their infants unreservedly, and should not be understood as deviant. Access to these understandings may encourage women to persevere with breastfeeding.

Women who believed that breastfeeding offered them a positive experience reveled in their embodied ability to nurture life. Breastfeeding was tangible evidence to them of the powerful position they held, even if it was unseen by others. This concept is related to Dennis's (1999) research into breastfeeding and confidence, which demonstrates that, prior to giving birth, if women are confident in their ability to breastfeed they are more likely to succeed at breastfeeding. Conversely, this study indicates that women gain confidence while breastfeeding through a gradual process of coming to understand that their bodies are amazing at responding to infant's needs (see Chapter Nine, Section 9.5), both physically and emotionally. Through breastfeeding, women are enabled to experience an otherwise unknown aspect of their embodied capabilities – physically growing another life while at the same time providing for their own wellbeing.

Breastfeeding is about life, about women living and opting to use their embodied abilities to sustain life. It may not be easily accomplished, but in doing so women creatively respond to their infant's needs and experience an aspect of life otherwise not available to them. Women in this study who engaged in breastfeeding over longer periods than most reported experiencing a relationship and closeness that no other experience had offered to them. Breastfeeding provides women with a privileged understanding of embodied

living and giving of life. It is important that women support each other, sharing the knowledge they have gained through the embodied act of breastfeeding.

10.10 Rebuilding Breastfeeding Support

As women dwell together, supporting each other and sharing breastfeeding narratives, they gain knowledge and encourage each other to persevere in the face of difficulties. This research has captured narratives of women as they navigate their way through the interpretations of breastfeeding offered by 'the they.' Women who persevere with breastfeeding despite encountering difficulties are powerful and strong women; they have managed to flee 'the they's' interpretations and prescribed ways of being. Women who choose to engage with their infants in ways that allow them to respond to their embodied knowledge, refusing to feel guilty over something they have no control over, exhibit strength. These women draw closer to their 'ownmost' potential as a result of their breastfeeding experience. However, the reality is that women are frequently not in a position to unpack and examine the force that is exerted by 'the they'. This research demonstrates that a woman's longing to offer her infant the best is a powerful motivator, and it is this desire that holds women captive to the compulsion to reflect the perfect breastfeeding woman and mother.

Women need to critically examine idealised notions of breastfeeding that confine their interpretations to that of being a "good" or "bad" mother. Women need to question their beliefs and understandings of what breastfeeding is, and what it will mean to them in the context of their relationship with their infant. This is a challenging task in our society, with its ready-to-hand frameworks by which we can measure our performance. Instead, women need to create their own individual framework by which their experience of breastfeeding can be measured. One such interpretation might be the one suggested by Hunter (1998), who promotes the use of the phrase 'good enough breastfeeding' to describe women's experiences. Such an interpretation would provide women the opportunity to understand their experiences through a framework that reflects the unpredictable nature of breastfeeding.

The loss of a breastfeeding culture has significantly undermined women's access to breastfeeding support networks. This loss can be attributed to a number of factors, most notably the demise of extended family structures, the relegation of breastfeeding to the private sphere, and the medicalisation of breastfeeding. It is also worth noting that community organisations that facilitate women-to-women breastfeeding support are often viewed as extremist. This interpretation emerges in light of the difficulties many women have experienced with breastfeeding, which makes it difficult for them to resolve personal experiences with the ideals publicly espoused by such groups. However, through the sharing of experiences and embodied knowledge gained through breastfeeding, women can find the support they need to initiate and continue to breastfeed.

As long as breastfeeding remains a silenced aspect of women's embodied experience, nothing will change. Language has the ability to create. This study is an attempt to speak the unspoken and give rise to alternative understandings about breastfeeding in New Zealand that enable women to fully experience their embodied capabilities.

10.11 Implications for Health Care Professionals Working Alongside Breastfeeding Women

This research offers health care professionals meaningful insight into what it is to be a breastfeeding woman in New Zealand. Traditionally, research that has explored the issue of breastfeeding has focused on demographic trends, biomedical topics, and interventions by which the breastfeeding process can be managed. In contrast, this study set out to explore the meaning that breastfeeding has for women who are actively engaged in breastfeeding. It has focused on their narratives to facilitate an understanding of their lifeworld as it emerges in accordance with their 'thrownness', as opposed to that of health care professionals.

What has emerged as paramount is the need for health care professionals to take time to listen to women's embodied experiences of breastfeeding. Any planned interventions need to take into account the culture, community and social supports that form the basis for women's previously-held understandings

about breastfeeding. Failure to do this will make any suggested interventions ineffective, as the context in which women reside will always dictate their interpretive frameworks. Ignoring a woman's embodied experience when assisting her to establish and continue breastfeeding will also undermine her ability to listen to her embodied knowledge – a skill that is crucial to the longevity of breastfeeding.

The vantage point offered to health care professionals who listen is pre-eminent, resulting in interventions that will support and nurture a woman who seeks to prolong breastfeeding. As described above, the breastfeeding process requires that women learn to listen to their embodied knowledge. This can be facilitated through health care professionals' awareness that each breastfeeding dyad is unique and will require certain adaptations for breastfeeding to work for both the mother and her infant. Health care professionals need to foster women's confidence in their ability to listen to their embodied knowledge and adjust breastfeeding practices accordingly. In so doing, they will enable breastfeeding women to speak the previously unspoken, increasing their confidence in their embodied ability to breastfeed, and assisting them in developing language that facilitates breastfeeding longevity.

Another important implication of this research is the key role that interpretations of embodied experiences play in women's view of their performance as breastfeeding mothers. Offering new and different ways of interpreting breastfeeding experience will alter the language they have at their disposal for describing their breastfeeding experience. For example, if a woman considers that she has 'failed' at breastfeeding one of her children, she may then interpret herself as a failure at breastfeeding, undermining future breastfeeding experiences; however, if she is enabled through language to gain an interpretation of each breastfeeding experience as unique, this may provide her with confidence that she is capable of breastfeeding subsequent offspring.

It is important for health care professionals to be aware that breastfeeding offers women a unique and new embodied experience. In particular, the experiences of a first time breastfeeding mother are completely new: her embodied sensations, interpretations of 'the they' and strong urge to care for her infant are all things that she has never experienced before. Her perceptions of them will be influenced by many factors, and may be positive or negative. A crucial part of the health care professional's role is to assist her to acknowledge and resolve

her experiences with breastfeeding if they have been negative. Women need to be supported in their role as mothers, and the resolution of an 'emotionally crippling' breastfeeding experience is paramount. This requires a high level of courage, commitment and empathy on the part of the health care professional; unfortunately, this research attests that we often contribute to negative breastfeeding experiences, rather than being of help.

10.12 Limitations of this Research

Unstructured interviews acquire validity and reliability through audit paths and decision trails, which are made evident when the researcher is documenting the analysis of the transcripts (Field & Morse, 1985; Omery, 1983). The validity and reliability of this research has been addressed by incorporating the participants' conceptualisations of issues raised during the interviews (Munhall & Boyd, 1993). This was achieved by constantly returning to the women's narratives, allowing their original intent to be continually called forth. Being mindful of these narratives throughout the process enabled the research to remain firmly established in the participants' reports of their experiences of the lifeworld.

It is widely acknowledged that research methods that employ unstructured interviews have limited applicability when attempting to extrapolate to wider populations; however, qualitative methods do provide in-depth perspectives on phenomena (Baker et al., 1992), thus increasing the reader's understanding of the participants' experience. By engaging with reflective lifeworld research methods, health care professionals can extend their personal horizons, allowing them to approach individuals in innovative and responsive ways. In the context of this study, reflective lifeworld research offers meaningful insights for health care professionals working alongside breastfeeding women in New Zealand, and demonstrates the need for contextualised, individual breastfeeding support.

This study allowed participants to self-select themselves for participation. This may have resulted in a disproportionate number of participants who had either unusually positive or negative breastfeeding experiences, creating a bias toward narratives that are strongly positioned and not necessarily reflective of the typical breastfeeding experience. However, the research findings have been presented in a number of forums, and the feedback that has been received

indicates that many women experience a resonance with the participants' narratives.

A limitation of the use of a reflective lifeworld research methodology is that it's intended to be interpretive, not emancipatory. I have found it very difficult to lay aside my desire, as a feminist, to examine the power structures that influence breastfeeding women's world and offer an emancipatory discourse by way of explanation. In trying to avoid laying a particular interpretive framework, such as feminism, over the women's narratives, I have attempted to limit my interpretations of women's breastfeeding experiences from Chapters Six through Nine, focusing only on the narratives as they have emerged from the transcripts. Instead, I have offered my own interpretive account in the present chapter, and have noted in Chapter One that I position myself as a feminist, and am unable to extricate myself from my 'thrownness'.

It should also be noted that, as a researcher, I am held sway by the scientific tradition, as evidenced by the traditional approach taken in setting out the research in this document. Despite its traditional format, however, the document has not been written in the traditional order. Writing began by outlining my 'thrownness', historicity and horizon, the understanding of which assisted me in examining the women's narratives. This approach allowed me to take into account those things that held meaning for me, and lay them aside accordingly. The methodology chapter and method chapter were completed next, followed by the findings chapters. The literature review chapters were developed after Chapters Six through Nine were completed, and the Discussion Chapter was written last. This atypical thesis development reflects my understanding of reflective lifeworld research as a methodology and method, and allowed me to focus on the women's narratives to the exclusion of what was previously written about the experience of breastfeeding.

10.13 Future Directions for Research

This study did not specifically target particular ethnic groups, and the participants were predominantly New Zealanders of European descent. Additional in-depth qualitative research that is expressly and appropriately directed towards women from differing ethnic backgrounds, such as Maori and

the Pacific Island and Asian nations, by researchers immersed in their specific world view, is needed. This would enable health care professionals to direct interventions that are specifically appropriate for women from these differing people groups.

Research that examines breastfeeding women's partners' experiences of breastfeeding would add to the knowledge base of New Zealand's breastfeeding culture, as would engaging women who had not breastfed in conversations about breastfeeding. An examination that specifically targeted breastfeeding women's experience of health care professionals would also be beneficial. Women who participated in this study highlighted significant concerns about the professional support they received whilst they were attempting to establish breastfeeding. These concerns are documented in this study; however, a more extensive examination is warranted so that health care professionals can critically examine the manner in which they engage with breastfeeding women.

This research has highlighted that many women struggle in the initial months of breastfeeding. Its findings could serve as the basis for a larger study into women's initial breastfeeding experiences, exploring which interventions assisted them to continue with breastfeeding, and which contributed to early weaning of their infants.

The use of technology to assist with the establishment of breastfeeding is another area of interest for future research. The women participating in this study spoke many times about the different pieces of technology they employed to assist them to breastfeed. For some participants, breastfeeding began to work the moment they threw away these devices and returned to baby-to-nipple and skin-to-skin contact. A theoretical understanding of how technology contributes to breastfeeding may allow health care professionals to unpack the concepts underpinning commonly-utilised implements, and their usefulness for breastfeeding dyads.

The impact of formalised breastfeeding support groups on women's breastfeeding experience in New Zealand also warrants additional research. If such groups were demonstrated to be beneficial, women might be more readily encouraged to form communities that support rather than undermine their breastfeeding experience.

Research into women's experience of maternal sensuality and sexuality in relation to breastfeeding is also warranted. Some of the women who participated in this study hinted that this was an aspect of their breastfeeding experience; however, cultural understandings of motherhood prevented an open discussion of this issue. If women were aware that breastfeeding can contribute to their emotional well being in this way, it may encourage them to persevere with the initiation phase of breastfeeding.

Finally, the use of other theoretical perspectives to explore other interpretations of women's experience of breastfeeding may offer additional insight. In particular, the use of a feminist methodology that examines the hegemonic discourses for how they support a patriarchal society at the expense of breastfeeding women would be useful. A researcher embracing a post-structuralist stance would offer a differing perspective. Women's narratives on breastfeeding are rich and complex, reflecting multiple contexts, and the use of a variety of lenses to interpret their stories can only enhance that which is known about breastfeeding.

10.14 Conclusion

This chapter has explored how reflective lifeworld research has offered an innovative perspective from which to examine issues surrounding breastfeeding in New Zealand. This research methodology has enabled the emergence of new knowledge that is meaningful for health care professionals working alongside women who are breastfeeding within New Zealand. Through breastfeeding, women gain access to unique embodied experiences that would have otherwise remained undiscovered. As women gain experience at breastfeeding, they come to understand it as a complex process that takes place between themselves and their infant. Breastfeeding longevity is dependent on a woman receiving knowledge and support from the community in which she finds herself; however, knowledge about the realities of breastfeeding is often hidden from women.

Finally, this chapter has highlighted potential limitations of this study and how future research can further add to our knowledge of breastfeeding. The next

chapter offers a summative account of this research and the thesis that has emerged from this study into women's experience of breastfeeding.

Chapter Eleven

The Conclusion

11.1 Introduction

This chapter offers a final account of the central thesis and major findings of this research study into the breastfeeding women's experiences of breastfeeding in New Zealand. A summative account of the written report is also offered.

11.2 Revisiting the Thesis

This research holds central the thesis that breastfeeding offers women experience that would otherwise remain hidden to them. Breastfeeding provides women with understandings of their embodiment, 'the they', and care for another, in a manner that they had previously not been able to experience. This thesis encompasses a number of sub-themes, which further illuminate the nature of breastfeeding as an opening to experience, including: breastfeeding as silenced, breastfeeding as embodied, 'the they's' interpretative framework, and breastfeeding as relational.

A key finding that emerges from the women's narratives in this study is that the realities of what it is to be a breastfeeding woman are hidden from those who have not yet breastfed, undermining their ability to establish breastfeeding when they become mothers. Women will always interpret their breastfeeding experiences in accordance with their thrownness. The culture in which they reside provides the language through which they understand breasts and breastfeeding. In New Zealand culture, women interpret their performance as breastfeeding women in relation to the espoused image of the perfect breastfeeding mother.

Motivated by a strong desire to provide their infant with the best, and influenced by societal perceptions through 'the they', women hide from public scrutiny if

they are unable to mirror the prescribed image. Not only does this leave them open to feelings of failure, guilt and sometimes depression, it prevents them from accessing support and hides their knowledge from other women, perpetuating a circle of silence. If knowledge of the realities of breastfeeding is made accessible to all women, the image of the perfect breastfeeding mother will be altered, effectively breaking the circle. Unveiling this knowledge, and establishing it as a normative part of preparing to mother, will enable women to persevere through the difficulties associated with initiating breastfeeding.

Breastfeeding is unavoidably an embodied experience. Despite this, we have inherited a language that constructs breasts and breastfeeding as objects that need to be controlled and managed with technology. This means that, during the initial stages of breastfeeding, women interpret their personal breastfeeding experiences in accordance with this body-as-object framework. However, this research has determined that, as women continue to breastfeed, they come to understand breastfeeding as an embodied act and create a language to reflect that. For some women, their embodied experience of breastfeeding is one of pain, tiredness and grief; for others it becomes a self-defining accomplishment.

Participants who were able to successfully establish and continue to breastfeed their infants spoke of breastfeeding as relational. The relationship between these women and their infants was nurtured through the time spent together breastfeeding, a process that involved coming to know their infants in a close manner. They valued this closeness for its unique, exclusive nature, and held the breastfeeding relationship privileged above all others. The breastfeeding relationship held open the possibility that women could achieve their ownmost potential, as they experienced authentic care for their infant. Ultimately, their own well-being was significantly enhanced through breastfeeding their infants.

11.3 A Review of the Chapters

Chapter One introduced this study and provided a justification for its pursuit. It outlined the context in which the study took place and introduced reflective lifeworld research as the methodology. This chapter also allowed me to position myself in relation to the research process, outlining my historicity and horizon when approaching the study.

Chapter Two outlined the history of infant feeding in New Zealand, examining this country's heritage and how it has influenced the development of breastfeeding knowledge. It also explored the influence of global policy documents on New Zealand's national strategies for increasing breastfeeding rates.

The literature that explores the experience of breastfeeding was examined in Chapter Three. This review highlights how breastfeeding falls into the domain of health care professionals at the expense of women's own knowledge about breastfeeding. Researchers' interests are served by their research, which elevates them to the position of experts who can redeem breastfeeding women from their breastfeeding problems. It is from this position that I have argued for a research approach that values women's embodied knowledge.

Chapter Four began with an overview of the development of Western philosophy, demonstrating the philosophical foundations for the chosen methodology of reflective lifeworld research. The principles inherent in this methodology were explored for their applicability to the phenomenon of breastfeeding women's experience of breastfeeding in New Zealand.

Chapter Five explored how reflective lifeworld research provides a method by which one can explore the phenomenon of being a breastfeeding woman. It outlined the research process in detail, highlighting how ethical concerns involved in research of this type were considered. Finally, issues related to trustworthiness were explored within the context of this research.

Chapters Six through Nine relayed the participants' narratives. Chapter Six focused on how breastfeeding women experience 'the they', capturing how women believe they must adhere to externally-prescribed images if they are to be considered a good breastfeeding mother. This chapter highlights how women struggling with breastfeeding suffer in silence because they do not want to be perceived as not being good enough. Ultimately, women's breastfeeding experiences are most often interpreted through 'the they's' interpretive framework, closing down on women's potential for being.

Chapter Seven explored how women have inherited a language that interprets their breasts as objects. Heidegger's account of objects is used as a lens to interpret these narratives; however, it is demonstrated that this

conceptualisation has limited value for understanding breastfeeding. Instead it is proposed that a different language is needed to more fully understand the phenomenon of being a breastfeeding woman. A language that articulates the embodied experience of breastfeeding was, therefore, explored in Chapter Eight.

A differing approach to interpreting women's breastfeeding experiences is offered in Chapter Eight. Examining the participants' narratives from the vantage point of Merleau-Ponty's (1981) exploration of embodiment, it emerged that the embodied breastfeeding experience is powerful and transformative in both positive and negative ways.

The falling away of breastfeeding as function, and the emergence of breastfeeding as relationship, was examined in Chapter Nine. This chapter discussed how the participant's expressed authentic solicitude for their infants, and for those who continued to breastfeed, the breastfeeding relationship was privileged because it enabled both the women and their infants to move towards their ownmost potential.

Finally, Chapter Ten explored the implications this research has for health care professionals who work alongside breastfeeding women. The major findings of this chapter were discussed in relation to the available literature, and the researcher's interpretations of the findings were also offered. It also noted the limitations of this work and proposed directions for further research.

11.4 Conclusion

Reflective lifeworld research has offered a methodology and method for examining the lifeworld of a breastfeeding woman. It has facilitated the emergence of knowledge that values the transformative effect that breastfeeding holds for women. Through its guiding principles of openness, historicity and the hermeneutic circle, it has emerged that breastfeeding offers women a unique embodied experience that allows them to experience 'the they' and authentic care for another.

Despite the undeniable power of the breastfeeding experience in a woman's life, the realities of breastfeeding remain hidden to those who have not breastfed. To establish breastfeeding, women need to come to understand their embodied breastfeeding knowledge, and have the language that enables them to interpret this knowledge. The availability of an embodied breastfeeding language would unveil the realities of breastfeeding, and offer an alternative perception of "the perfect breastfeeding mother"; this may offer an avenue for increasing breastfeeding rates in New Zealand.

This research also offers fresh understandings for health care professionals working alongside breastfeeding women. It is important that professionals examine their own historicity and prejudices surrounding breastfeeding, and listen to individual breastfeeding women's experiences, taking into account the context women are in when planning interventions. The valuing of embodied knowledge and its associated language will encourage women to articulate their breastfeeding experiences, and increase their confidence in their embodied abilities and knowledge.

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Appendix I

Information Sheet

My name is Karen McBride. I am a Registered Nurse who is a doctoral student at Massey University. I would like to invite you to be a part of a research project that explores what it is like for women in New Zealand to breastfeed.

The benefits of breastfeeding are well known and the World Health Organisation says that all infants should be breastfed for the first four to six months. However, women are choosing to stop breastfeeding their babies before they are four to six months old.

This study is being done in order to gain an understanding of what it is like for women to breastfeed infants in this country. It is hoped that this study will help health professionals who work with new mothers to better understand what breastfeeding is like for women here in New Zealand.

Even if you are not currently breastfeeding or chose to not continue to breastfeed I am interested in your personal story. You have been invited to join this study because you have had previous experience with breastfeeding in New Zealand.

The study will consist of one audio-taped interview. If you do not want the interview taped I can take notes on what we talk about instead. Another way of telling your story may be to write down your experience of breastfeeding.

The interview will last no longer than 90 minutes. The interview will take place at a time and place that you choose. The interview will be one on one. I will be the only interviewer. During the interview you will be asked to tell your story about breastfeeding in New Zealand. At the interview if you have any item(s) (for example a poem or a picture) you wish to bring that you feel helps to describe what breastfeeding is like for you, bring it with you to the interview. The goal is to describe your experience as fully as possible.

During the meeting with the researcher you will have the opportunity to select a name, other than your true name, by which you will be known while you take part in the study.

I will be talking to women about their experience of breastfeeding over the next year. After this year is over I will start analysing the interviews. The analysis of the transcripts will take some time and will continue over approximately three years.

You might wonder if there are any risks for you being involved in this research. Your experience of breastfeeding may not have been a positive one, and you may find it hard to talk about. It may also be that sharing your story, good or bad, may be helpful to you and other women who have had similar experiences. You may gain little personally from participating in this study, however, it is hoped that this study will help women in the whole of New Zealand.

A trained typist will transcribe the audiotapes produced from the interviews. The typist will sign a confidentiality agreement. These audiotapes will then be kept in locked storage at the School of Health Sciences at Massey University – Albany, in a different location to the consent form signed by you. Unless you want the tape of your interview returned, all tapes will be destroyed at the finish of this research project.

All transcripts will be identified by number codes, or by the false name you have chosen. The only other people who will have access to these items will be the research supervisors. No research participants' names will appear on any material produced as a result of this research without the permission of the individual involved. I want to let you know that every step will be taken to ensure your identity is not disclosed.

The transcripts of all the interviews will be returned to you so you can confirm that the transcripts are a true copy of our talk together. After you have read the transcript you can ask for any information to be changed or withdrawn. After you have approved the transcript, the analysis of the transcripts will start and your story will become a part of many stories.

Massey University Human Ethics Committee and The Royal New Zealand Plunket Society of New Zealand Ethics Committee have approved this research. If you have concerns about ethical conduct involved with the research project please contact either of the following agencies:

The Chairman
Massey University Human
Ethics Committee
Massey University – Albany
Private Bag 102904
North Shore Mail Centre
Phone: (09) 443 9700.

Health Advocates Trust
97 Manukau Road
Epsom
Phone: (09) 623 5798

Feel free to ask any questions you might have about the project before, during and, after the interview process. Taking part in this research is entirely voluntary.

The supervisors for this research are:

Dr. Gillian White
Albany Group Co-ordinator
Midwifery Programmes Co-ordinator
School of Health Sciences
Massey University, Albany

Dr. Cheryl Benn
Associate Professor
School of Health Sciences
Massey University,
Palmerston North

Yours faithfully,

Karen McBride

Appendix II

Consent Form

- I have read and understand the information sheet provided on the research to be conducted.

- I agree to participate in this study exploring women's experience of breastfeeding.

- I am aware that I am entitled to ask any questions I might have about the research at any time.

- I understand I have the right to withdraw from the study, until such time that the analysis of the interview has commenced, without providing any reason for this action.

- I understand that all precautions will be taken to secure my anonymity. No personal details will at any time appear on the interview transcripts. This form and any audiotapes will be kept in separate locations under lock and key in the locked archives at the School of Health Science at Massey University - Albany. I have the right to request the audiotape of my interview at the conclusion of the project. If I do not request the audiotape it will be destroyed upon the completion of this project. This research project should be completed within the next four years.

- I understand that unidentifiable transcripts may be discussed with other health

  care professionals so a more full interpretation of the text can be developed.

- I understand that I have the right to have a copy of my interview transcripts.

- All information about my identity will be destroyed upon the completion of the research.

- I understand that a copy of the research report will be made available to me, at my request, upon its completion. The final project report will be made available to me through contact with the researcher.

Signature: Date:

Address: Telephone:

Appendix III

Typist's Confidentiality Contract

I .....

Have accepted the job of transcribing the taped interviews of the research data collected by Karen McBride as a part of her doctoral research at Massey University.

I understand that the information gathered for the research is confidential.

I will undertake all necessary steps to ensure any material pertaining to, or concerning the research data will be treated as confidential. Only I will hear the audiotapes. The transcriptions will be done in private and stored in a safe place. Whilst in my possession all transcripts and audiotapes will be kept in a locked storage facility. I will be the only person with access keys to the storage facility. No copies of any transcripts will be retained, either on disk, paper, or hard drive, by myself after the transcriptions are complete.

Signed: Date: