

EXPLORING THE EXPERIENCES OF WOMEN WHO BREASTFEED LONG-TERM

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My life has been changed in many ways by my experiences of breastfeeding all three of my daughters. The journey that culminates with this PhD began with those three very different experiences and it is dedicated to them, my lovely girls.

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Abstract

This thesis reports the results of qualitative research using ethnographic methods to explore the experiences of women who have breastfed long-term. Data collection methods included participant observation in three breastfeeding support groups, face-to-face interviews and online asynchronous interviews using email.

A clear contribution to new knowledge has been demonstrated in a number of areas. Knowledge has been furthered by presenting in-depth, rich findings about the experience of an under-researched group in a sensitive area. Placing these within the context of a cross-disciplinary perspective and by using insider research methods has strengthened their authenticity and credibility. The Social-Ecological Model is used both to structure a review of relevant literature and to underpin the thesis as a whole, demonstrating the complex social and cultural contexts within which women breastfeed long-term.

Findings, from a group of strong-willed and determined women show that breastfeeding long-term is a rewarding but challenging commitment, often undertaken in the absence of societal support. Theoretical concepts of liminality, stigma and taboo are explored within the thesis and used as a lens through which to view the findings from the study. Previous work using these concepts to think about breastfeeding is drawn on and developed to further understanding of the experiences of long-term breastfeeding.

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Chapter 1: Introduction and background

1.1 Background - orientation

This thesis reports the results of qualitative research using ethnographic methods, including participant observation, face-to-face and online interviews, to explore the experiences of women who have breastfed long-term. It explores the experiences of these women in two ways, being both about the experiences of the women whom I met, talked, listened and wrote to, and also about what it has been like for me to explore those experiences.

The research has been undertaken at a time when an unknown number of babies in the UK are breastfed until age two, even though this is the recommendation of the World Health Organisation (WHO, 2003). Currently, many women find it hard to breastfeed their babies – whatever their age – in public, and breastfeeding older babies and children is nearly always interpreted culturally as odd or bizarre. Breastfeeding initiation rates have risen slightly in the UK in recent years, but increasing duration is more problematic. This research was undertaken when I was also a long-term breastfeeder. My youngest daughter was breastfeeding (aged nearly three) when I started this project and, very occasionally, still breastfeeding (aged nearly six) when I wrote up the results of the work.

This chapter acts as an introduction to the thesis as a whole, providing background information to the topic and describing my motivation for

undertaking the work. A number of ideas will be briefly introduced; most will be re-visited in subsequent chapters in more depth. The first part of the chapter gives an overview of the contemporaneous media and academic debate surrounding the social and cultural context within which the research took place. An introduction to the subject area and its importance as an area of research will then follow and the research questions and aims introduced. This will be followed by a discussion of the terminology used throughout the thesis and its justification, highlighting areas which might be viewed as problematic.

A significant proportion of this chapter will be taken up with an explanation of the personal and professional motivations for undertaking the work. Although I have chosen not to explicitly use the techniques employed by autoethnographers (see Chapter 5), my own breastfeeding experience - both before and during the study - has been integral to the work. Feminist researchers have often reflected on the use of information about their own lives in their work (Oakley, 1981; Letherby, 2003); I have included some very personal information about myself and my relationship with my breastfeeding children, throughout the thesis. I consider its inclusion to be very important and will discuss this further in Chapters 4 and 5. Although my children's identity will be apparent to anyone who knows me I have decided not to refer to them by name (although, unlike other participants in this study, they have not been given pseudonyms).

I have been mindful, throughout the process of undertaking this work, of wanting to remain honest and open – both about my own experiences and the ways in which these have influenced and impacted on the research, and also about the ways in which I have interpreted and used the experiences of the women who have taken part in my study. As I will discuss later in this introduction, I have chosen to have separate chapters in the thesis looking firstly at reflexivity and then at the research findings. Throughout I include words from my own reflections, field notes and research diary, and from participants. These will be used where they illuminate or illustrate an aspect of the discussion, even if this is not overtly about the research findings. This chapter concludes with a description of the rest of the thesis, outlining the areas to be discussed and the rationale for their placement within the work as a whole.

1.2 Context of contemporaneous media and academic debate

The focus of this thesis is on long-term breastfeeding, looking at the experiences of a number of women who have breastfed their children for between six months and six-and-a-half years. During the time that I was planning the work, collecting data and carrying out analysis, long-term breastfeeding was in the news and represented in popular culture in a number of ways, providing at times an interesting background to the work.

In the year before commencing this study, while I was breastfeeding my two year old daughter, Channel 4 first aired the programme '*Extraordinary Breastfeeding*' (Channel 4 Television, 2006), in which viewers in the UK saw, for the first time, a seven year old breastfeeding on national television. In 2008, while I was in the midst of data collection, '*Other People's Breastmilk*' (Channel 4, 2008) explored a number of related issues, including shared feeding, long-term breastfeeding, the use of breastmilk as a treatment for cancer and how members of the public felt about tasting breastmilk. Both these programmes elicited strong reactions and included scenes that appeared designed to shock, feeding into prevailing cultural beliefs about these issues as strange and bizarre. Similarly, BBC television's comedy show, '*Little Britain*', included a sketch (the 'bitty' sketch) in which an adult man is shown breastfeeding in various 'comedy' situations (Little Britain, 2007). All three programmes were referred to by participants during data collection.

Breastfeeding in general was in the news on several occasions. In the summer of 2009 a number of high profile articles about breastfeeding called for a backlash against breastfeeding promotion (Rosin, April 2009; Groksop, 18 July 2009). Various media reported the results of research suggesting that the evidence for some health benefits was not as strong as previously believed (Kramer *et al.*, 2009) and these issues were picked up and debated elsewhere, for example, on Radio 4's Woman's Hour (Woman's Hour, 23 July 2009). Towards the end of the writing-up period long-term breastfeeding was again newsworthy following a *Time* magazine cover featuring a young woman breastfeeding her four year old, as illustration for a piece on attachment parenting (Time Magazine, May 21 2012). Articles about this and other aspects of breastfeeding appeared in a range of newspapers (Bekiempis, 11 May 2012; Williams, 25 May 2012; Lau, 10 May 2012); most were not supportive of long-term breastfeeding.

Throughout the duration of this study, health writer Ann Sinnott was conducting research for, and writing, her book 'Breastfeeding Older Children' (2010), which was published as I started writing up. I participated in her survey as I was beginning my research. The publication of Sinnott's work led to renewed interest in breastfeeding long-term, including newspaper articles (Cook, 9 January 2010) and television discussions. Her appearance on national television provoked a lot of interest following her fellow guest Clare Byham-Cook's comments about the appropriateness of long-term breastfeeding (Bryant, 20 January 2010; Shaw, 29 January 2010). This

period also saw a proliferation of websites and discussion groups, some aimed at offering general parenting (including breastfeeding) support, others specifically for women breastfeeding long-term or who were interested in other parenting issues, sometimes collectively known as 'attachment parenting' (Sears and Sears, 2001).

During this time there was also an increased interest in the issue of breastfeeding in public and how this might be protected by the law. Before I started my project the Breastfeeding etc. (Scotland) Act (Scotland, 2005) made it illegal to prevent a woman from breastfeeding a baby/child up to the age of two in a public place in Scotland. Throughout the period of my research debates in England continued about the proposed Equality Bill which would give similar rights to women in England, but only if their baby was up to six months old. The bill became law in October 2010 (Great Britain, 2010). Debates about breastfeeding in public – particularly breastfeeding babies older than six months – have continued in the media during the past few years. The catalyst is often an incident such as when a mother, breastfeeding her ten month-old in a shop changing room was told "*Your breast milk stinks*" (Evans, 8 March 2010, in response to Jan Moir in the Daily Mail, 6 March 2010).

Academically, it was also an interesting time to be a breastfeeding researcher. I started my PhD believing that most academics would promote breastfeeding, as it was clearly beneficial to both mothers and babies/children, this contention being both common sense and supported by

good quality evidence. I began to discover that this was not necessarily true, and that there were a number of academics (particularly feminists) who were constructing arguments against breastfeeding promotion. These arguments are connected with growing academic interest in examining a range of 'parenting issues', as exemplified by the formation of the Parenting Culture Studies Network in 2007, later the Centre for Parenting Culture Studies (CPCS, 2011a) and a range of public events including those supporting anti-breastfeeding promotion writer Joan Wolf (CPCS, 2011b). Some of these issues will be further explored in Chapter 2.

As I started my project I was aware that another PhD candidate in the UK was also investigating the experiences of a group of women who were breastfeeding long-term. I followed her work with interest and we met at several conferences. Her final work (Faircloth, 2010a, 2010b, 2011) has a specific focus on parenting issues, on motherhood and on 'identity work' (Faircloth, 2009); this is discussed further in Chapter 2.

1.3 Personal stance, motivation and professional experiences

My background, both academically and professionally, has been multi-disciplinary and I have brought skills and perspectives from these different experiences to bear on this PhD. I trained as a mental health nurse, and worked in acute and community psychiatry and in a busy city centre sexual health clinic. There I undertook sexual health promotion with individuals and groups, carried out partner notification for sexually transmitted infections, including HIV, and provided pre- and post-test HIV counselling. Involvement with a large outbreak of heterosexual syphilis led to an interest in public health and a move into this discipline at senior Primary Care Trust (PCT) level.

My academic background is in social sciences at first degree level. A long-term interest in feminism and women's studies led to a Women's Studies MA (1993) followed by a Masters in Public Health (MPH), (2001). I became a Member of the Faculty of Public Health, by examination, in 2006. My academic work is heavily influenced by these professional and academic experiences and the skills that I acquired through them. I have always been interested in different ways of looking at experiences of health, particularly women's experiences; latterly this has also been influenced by an increased understanding of the importance of a population health perspective.

I have three daughters and my experience of breastfeeding each of them has been different. My eldest daughter was born in 1985, when I was in my early

20's, at a time when breastfeeding knowledge and experience had declined in the UK (Palmer, 2009). This was both in terms of cultural support and understanding, but also in relation to the quality of the skills of health professionals and the support and information available from them. I struggled to breastfeed my baby, was unable to successfully latch her on and was told by my General Practitioner and Health Visitor that I did not have enough milk for her. I was advised to supplement my milk with formula milk and only managed to carry on breastfeeding her for three weeks before she became totally formula fed. With the benefit of hindsight and increased knowledge, I know that I received poor advice; once I started supplementing my feeds in the way I was advised it was unlikely that I would be able to fully breastfeed. Once a baby has been introduced to formula milk there are a number of issues, including the possibility that they will find it harder to latch on properly to a nipple after using a bottle teat and, often, a reduction in milk supply due to lack of continued stimulation (Wiessinger *et al.*, 2010). With good support and accurate information it would be possible for a woman in the same situation to return to breastfeeding and, with some hard work and determination, to eventually fully breastfeed (Wiessinger *et al.*, 2010). This is not something that either I, or the health professionals I came into contact with at this time, were likely to have known.

My second two daughters were both born when I was in my forties. They were born at home, the first with an independent midwife in attendance and the second with the assistance of a close friend who is a midwife. On both

occasions I was fully supported in my desire to achieve a more successful breastfeeding outcome than I had with my first child. Both babies had difficulties latching-on; the first was consequently cup- and then bottle-fed with expressed breast milk (EBM) for a total of three months before successfully latching on and feeding from the breast herself. This was extremely hard work as it involved expressing milk very frequently throughout the day and night in order to establish and maintain supply. She was exclusively fed on breastmilk until four months (in line with the Department of Health policy at the time) and continued to breastfeed until she was about three years and three months old, feeding throughout my next pregnancy and in tandem with her sister for a further seventeen months.

During the time my second daughter was a baby I was introduced to the support available through the local La Leche League (LLL) group (see Chapters 2 and 6 for further explanation and discussion). I was not a regular attendee as I returned to work when she was eight months old, but became interested in the ideas and philosophy of LLL. When I was pregnant with my youngest daughter I knew that I wanted to continue to breastfeed her sister for as long as she wanted (known as 'child-led weaning', Hauck and Iruita, 2002, or 'natural weaning', Sinnott, 2010). I wanted to find a place where it would not be considered odd to be both pregnant and breastfeeding, and so became a regular LLL attendee. I continued to attend meetings throughout my pregnancy and for some time afterwards, when I was breastfeeding both girls at once. As well as seeking support during my pregnancy I also wanted

to build a network of 'experts' to call on if I had the same latching-on problems that I had experienced with my other two babies, knowing that it would be very difficult to sustain expressing milk as intensively as I had previously done if I were also looking after a toddler.

My third daughter, like her sisters, initially had difficulties in latching-on. I drew on my connections with LLL and received excellent support and advice during the early weeks. She was fed EBM with a pipette and from a cup but quickly, as we drew on suggestions made by the local LLL leaders, learnt to take milk herself from my breast. I expressed milk for a few weeks only as a back-up and then fully breastfed her myself. She was exclusively breastfed for six months and then continued to breastfeed until she was just over five years old (by which time she was nursing once a day only, at bedtime). For about eight months after this she very occasionally asked to have 'mummy milk', with increasingly long intervals in between.

My experience of breastfeeding my daughters has affected my life in many ways. It has changed the way that I see parenting in general, and mothering in particular. It has changed the way I see my body in relation to my children and the way I see my role in relation to my partner's. This experience has also been the impetus for undertaking this study and a crucial element in carrying out the data collection, informing the analysis and sustaining my interest (discussed further in Chapters 4 and 5). This interest in both breastfeeding practice and research (which developed during the time that I

was breastfeeding my youngest daughters) brought together a number of academic and personal concerns.

My increasing awareness of how other academics had incorporated their breastfeeding experiences into their work was both interesting and supportive during a period in which I found myself affirming my identity as an academic and as a breastfeeding researcher. Bartlett has written about this:

...As an academic trained in literature I love looking for narratives and how they function as stories through which we imagine our lives...when I began breastfeeding I looked to books to help make sense of my changed maternal self and how I might fit into this new identity. I was mostly appalled by what I read about breastfeeding...and so I began thinking about what sort of narratives I was seeking...[I] wrote an academic paper about breastfeeding narratives as my daughter entered her second year of serious attachment to my breasts...I was particularly curious about how this transformation of my identity could be (properly) taken to work: how does a woman academic incorporate her maternal self into her professional work? How does her work affect her maternity?...

(Bartlett, 2005:2). Others have written in different ways about how their breastfeeding experience has both led to and influenced their academic work (discussed further in Chapter 5).

1.4 Justification for long term breastfeeding research

Breastfeeding is widely understood to be beneficial to both mothers and babies. The recognised health benefits of breastfeeding are the impetus behind international and national targets aimed at increasing both initiation and duration rates, with the goal of six months exclusive breastfeeding for all babies (World Health Organisation, 2003). However the most recent available UK data shows that few babies are in fact exclusively breastfed (23% by 6 weeks, and less than 1% by 6 months - McAndrew *et al.*, 2012). An unknown number continue beyond the recommendations of the Department of Health (2011) and of the World Health Organisation (WHO, 2003; Pontin *et al.*, 2007). 19% of babies in the UK never have any breast milk at all while only 34% of babies in the UK are still breastfed (almost all of them alongside other foods) at 6 months of age (McAndrew *et al.*, 2012). The numbers of children in the UK having breast milk at age 2 (the minimum age of cessation suggested by the WHO) are unknown, but probably tiny. My reason for undertaking this research was that I am particularly interested in what it is like for those women who choose to breastfeed their babies after the majority of their peers have stopped. As only a minority of babies are breastfed beyond 6 months I chose to look at the experiences of women who continue beyond this time, women who breastfeed knowing that the longer they continue to do so, the more unusual they become. Interventions and government targets are appropriately aimed at increasing initiation rates (Department of Health, 2011) and offering support to prevent early cessation (Renfrew *et al.*, 2012). However, beyond the 'grey' literature, little is known

about how women manage to continue breastfeeding beyond the early months and what this experience is like for them.

Increasing the numbers of women who breastfeed has implications for current public health concerns including population health improvement through the reduction of cancers, coronary heart disease and childhood obesity (summarised by UNICEF, 2011a; Labbok, 2012). The evidence for the health benefits of breastfeeding will be further discussed in the following chapter; I will also consider the views of those who present this evidence as fundamentally flawed (for example, Lee, 2007; Wolf, J.B., 2011). Recent debates around breastfeeding view it solely in terms of nutrition, rather than nurture, and a complex relationship has developed between the ideas of 'intensive parenting' (Hays, 1998), 'natural motherhood' (Bobel, 2002) and the behaviour and beliefs of those who breastfeed long term (Bumgarner, 2000; Faircloth, 2007). There are inherent tensions in promoting and practising breastfeeding in a culture not currently breastfeeding friendly.

1.5 The research questions

The primary aim of my research was to increase understanding of the experiences of women who have breastfed for longer than six months (the reason for choosing 'longer than six months' was outlined above). The majority of babies in the UK are fed formula milk (McAndrew *et al.*, 2012), yet some women persist in breastfeeding, some doing so for long periods of time. As an 'insider' who has breastfed two children until they were over three years old, the original intention of my research was to address the following questions:

1. What can be learnt from the experience of women who have successfully breastfed their babies for over six months?
2. What are the sources of support these women receive, and why do they continue?
3. What are the obstacles to receiving support?
4. What enables these women to do this for themselves, their babies and children when others are unable to?
5. Can this knowledge be used to help other mothers breastfeed beyond six months?

During the course of an iterative research process (discussed in detail in Chapter 4) these questions were developed and refined. Question 3 became more about the difficulties that women experienced with breastfeeding long-term (specifically in relation to any negative feelings that they may have

about it) than about obstacles to support (which in some ways was addressed through the broad nature of question 2). Throughout, the overall aim of obtaining an in-depth understanding of the experiences of women who breastfeed long-term was retained. A discussion of the methodology used to address these research questions follows in Chapter 3. As the work developed, a further aim was identified in relation to considering how the theoretical concepts of liminality, stigma and taboo could be used to think about the experiences of women who breastfeed long-term. These concepts were subsequently used as a lens through which to view the data.

1.6 Terminology

There is no accepted or commonly used term to describe the practice of breastfeeding for longer than six months. Breastfeeding women, the support literature and academics use ‘extended’ (Sugarman and Kendall-Tackett, 1995; Hausman, 2003), ‘full term’ (Faircloth, 2010a; Robinson, 2007), ‘long term’ (Reamer and Sugarman, 1987; Buckley, 2001; Rempel, 2004; Gribble, 2008; Sinnott, 2010), ‘prolonged’ (Hausman, 2003) and ‘sustained’ (Sinnott, 2010). Others write about it extensively without giving it a name (Giles, 2003). At the beginning of this project I used the term ‘extended’ although I became increasingly uncomfortable with this. It seemed to suggest to me – as well as to some of the women I met during my data collection – that breastfeeding beyond six months was seen as ‘extending’ what was seen as normal or usual:

‘...imply[ing] the normalcy of a shorter period...’

(Sinnott, 2010:1) and I wanted to avoid these implications. When I interviewed Mandy, she recognised that it was a difficult issue:

...it is hard, we don’t have the positive language so I tend to revert to ...that language of ‘I chose to do this extended breastfeeding’...And then explain it a bit more, but...it’s really hard...

(18th November, 2008). When I asked participants who were breastfeeding for longer than six months what name they gave to what they were doing, I received a variety of responses. Some had heard – and liked – ‘full term’:

...I love that phrase for it!...

(Jess, email; 3rd June 2008), whereas others were keen to emphasise that they tried to normalise the practice by not giving it a special name:

...I think when I first started I probably called it extended breastfeeding but as I've learnt more about language surrounding breastfeeding and normalising...it's changed, I wouldn't call it extended breastfeeding or even long-term breastfeeding now... I just tend to talk about 'breastfeeding older babies and toddlers'...which is, you know, what it is, really!...

(Jane, interview; 19th March 2009). Others said that it wasn't something that they talked about much, or at all:

...I wouldn't give it a special name...I think I just say I breastfeed. I guess I rarely talk about it with other people, but if I did I'd just say I still breastfeed...

(Josie, interview; 28th October 2008), and:

...Well I don't really [talk about it], because there aren't that many people who don't want to call Channel 4 and get the film crew round...

(Tina, interview; 5th July 2007, making a reference to the 2006 Channel 4 programme *Extraordinary Breastfeeding*, noted above).

For the purposes of this thesis I have decided to use 'long-term' to describe what women are doing when they breastfeed for longer than most others in this culture (as discussed above, for these purposes identified as longer than six months). I recognise that this could be viewed as problematic, but feel that it best identifies what the women I am writing about are doing, and have done. My own breastfeeding journey lasted for over seven and a half years, during which time I breastfed two children (separately and at the same time). This did feel to me like something I did 'long-term': it was part of my life for a long time, and was something that I had committed to for 'the long-term'.

The absence of a language to describe breastfeeding babies and children for longer than the norm has a number of implications. It reinforces the hidden nature of long-term breastfeeding and highlights its nature as 'not normal'. It contributes to the ways in which women who breastfeed long-term have to

repeatedly explain and justify their actions (discussed further in Chapters 7-10). Doing something for which you have no name, or that you feel that you cannot discuss with others (illustrated by the comments of Josie and Tina, above), has profound implications, for women, children and society.

Talking and writing about breastfeeding *per se* is also inherently problematic as there are few terms with common understanding and usage, discussed further in the next chapter. The use of 'nursing' sometimes causes confusion (used more in the US, but also sometimes in the UK, to mean breastfeeding). In this writing I mostly use 'breastfeeding' but 'nursing' is sometimes also used. I also use the formulation 'breastfeeding' consistently, rather than 'breast feeding' as I like the inference that it is more than just 'feeding from the breast' and because it is consistently used by the WHO and UNICEF.

1.7 Outline and structure of the thesis

This thesis contains twelve chapters, including this introduction and a conclusion. Chapter 2 discusses and reviews the literature in a number of major areas, thus giving a detailed context to the chapters which follow. The structure of the review is influenced by the Social-Ecological Model (SEM) – outlined and discussed at the beginning of the chapter - both providing a context within which to think about the range of influences on breastfeeding behaviour and experiences, and underpinning the thesis as a whole. The SEM can be used to understand the complex social and personal structures within which women decide to carry on breastfeeding beyond culturally accepted norms, and is shown to be a useful way to think about long-term breastfeeding. Literature reviewed in this chapter addresses issues at the societal, community, interpersonal and individual level, thus considering and critically examining the social and cultural contexts within which women breastfeed.

Chapter 3 outlines and discusses the theoretical concepts that influenced the analysis and interpretation of the findings. It discusses ideas of liminality, stigma and taboo, relating these to ways of thinking about health and breastfeeding. The literature in this chapter is drawn on in the later discussion of the findings (Chapter 11), which considers both how the concepts are related and how they might be used to deepen understanding of long-term breastfeeding in the UK.

Chapter 4 discusses the methods used in the research through an in-depth discussion of data collection and analysis. Themes that cut across all elements of the data collection are identified and discussed, including issues of access, ethics and consent. The three methods used in this study – participant observation, online and face-to-face interviews – are justified with detailed explanation of their use. Chapter 5 looks in detail at my role as an insider in the research process with a discussion of the role of reflectivity in the research, considering methodological issues and approaches. Chapter 6 continues the reflexive strand by considering in detail what it was like for me to be in breastfeeding support groups as an observer.

Chapters 7 -10 explain and discuss the findings of this research. Four main themes relate to breastfeeding long-term – ‘Deciding to breastfeed’, ‘Living with the commitment’, ‘Challenges’ and ‘Being supported’. Chapter 11 draws specifically on Chapter 3 and on the research findings, using the concepts outlined earlier as a lens through which to view and further understand the experience of women who breastfeed long-term. It contains a more wide-ranging discussion than the previous chapters as, instead of looking in detail at specific themes, it looks at ideas of liminality, taboo and stigma in relation to the experience of the women who took part in the study.

Chapter 12 concludes the discussion, drawing together the ideas discussed in the rest of the thesis. The main findings from the study are summarised, the contribution to new knowledge outlined, and strengths and limitations of the work considered. It ends with a reflection on the contribution of this

research to the body of work on breastfeeding experiences, identifying issues for further exploration.

Chapter 2: Background to the research and discussion of contextual literature.

2.1 Introduction

This chapter outlines a number of key issues. The Social-Ecological Model (SEM) is used to structure a review of the relevant literature. This is to explain, contextualise and justify the research, and outline the context within which women breastfeed long-term. Difficult choices have been made about what issues to include and exclude and throughout this chapter I justify the reasons for making these decisions.

The choice of literature is influenced by the research aim – to gain a deeper understanding of what breastfeeding long-term is like for UK women. This involved interrogating a wide range of literature from different disciplines and a plurality of discourses. Various methods were used to search for literature including systematic database searches (two examples are given below), hand-searching reference lists from papers, maintaining an awareness of new literature through email research digests, reading current journal issues, attending conferences, communicating with university colleagues elsewhere and internet searches. Other useful material has been sourced by word of mouth and grey literature sources such as La Leche League (LLL), Association of Breastfeeding Mothers (ABM), National Childbirth Trust (NCT) and breastfeeding websites. Much of this material informs this discussion rather than being specifically identified and drawn on.

Database searches were undertaken for literature to support the discussion on the health benefits of breastfeeding. Medline, CINAHL Plus and Maternity and Infant Care were systematically searched with a combination of key words and phrases using truncation (breastfeed*, for example) and the Boolean operators AND and OR where appropriate. Abstracts were reviewed and papers further selected for relevance. In addition a search was undertaken in the Cochrane Database of Systematic Reviews, looking for the term 'breastfeeding' in the title, abstract or keywords and the 83 results scanned for relevance. The WHO documents on infant feeding/breastfeeding (WHO, 2013) were reviewed online to ascertain which evidence was cited in relation to WHO policy, and to cross check this against results from searches elsewhere. In the same way, and for the same purpose, the UNICEF/BFI research archive (UNICEF, 2011a) was also reviewed. Most of the resulting papers have been used for background reading; the major reviews that are the foundation for policy and guidance are discussed in more detail (see below).

Literature searches to support the discussion on attachment parenting were undertaken using the databases PsycInfo, PsycArticles and SocIndex. This was in order to access a range of psychology and social science literature. As above, combinations of keywords and phrases were used, along with truncation and Boolean operators as appropriate. Searches were combined to focus findings more precisely and abstracts scanned to assess the relevance of papers identified. Other literature was sourced by scanning

reference lists of papers already selected and undertaking internet based searches.

Different forms and sources of literature have been used including empirical research (quantitative and qualitative studies) examining women's experiences and support issues and the potential health benefits of breastfeeding. Other literature also considers relevant topics in discussion papers or commentaries and key texts discussing the social and cultural contexts within which women breastfeed.

The literature used is from a wide range of disciplines, including anthropology, sociology, human and medical geography, women's studies, cultural studies, midwifery and breastfeeding support. Other influential literature drawn on includes seminal texts such as *The Politics of Breastfeeding* (Palmer, 2009), *Breastfeeding Older Children* (Sinnott, 2010) and La Leche League publications, including *The Womanly Art of Breastfeeding* (Wiessinger *et al.*, 2010), *Mothering your Nursing Toddler* (Bumgarner, 2000), as well as newsletter/magazines from ABM and LLL. I have drawn on the DIPEX project interviews with women about their breastfeeding experiences, some of whom breastfed long-term (www.healthtalkonline.org). For pragmatic reasons I focused on English language publications. This allowed some comparison with Anglophone post-industrialised countries, but not those in Europe. Contemporaneous literature has been used where possible, but in some areas there is little that is recent.

Following this introduction I introduce the SEM and its relevance to breastfeeding. Feminist approaches to breastfeeding are briefly discussed. The following sections look at the layers of influence on breastfeeding by examining broad social and cultural influences, including policy, at an international level. I consider what is known about the health benefits of breastfeeding by discussing the major reviews which support WHO and other public health policy and the duration and experience of breastfeeding in the world-wide context. Other issues relating to influences on breastfeeding are also outlined. I conclude with a discussion about individual experiences and how these are addressed in the literature. Broader social and cultural issues are addressed first, followed by narrower social and cultural influences including the importance of individual experiences.

At times I have deliberately compared UK and US breastfeeding policy and experience. Although the US is culturally different from the UK, most of the long-term breastfeeding experience literature is American; only a small amount of relevant literature originates from Canada, Australia and the UK. Connections with US breastfeeding researchers were made during the PhD through international conference presentations and a book publication (Dowling *et al.*, 2010; Dowling, 2011a; Dowling *et al.*, 2012; also Appendix I). These links have been useful when thinking about issues discussed here.

One difficulty in trying to organise this discussion is my position in relation to opposing views in some areas. These fundamentally question the basic premises underpinning my research and, where appropriate, I clarify my

position. Other literature, on the theoretical concepts of liminality, stigma and taboo used in the findings discussion, is reviewed in Chapters 3 and 11.

2.2 The Social-Ecological Model (SEM)

2.2.1 The development of the SEM

There is a large body of relevant literature and I wanted to organise it in relation to women's experience. I have drawn on health promotion models to aid my thinking and structuring. I was drawn to the simplicity and relevance of social-ecological models (SEM) such as the 'determinants of health model' (Dahlgren and Whitehead, 1991; Dahlberg and Krug 2002), as they recognise the factors that impact on individual health through social and community influences to wider society and cultural conditions.

The SEM originates from Ecological Systems Theory (Bronfenbrenner, 1979). Bronfenbrenner uses the terms *micro* (for example, the family), *meso* (interaction of micro influences), *exo* (wider influences such as community) and *macro* (the larger socio-cultural context) to describe the systems where developmental experiences occur. SEM models commonly recognise that behaviour is influenced at many levels, including:

...intrapersonal (biological, psychological), interpersonal (social, cultural), organizational, community, physical environment and policy...

(Sallis *et al.*, 2008). They have been used by WHO and the CDC to focus and guide public health programmes and policies, considering:

...the complex interplay between individual, relationship, community and societal factors...

(Labbok, 2012:44). The CDC uses the SEM in violence prevention (CDC, 2012), and it has been used in the US with other health promotion issues including obesity prevention, HIV prevention and child abuse. The SEM is

useful for this research as it considers the complex interplay of influences on decisions about behaviour and offers a structure within which to consider influencing change:

...Ecological models of health behavior emphasize the environmental and policy contexts of behavior, while incorporating social and psychological influences. Ecological models lead to the explicit consideration of multiple levels of influence, thereby guiding the development of more comprehensive interventions...

(Sallis *et al.*, 2008).

2.2.2 The use of the SEM in breastfeeding health promotion

The SEM has been used with breastfeeding issues in the US (Tiedje *et al.*, 2002) where 'breastfeeding coalitions' co-ordinate activity to improve breastfeeding initiation and duration amongst low-income and disadvantaged groups. This is evident when breastfeeding coalitions refer explicitly to the SEM and implicitly through activity levels named as '*individual*', '*interpersonal*', '*community/environment*', '*organizational*', '*policy*' and '*media*' (Breastfeeding Coalition of Oregon, 2012). There is no evidence of this model influencing UK breastfeeding promotion policy. There is some evidence that it has been considered by those working with breastfeeding women, although not specifically in relation to breastfeeding (Bryans *et al.*, 2009).

Feminist commentators note the SEM's usefulness in contextualising women's decisions to breastfeed and continue breastfeeding in relation to gender (Labbok *et al.*, 2008; Labbok, 2012). Labbok notes breastfeeding is

poorly supported through public health action and calls for SEM development, along with lifecycle models, to focus on:

...when we act...where we act...and how we act...

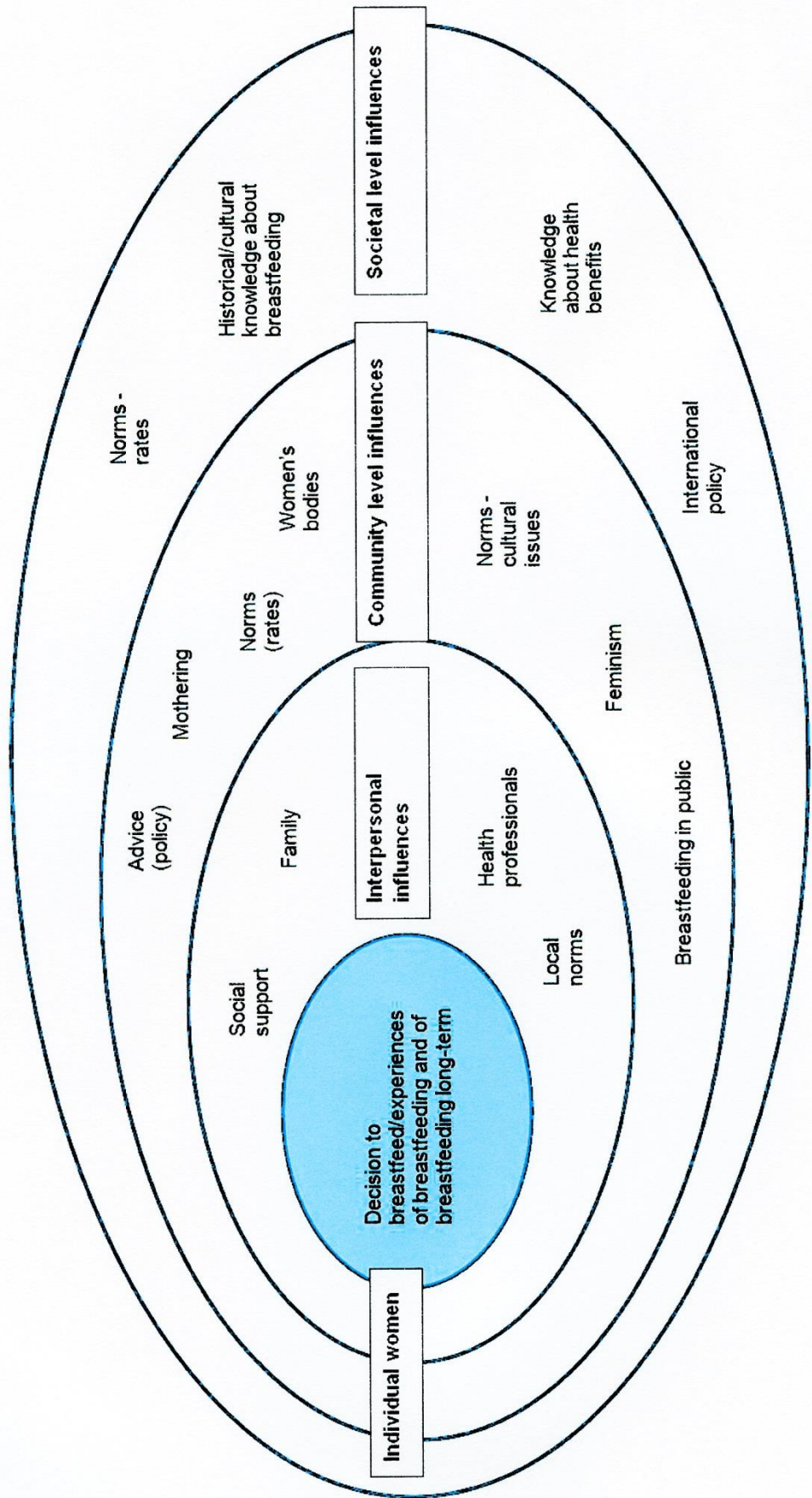
(Labbok, 2012:47).

2.2.3 The use of the SEM to think about breastfeeding long-term

By addressing issues at the societal, community, interpersonal and individual level this review considers the social and cultural contexts within which women breastfeed long-term. The SEM has been used to consider breastfeeding policy and promotion (Labbok, 2012). It has not previously been used as a structure within which to think about long-term breastfeeding. This chapter therefore provides a context for reading and thinking about the findings (Chapters 7-10) within which the described experiences occur.

This literature review is based on Dahlgren and Whitehead's determinants of health model (1991), Dahlberg and Krug's interpretation of the SEM (2002) and Labbok's version of the CDC model (2012). It is structured around the main themes in the above models, represented in Figure 1, although the interpersonal and community levels are collapsed and some of these influences are considered together. The influences identified in the model are not all addressed here for the sake of brevity.

Figure 1: Influences on breastfeeding behaviour and experiences



2.3 Breastfeeding and feminism

Breastfeeding has posed challenges for feminists, resulting in polarised approaches which are beyond in depth review here. The main issues are identified because the debates contribute to the context within which this study was undertaken and within which UK women are breastfeeding.

Feminist debates about breastfeeding have been evident for some time.

Blum noted that:

...feminist discussions of motherhood...continually ponder how to retain the empowering or pleasurable aspects of motherhood without reinforcing the straightjacket of traditional gender arrangements and how to demand political and economic rights on a par with men's without denying the value of women's experiences...

(1993:291). Some feminist academics consider breastfeeding promotion to be oppressive, constraining women's choices and continuing the gendered nature of caring. Much of this work focuses on the ways breastfeeding is associated with 'good' mothering and leading to the:

...vilification of women who do not breastfeed...

(Kukla, 2006:173). The choice to breastfeed is a highly charged issue, with moral associations and difficult consequences for women who choose not to breastfeed (Knaak, 2006). The literature addresses this in various ways.

Breastfeeding is considered in the context of the 'control of mothering' (Wall, 2001), and risk and motherhood (Murphy, 2000; Faircloth, 2010b; Knaak, 2010; Wolf, J.B., 2011), drawing on the concept of 'intensive motherhood' (Hays, 1998; Lee, 2008).

Other work examines women's experiences of formula feeding, using ideas of deviance to discuss women's accounts of their feeding choices within the context of 'breast is best' (Murphy, 1999; Lee, 2007). This work reports how non-breastfeeding mothers may feel judged, judge themselves, and how they work hard at establishing themselves as 'good' mothers when their behaviour contradicts health advice. Guilt felt by formula feeding mothers is prominent, as is the link with breastfeeding promotion, health policy and cultural ideas about mothers' responsibilities for their children's health (Taylor and Wallace, 2012a).

Feminist academics have recently focused on criticisms of breastfeeding health benefits research and associated health promotion messages. Using Rosin (2009) and Wolf, J.B. (2011) as the basis for their arguments, a small number of feminists have argued that pressuring women to breastfeed based on current evidence is a fundamentally flawed position (Faircloth and Lee, 2011; Lee, 2011a). They dismiss the evidence connecting breastfeeding to health benefits and to reducing health inequalities, and argue for a different focus on women's lived experiences of infant feeding instead. Although their work considers the social and cultural constraints in which infant feeding takes place, the focus is less on women's abilities to breastfeed or to choose breastfeeding and more on whether promoting breastfeeding can be seen as an unjustifiable pressure on women. Criticisms of this perspective consider that it is:

...helpful at best and destructive at worst...

(Hausman, 2012:15).

Many of these issues have been also considered by breastfeeding promotion supporters, albeit with a positive emphasis on women and children's health and the role of breastfeeding in women's lives. An example is Ryan *et al.*'s (2010) examination of the 'moral work' of infant feeding in relation to the experiences of those who have decided, and are continuing, to breastfeed (drawing on the healthtalkonline interviews). This is interesting as its focus is in contrast to other literature which considers the work that women do to make sense of formula feeding decisions, as discussed above. In Ryan *et al.*'s study women undertook 'moral work' in order to make sense of their infant feeding decisions, within the context of what was possible for them '*given their familial, social, cultural and economic constraints*' (2010:953). This work is discussed in relation to 'biographical preservation', 'biographical repair', 'altruism' and 'political action' and is important as it extends discussion about the complicated factors involved in women's decisions to breastfeed and continue breastfeeding.

Many feminist academics focus on promoting breastfeeding within the context of maternal rights, and examine the social and cultural constraints affecting women's choices about infant feeding (Hausman, 2012). Their work examines a range of issues impacting on women's experiences where gender inequalities can be seen to persist (Smith, 2008), including support in establishing breastfeeding, breastfeeding and work (workplace issues and the impact of caring roles on careers), breastfeeding in public and perceptions of breastfeeding in contemporary culture. In this way

breastfeeding is seen as an issue for feminist health advocacy (Hausman, 2003).

Feminists have specifically addressed gendered care-work and how breastfeeding may be seen as:

...a gender difference that stands in the way of liberating women...

(McCarter-Spaulding 2008:207). Combining breastfeeding with paid employment outside the home is too challenging for most women and conflicts with cultural views about the separation of home/family and work (Law, 2000). McCarter-Spaulding argues that:

...the goal is not simply to promote breastfeeding but to create the social and economic conditions that make breastfeeding possible, successful and valued for all women. Breastfeeding cannot be promoted without it also being supported socially, economically, and politically...

(2008:210) and it is this goal on which much feminist debate focuses. Wolf, J.H. comments that:

...If not feminists, who will push for the reconciliation of women's busy lives and their infants' need for their milk?...

(2006:417). Others focus on the conflicts women face in contemporary cultures when expected to be both 'sexual woman' and 'maternal woman' (Stearns, 1999), particularly when breastfeeding in public and managing the social constraints placed on breastfeeding (Hausman, 2012; Dowling *et al.*, 2012; Smyth, 2008; Pain *et al.*, 2001).

This brief review of the work illustrates the perspective taken in this study which is supportive of the latter ideas. Women's experiences are considered

in relation to the contexts in which they occur and these contexts form a backdrop to the thesis.

2.4 Societal level influences

This section considers the SEM 'outer layer' of influence on breastfeeding decisions and behaviour – the world-wide context in which breastfeeding takes place. Breastfeeding policy and breastfeeding promotion are briefly examined but the majority of this section looks at what is known about the health benefits of breastfeeding, opening with a discussion of issues relating to undertaking breastfeeding research. A review of the evidence for the health benefits of breastfeeding follows. This establishes the basis for the WHO recommendations for breastfeeding, on which most major policy worldwide is founded. There has been some criticism of this evidence and this viewpoint is also considered. This section concludes with a brief discussion about what is known about the health benefits of long-term breastfeeding.

2.4.1 Breastfeeding policy worldwide

There is acknowledgement at an international level that breastfeeding is important for health, and so the public health advice and policy around breastfeeding is clear:

...infants should be exclusively breastfed for the first 6 months of life...thereafter...infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for *up to two years of age or beyond...*

(WHO, 2003; 7-8, my emphasis). This advice is now supported by results from large systematic reviews, and a substantial body of other evidence. It has been adopted by many countries and used by WHO/UNICEF BFI to

support and promote optimal infant feeding (WHO/UNICEF, 2009). Recent work funded by the European Commission echoes the WHO advice :

...While fully accepting that mothers make the decision about how long they and their babies wish to breastfeed, they should receive all the support necessary to help them continue breastfeeding to two years of age and beyond, as recommended by WHO and most national and professional policies and practice recommendations...

(European Network for Public Health Nutrition, 2005a).

Despite these recommendations, some countries provide clearer advice on the duration of breastfeeding than others. The American Academy of Pediatrics for example, has said that:

...Increased duration of breastfeeding confers significant health and developmental benefits for the child and the mother...There is no upper limit to the duration of breastfeeding and *no evidence of psychologic or developmental harm from breastfeeding into the third year of life or longer...*

(AAP, 2005:500; my emphasis). On their website, they advise parents that:

...Babies should continue to breastfeed for a year and for as long as is mutually desired by the mother and baby...

(AAP, 2013), and this is reaffirmed in their recent updated policy statement (AAP, 2012). This is supported by the Surgeon General (US Department of Health and Human Services, 2011) and by the Obama administration.

Similar advice is given in Australia (National Health and Medical Research Council, 2003) and other developed countries although practice often falls short of recommendations (European Network for Public Health Nutrition, 2005b). The UK advice on the upper age limit of breastfeeding is less clear:

...Breastfeeding is the healthiest way to feed your baby. Exclusive breastfeeding (giving your baby breast milk only) is recommended for around the first six months (26 weeks) of your baby's life. After that, giving your baby breast milk alongside other food will help them continue to grow and develop...

(NHS Choices, 2011).

International policy is spearheaded by WHO and UNICEF and is used by many countries in developing nation-specific policy and guidance. The WHO *Global strategy for infant and young child feeding* (2003) underpins breastfeeding advice on many levels. It is this document that the breastfeeding women in my research referred to when they made comments such as:

...I'd always planned to do at least a year, probably two because I knew about the WHO stuff...

(interview with Tina; 5th July 2007).

The *Global Strategy* built on previous work: the Baby Friendly Hospital Initiative (WHO/UNICEF, 2009), the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding (World Health Organisation/UNICEF *et al.*, 1990, updated 2005) and the International Code of Marketing of Breastmilk Substitutes (WHO, 1981). The links between child nutrition, poverty and socio-economic development were made clear:

...The aim, from the outset, was to move towards formulating a sound approach to alleviating the tragic burden borne by the world's children – 50 to 70% of the burden of diarrhoeal disease, measles, malaria and lower respiratory infections in childhood are attributable to under nutrition – and to contribute to a lasting reduction in poverty and deprivation...

(WHO, 2003:v), and the *Strategy* called for:

...governments, the international community and other concerned parties to renew their commitment to promoting the health and nutrition of infants and young children and to work together for this purpose...

(WHO, 2003:3-4).

Breastfeeding policy and increased global awareness of the damaging effects of formula milk marketing (particularly in developing countries) have developed in parallel. Influencers in the UK include the Baby Milk Action

pressure group, *The Politics of Breastfeeding* (Palmer, 2009), *The Innocenti Declaration* (WHO/UNICEF, 1990, 2005) and the *International Code* (WHO, 1981). Increased understanding of the evidence and knowledge about the benefits of breastfeeding has led to a greater awareness of the potential risks of formula feeding. Some have framed this as a human rights issue - the right to breastfeed and be breastfed (Bar-Yam, 2003); others conceptualise it as the economic benefits to nations and communities of promoting breastfeeding over formula feeding (Smith and Ingham, 2001; Smith, 2004; Smith and Ingham, 2005).

However, institutionalised support does not necessarily translate into increased breastfeeding rates or unproblematic breastfeeding experiences for women. Breastfeeding initiation rates and exclusive breastfeeding vary considerably between developed and developing countries (WHO, 2011). WHO works to collate good, comparable data but comparisons between countries are difficult due to variation in data collection and sample sizes. WHO data tables (2011) are more complete on whether babies have ever been breastfed rather than duration of breastfeeding.

2.4.2 Issues in undertaking breastfeeding research

There are a number of difficulties in undertaking breastfeeding research, particularly when looking at health benefits. Lack of consistency in breastfeeding definitions (Labbok and Krasovek, 1990; Labbok and Jared Coffin, 1997) continues to be an issue for breastfeeding researchers

(Cadwell, 2002). Breastfeeding is sometimes defined as putting a baby to its mother's breast at least once (initiation), which causes confusion over terms such as 'exclusive breastfeeding' and 'full' or 'partial' breastfeeding (Dyson *et al.*, 2008).

WHO/UNICEF (1981, 2008) have published definitions to resolve the issue, but it is unclear whether this has been successful as journals still accept breastfeeding research papers without a definition of terms (Labbok, 2000). Some journals specifically ask contributors to use definitions such as Labbok and Krasovek's (1990) but this is not universal. In a recent personal communication Labbok commented:

...I do not think we are nearer to consistency. The WHO definitions are squiggly and many papers offer none. In many countries that follow WHO definitions, feeding of expressed milk is considered exclusive breastfeeding and "pump" is now given the same definition as breastfeeding...

(Labbok, 2011).

Consequently, direct comparisons between papers raise the problem of whether researchers refer to the same issues. Similarly, breastfeeding women, writers and commentators about breastfeeding do not always make clear distinctions between different modes of feeding – so the terms exclusive, mixed or replacement feeding may be used without explanation of their contextual meaning. Also, as noted in Chapter 1, there is no commonly used term to describe 'long-term' breastfeeding.

Another problematic issue is the ethical impracticality of randomised control trials (RCTs) to examine health benefits of breastfeeding (Labbok, 2012).

RCTs are high on the traditional 'hierarchy of evidence' (Moule and Hek, 2011) as they provide very strong evidence of intervention effects. The design promotes reliability and validity of findings (Horta *et al.*, 2007). Confounding variables are a particular issue in breastfeeding research, where higher socio-economic status and improved maternal education may lead mothers to make healthier choices for their babies in addition to breastfeeding, making it difficult to support causal statements about breastfeeding and health outcomes.

Carrying out an RCT now into the effects of an intervention already known to be beneficial is unethical and trials would not gain approval to randomise women to breastfeed or not (UNICEF, 2011a; Ip *et al.*, 2007; Horta *et al.*, 2007). The majority of studies looking at breastfeeding health benefits are observational studies (cohort or case-control studies), weaker evidence but nonetheless important, as well controlled observational studies and RCTs are likely to produce similar results (Benson and Hartz, 2000; Concarto *et al.*, 2000; Ip *et al.*, 2007; Horta *et al.* 2007).

RCTs have been used to examine breastfeeding benefits: Horta *et al.* (2007) refer to studies undertaken before breastfeeding health benefits were so well understood and before their use would be considered unethical. More recently, PROBIT - the Promotion of Breastfeeding Intervention Trial (a large RCT) - randomised women in Belarus to receive different levels of breastfeeding support and then examined the differences in outcomes for the two groups of women/babies (there are many published papers about this

trial see for example, Kramer *et al.*, 2001; Kramer *et al.*, 2003; Kramer *et al.*, 2008). This RCT was considered ethically acceptable as the women were not randomised to breastfeed *per se* but to different levels of breastfeeding support. Using RCTs like this has been criticised (Wolf, J.B., 2011; Knaak, 2006) but is generally recognised as acceptable, providing evidence supplementary to that provided by other methods, albeit with limitations in statistical power (Horta *et al.*, 2007).

Systematic reviews and meta-analyses of RCTs are recognised as the 'gold standard' of research evidence (Moule and Hek, 2011; Parahoo, 2006).

There has been recent acknowledgment of the importance of systematic reviews using evidence from non-RCTs, and a recognition that reviews often have to pragmatically combine different types of study to evaluate the available evidence (Parahoo, 2006). UNICEF is clear about the benefits of systematic reviews in breastfeeding research:

...Where systematic reviews or meta-analyses are available, allowing analysis of findings from a number of well-selected studies, these obviously provide a stronger evidence base on which it is possible to base arguments with greater conviction...

(UNICEF, 2011a). New breastfeeding studies are published frequently; assessing the evidence is therefore challenging. Using systematic reviews is helpful but even WHO systematic reviews become rapidly outdated. In recognition of this the WHO recently commissioned an update of the 2007 review (Horta *et al.*, 2007). This identified 60 new publications (Horta and Victora, 2013).

Critics of the breastfeeding health benefits evidence focus on study design and confounding factors and on the presentation of evidence to breastfeeding women (Knaak, 2006; Lee and Bristow, 2009; Wolf, J.B., 2011; Lee, 2011a). Most reputable bodies, such as WHO and UNICEF, recognise these difficulties, particularly in the large systematic reviews and meta-analyses where these issues are overtly discussed. One frequent criticism is the lack of breastfeeding RCTs and common use of observational designs. In UNICEF BFI research summaries they address the four criteria that non-randomised studies need to meet to maximise their scientific validity and generalizability: prospective studies, confounding variables controlled, and outcomes and “breastfeeding” clearly defined (2011a).

2.4.3 The health benefits of breastfeeding

Overview

Literature about women’s breastfeeding experiences often refers to health benefits using phrases such as:

...the benefits of breastfeeding...are well established...

(Marshall, Godfrey and Renfrew, 2007:2147), or:

...breast milk is now the gold standard for infant feeding...

(Stearns, 2009:63), or provides a brief, uncritical summary of current evidence. A large amount of work is available and numerous claims made about breastfeeding benefits or formula feeding risks. A small amount of literature considers the specific benefits of breastfeeding long-term. I provide a brief summary of breastfeeding health benefits here, focusing on the work

that is used to support national and international policy. I discuss it here as part of considering the 'outer layer' of influence on women's experiences and also to set the context in which women breastfeed, as women breastfeeding long-term frequently refer to the 'known' benefits of breastfeeding to support and justify their decision to breastfeed long-term (Faircloth, 2010a).

Most reputable health bodies and commentators recognise that breastfeeding confers a wide range of benefits on babies and mothers. Worldwide, these include increased infant survival and better infant health outcomes and these are acknowledged as also important in the developed world (Ip *et al.*, 2007). There is a trend to talk about the 'greater health risks to artificially fed babies' as opposed to the 'health benefits of breastfeeding', this is in relation to efforts to:

...re-position breastfeeding as a natural, normative behavior...

(McNiel *et al.*, 2010:51). I talk here about both the breastfeeding benefits and formula feeding risks; however, most papers and breastfeeding women still frame the issue as breastfeeding *benefits*.

The WHO uses research-based evidence to support its global work on infant feeding: some specific to breastfeeding, some to related issues (for example, breastfeeding and HIV and breastfeeding in disaster situations), some on infant and child nutrition. This evidence is in turn drawn on by major policy making bodies including the UK Department of Health. Four publications are of particular interest here: the systematic review on the long-term effects of breastfeeding (Horta *et al.*, 2007), the updated version of this review (Horta

and Victora, 2013) and the systematic review on exclusive breastfeeding (Kramer and Kakuma, 2012). Ip *et al.*'s (2007) systematic review is also important as it examines health outcomes and breastfeeding in developed countries and informs UNICEF BFI work. Although published in 2007 this review is considered here as searches did not find any other large review of this nature published since.

In order to consider the strength of the evidence used to support the work of WHO and UNICEF and to inform public health policy I will focus on discussing these major evidence reviews – Kramer and Kakuma (2012), Horta and Victora (2013) and Ip *et al* (2007). This is in order to consider the evidence used to support policy drives to promote and increase rates of exclusive breastfeeding for six months, as well as the recommendation for continuing with breastfeeding beyond this time. Although there are a large number of other research papers considering health issues in relation to breastfeeding, including some systematic reviews, I have chosen to focus on these three evidence reviews as they are explicitly used by WHO to support its policy (WHO, 2013) and drawn on by UNICEF/BFI in its work.

The evidence for exclusive breastfeeding for six months

In a review for the Cochrane Database of Systematic Reviews Kramer and Kakuma (2012) updated their previous review on the optimum duration of exclusive breastfeeding. They acknowledge that although the health benefits of breastfeeding are widely recognised there is less consistency and

agreement about this issue. Consequently the stated primary objective of the review is to:

...assess the effects on child health, growth, and development, and on maternal health, of exclusive breastfeeding for six months versus exclusive breastfeeding for three to four months with mixed breastfeeding (introduction of complementary liquid or solid foods with continued breastfeeding) thereafter through six months...

(Kramer and Kakuma, 2012:1). A secondary objective was to assess the effects of exclusive breastfeeding for longer than six months, compared to exclusive breastfeeding to six months followed by breastfeeding and solid foods.

The review gives appropriate detail on search strategy, assessment of papers, study quality and data extraction. Information is also included on how many new papers are in this version of the review. Detail is included on the characteristics of chosen studies, including an assessment of the risk of bias in the study design. Internally controlled trials and observational studies were included and there were 23 studies which met the criteria for the review, 12 of which were from developed countries. Outcomes considered were growth, development, morbidity, and survival of healthy, term infants and their mothers; low birth weight babies were included if the pregnancy was 37 weeks or longer in duration. Within the review five different comparisons were made, in order to look at different types of studies, different durations of exclusive breastfeeding and developed and developing countries.

The results of the review demonstrate that evidence in this area is still variable in relation to some issues but clearer in relation to others. No evidence was found that exclusive breastfeeding for six months negatively impacts on growth (length or weight) although the authors acknowledge that the data was not sufficient to rule out a small risk or to reach any conclusions about exclusively breastfeeding for longer than six months.

The authors conclude that six months of exclusive breastfeeding (as opposed to three or four months followed by complementary foods) leads to a significantly lower risk of gastrointestinal infection for the baby. For the mother there is a delay in resumption of menses and more rapid weight loss after the birth. These results might be considered more important in relation to developing than developed countries but the authors confirm that this is an appropriate recommendation for all babies and that previous versions of this review have formed the basis for WHO policy in this area. The review also demonstrated that exclusive breastfeeding did not reduce risks of other infections, allergic diseases, obesity, dental caries, or cognitive or behaviour problems. There was a slight risk of iron deficiency in exclusively breastfed babies in developing countries but the authors conclude that supplementation would be acceptable in order to retain the other benefits demonstrated.

The authors recognise that there are problems with confounding and study design in this area and recommend that further research is undertaken using large randomised trials, perhaps using cluster randomisation.

The results of this review are important as this is an issue which is much debated; it was the subject of media interest and academic discussion whilst this thesis was being written. The reduction in gastrointestinal infections in infants is important in the settings in which women in this study breastfed, as well as for women in developing countries. A modest increase in the number of women exclusively breastfeeding in the UK each year would lead to a significant reduction in hospital admissions for gastrointestinal infections and associated GP consultations and a reduction of millions of pounds in treatment costs (Renfrew *et al.*, 2012).

The health benefits of breastfeeding for women and babies

Ip *et al.* (2007) is a large systematic review which looks at the effects of breastfeeding on both short- and long-term health outcomes in relation to maternal and infant health and developed countries. Although other research has been published since 2007 I have chosen to discuss this review here as it is a large and significant one, referred to by both the WHO and UNICEF BFI, and of particular relevance because of its focus on health outcomes in developed countries. The review is very broad in scope and considers many health outcomes which have been associated with breastfeeding in a range of previous research studies. In total 23 different outcomes are addressed (the authors acknowledge that there are other potential health outcomes that they were not able to consider). In some areas this is a review of reviews as, where previous systematic reviews existed these were used or updated. For health issues with no existing systematic reviews primary studies were used

and new systematic reviews undertaken. The authors clearly explain their inclusion and exclusion criteria, definition of terms, search strategy and grading criteria. The results draw together findings from a large number (400) of different studies.

The review summarise the evidence in a range of health outcomes for full-term infants. These were: acute otitis media, atopic dermatitis, gastrointestinal infections, lower respiratory tract diseases, asthma, cognitive development, obesity, risk of cardiovascular disease, type 1 diabetes, type 2 diabetes, childhood leukaemia, infant mortality and sudden infant death syndrome (SIDS). For pre-term infants outcomes were: cognitive development and enterocolitis (NEC). For maternal health outcomes were: return to pre-pregnancy weight, maternal type-2 diabetes, osteoporosis, postpartum depression, breast cancer and ovarian cancer.

As with other systematic reviews in this area the authors note particular difficulties with study design, the reliance on observational studies, definitions of breastfeeding used and confounding factors. These issues mean that for many of the outcomes the results are reported with some caution and there is discussion of limitations both of data and of study design. As the results of so many outcomes are complicated to report I reproduce the authors' summary from the abstract here:

...We found that a history of breastfeeding was associated with a reduction in the risk of acute otitis media, non-specific gastroenteritis, severe lower respiratory tract infections, atopic dermatitis, asthma (young children), obesity, type 1 and 2 diabetes, childhood leukemia, sudden infant death syndrome (SIDS), and necrotizing enterocolitis. There was no relationship between breastfeeding in term infants and

cognitive performance. The relationship between breastfeeding and cardiovascular diseases was unclear. Similarly, it was also unclear concerning the relationship between breastfeeding and infant mortality in developed countries. For maternal outcomes, a history of lactation was associated with a reduced risk of type 2 diabetes, breast, and ovarian cancer. Early cessation of breastfeeding or not breastfeeding was associated with an increased risk of maternal postpartum depression. There was no relationship between a history of lactation and the risk of osteoporosis. The effect of breastfeeding in mothers on return-to-pre-pregnancy weight was negligible, and the effect of breastfeeding on postpartum weight loss was unclear...

(Ip *et al.*, 2007). The association of breastfeeding with a reduced risk of disease in women and children is behind the public health policy which forms the context in which women breastfeed in developed countries. Although the authors point out that causality cannot be inferred from these findings, the strength of the association supports breastfeeding policy and health promotion practice.

The evidence for the long-term health benefits of breastfeeding

In their systematic review and meta-analysis, commissioned by the WHO, Horta and Victora (2013) updated a previous review (Horta *et al.*, 2007) to look at evidence in relation to the long-term effects of breastfeeding. This is important as WHO policy, drawn on by public health policy makers, recommends that breastfeeding continues alongside complementary foods after the initial period of exclusive breastfeeding. The authors acknowledge that good research evidence demonstrates the short term benefits of breastfeeding; their review updates what is known about the longer-term benefits. In the review they focus on five specific outcomes - blood pressure, type-2 diabetes, serum cholesterol, overweight and obesity, and intellectual performance.

The authors of the review acknowledge the difficulties in undertaking RCTs in this area, recognising that most research evidence (with the notable exception of the PROBIT trial, discussed above) comes from observational studies. The review contains a full discussion of the factors which can affect the validity of such studies as well as techniques to overcome them. These factors were considered in the selection and assessment of papers for the review, adding another level of robustness. As issues of confounding and bias are often raised by critics of the evidence for the health benefits of breastfeeding it is important that these issues are considered overtly.

The review searched for papers published since the earlier review and is clear about the parameters set for this. Selection criteria, outcome measures and search strategy are clearly explained and the rationale given for decisions made. The assessment of the studies found is also clear, including information on the assessment of quality and heterogeneity. Explanation is given about data extraction including the statistical tests used in meta-analysis and to assess publication bias and heterogeneity. Transparency and clarity about all these issues is important as it helps the reader to assess the quality of the review, including its strengths and limitations.

The results of the review are discussed in relation to each of the identified outcome measures. Results are given as an overall summary plus charts and tables giving detail of the studies used and statistical analysis of pooled data. For each the biological plausibility of the association of the measure with breastfeeding is briefly discussed, as well as specific methodological

issues related to its investigation. The results of the previous review are summarised and updated with the new findings. The overall summary for each is as follows:

Obesity and overweight – the authors found a small reduction in the prevalence of obesity or overweight in children who were breastfed for longer periods. They note that it is not possible to rule out residual confounding – breastfeeding duration was usually longer in higher income, better educated families which may also have an effect on diet and obesity.

Blood pressure – the findings of the updated review were consistent with a small protective effect of breastfeeding against systolic blood pressure. Again it is not possible to rule out residual confounding and publication bias was recognised as a considerable issue.

Total cholesterol – a smaller effect on the reduction of total bloods cholesterol amongst adult who had been breastfed was found than in the previous review. The statistical analysis suggested that breastfeeding did not have a long-term effect in this area.

Type-2 diabetes – evidence from this review suggests that breastfeeding may have a protective effect against type-2 diabetes, particularly amongst adolescents. This evidence is based on a small number of studies with significant heterogeneity.

Performance in intelligence tests – this review found that breastfeeding was associated with better performance in intelligence tests for children and adolescents and that this was even after maternal IQ was adjusted for in the analysis.

In summarising their results the authors of this review note that it draws on a much larger evidence base than their previous review. They also note that all results show a larger effect amongst children than adults, suggesting that the benefits are diluted over time. In some ways the results of this review are disappointing – the authors conclude that breastfeeding does not seem to protect against cholesterol and that the protective effect against blood pressure is too small to be of public health significance. The results show protection against diabetes and overweight/obesity but identify that further work is needed. Strong evidence was found of a causal link between breastfeeding and IQ.

Although some of the detail of these reviews is difficult to summarise here the overall message is that breastfeeding confers significant benefits to mothers and children, some short- and some long-term. There are some apparent contradictions between the Horta and Victora review and that of Ip *et al.* but it is important to note the different focus and populations of interest in each. Criticisms of this evidence often focus on the problems with study design and particularly on confounding and bias. Careful reading of these reviews suggests that these issues are well recognised; high quality research and reviews are careful to consider them and to use specific techniques to

mitigate against bias as far as possible. Each review is also realistic about the interpretation that can be placed on results and, where appropriate, the limitations of these.

2.4.4 The benefits of long-term breastfeeding

Evidence for long-term breastfeeding benefits is less clear because of the limited research. The focus has been on the breastfeeding benefits to *babies* in the short and long term so there is more evidence about long-term benefits of having been breastfed than about benefits of long-term breastfeeding. It is hard to conduct research on the evidence of long-term breastfeeding because there are many other factors influencing children's health as they grow older (introduction of other foods, environmental influences, mother's education and socio-economic situation). There are also other complicating factors, including the accuracy of recall of breastfeeding behaviour and duration. In countries where breastfeeding continuation rates are low (as in the UK), quantitative work on longer-term breastfeeding is difficult as sample sizes are very small (UNICEF, 2011a).

A number of publications supportive of long-term breastfeeding discuss the 'known' health benefits, although often cite dated research. Women who breastfeed long-term often talk about the on-going nutritional and immunological benefits but there is little contemporaneous scientific literature to support this view. Both the LLL publication *Mothering your nursing toddler* (Bumgarner, 2000) and Sinnott's *Breastfeeding older children* (2010) cite little

work published since the 1990's. Literature searches undertaken to support this section revealed no further published evidence than that used by Bumgarner or Sinnott. Some authors write as if there is more concrete knowledge than there actually is. Dettwyler's work is often referred to by supporters of long-term breastfeeding:

...Parents and health professionals need to recognize that the benefits of breastfeeding (nutritional, immunological, cognitive, emotional) continue as long as breastfeeding itself does, and that there never comes a point when you can replace breast milk with infant formula, cows' milk or any other food, or breastfeeding with a pacifier or teddy bear, without some costs to the child...'

(Dettwyler, 1995:204).

There is, however, no evidence that long-term breastfeeding causes harm. Women breastfeeding long-term often refer to the psychological benefits of long-term breastfeeding being as important as physical health benefits (Gribble, 2008). There is little published research about this, partly because of the pragmatics of undertaking longitudinal studies. Respondents to Sinnott's survey (2010) highlighted the relational aspects of long-term breastfeeding: closeness with their children, instilling confidence in them and using breastfeeding to comfort. These have also been noted by others, including Buckley (2001) and Rempel (2004). Breastfeeding women recognise these aspects as important and they are often referred to in publications from breastfeeding support organisations or in web-based discussion groups.

2.4.5 Criticisms of the evidence for the health benefits of breastfeeding

To give a balanced view of how evidence is perceived I will critically review the position of those who consider the breastfeeding benefit evidence to be flawed. This viewpoint has received publicity recently and is part of the context in which women breastfeed and make decisions about breastfeeding, as well as the context in which this study took place.

The Centre for Parenting Culture Studies (CPCS) at the University of Kent has given a platform to anti-breastfeeding promotion ideas (CPCS, March 2011a), published documents and articles calling for a review of UK breastfeeding promotion based on a supportive reading of Wolf's ideas (Lee, 2011a; Faircloth and Lee, 2011) and used a range of media outlets, including social media, to challenge accepted ideas about breastfeeding (CPCS, 2011b). This is in the context of broader CPCS aims to critique what they see as a:

...growing professionalisation of parenting...(and)...growing cult of parent blaming...

(Clark, 2009:13). I support their overall aims, but take issue with their choice of targets.

There are a number of recent high profile instances of criticisms of the breastfeeding promotion evidence, including Fewtrell *et al.* (2011) and Wolf, J.B. (2011); I briefly discuss Wolf's work here. They received a significant amount of publicity during the project and have been used by others to call for changes in UK breastfeeding policy (Lee, 2011a). These recent

examples do not constitute the context in which the women in my research were breastfeeding but form part of the on-going context for short- and long-term breastfeeding in the UK, as well as challenging those who want to promote breastfeeding as optimal for babies' health.

In *Is breast best?* Joan B Wolf (2011) argues against the evidence for the health benefits of breastfeeding and discusses breastfeeding promotion in relation to academic work about risk, in particular, risk and motherhood and what she calls '*total motherhood*' (2011:71). The book builds on work published in a previous paper (Wolf, J.B., 2007). Wolf argues that the breastfeeding health benefits evidence is flawed, that promotion of breastfeeding based on this evidence is unjustified and that mothers make decisions based on false information about risks to children's health. Her criticisms are based on the weaknesses inherent in observational studies and the lack of RCTs. She is dismissive of evidence which is highly respected elsewhere, and ignores the systematic reviews used by WHO and much of the existing science (discussed earlier in this chapter).

Joan Wolf argues against using evidence from peer reviewed breastfeeding journals as their:

...mission is to promote breastfeeding...

(2011:22). She does not conduct a robust, systematic review of the evidence and chooses evidence which supports her claims, undermining her critique of peer-reviewed journals. Her book, the associated supportive media coverage (Rumbelow, 2009), internet discussions (FearlessFormulaFeeder,

2011), facebook pages, online feminist debates (Goldstein, 2011) and personal UK appearances (CPCS, 2011a; CPCS, 2013) have ensured wide UK and US coverage. Some journals have published pro-Wolf book reviews which fail to critically examine her claims and re-iterate her flawed points, for example:

...the controversy about what she has to say simply reflects the fact that she has been determined and hard-working enough to take apart and expose a fiction that many are highly reluctant to see called into question...

(Lee, 2011b: 594).

LLL GB published a response to the work following Wolf's second UK lecture (Burbidge/LLL GB, 2013), however, although anecdotally there are many breastfeeding researchers who have concerns about Wolf's work and the way it is used by some academics (Lee, 2011a), there have been few responses to it in academic journals. There are, however, a small number of pieces addressing issues raised by Wolf, both directly and indirectly. These pieces, although not endorsing Wolf's viewpoint, are not overtly critical.

Heinig (2007) reviews Wolf's earlier work from the perspective of breastfeeding advocacy, considering issues raised by a risk-based approach, whereas Taylor and Wallace (2012b) discuss Wolf's ideas in the context of maternal shame in relation to breastfeeding decisions. Jacqueline H Wolf (2012) is one of the few academics to overtly oppose Joan Wolf's ideas in her published review of the book. Drawing specifically on research on obesity she comments that:

...Due to her cherry picking of articles, Wolf managed to neglect the array of research that is unravelling the mysteries of the complex, bioactive colloid that is human milk...

also noting that Joan Wolf's criticisms of breastfeeding promotion are made within the context that:

...We are a formula feeding culture; even "breastfed" infants tend to consume more formula than human milk in their first year of life...

(2012:375).

In the UK the Institute for Social and Economic Research (ISER) is conducting research (based on two very large cohorts) entitled *The effects of breastfeeding on children, mothers and employers*. In October a public event was held to disseminate early results (ISER, 2011a, 2011b). Called '*Early intervention and social mobility: Are pro-breastfeeding policies worth it?*' it could be interpreted as a backlash against the publicity that Joan Wolf had received although others perceived it as defensive (Lee and Faircloth, 2011).

2.5 Community and interpersonal level influences

In this section I consider social and environmental conditions in which women decide to breastfeed and continue breastfeeding. UK policy, breastfeeding promotion and advice are outlined first, followed by UK breastfeeding rates and norms, in relation to who is most likely to breastfeed and for how long.

2.5.1 UK policy, breastfeeding promotion and advice

UK public health campaigns have centred on the notion of 'breast is best' (Stanway, 2005), although this is not the current UK government official slogan (DH, 22nd June 2010). However, policy, official advice and public health campaigns consistently support breastfeeding as the optimal way to feed babies, based on the large amount of good research evidence on breastfeeding health benefits. UK advice has followed WHO guidance, albeit with a time-lag, for example, when the WHO revised the guidance on duration of exclusive breastfeeding in 2001 (WHO, 2001), the UK did not until 2003. This affected many mothers, including me, who were advised to breastfeed exclusively for four months with one child and then to breastfeed exclusively for six months with the next, leading to confusion.

2.5.2 How are women supported to breastfeed in the UK?

The importance of early feeding support is recognised in the UK through UNICEF BFI work. Maternity hospitals and units are encouraged to implement the Ten Steps to Successful Breastfeeding (UNICEF, 2011b) and

follow the International Code of Marketing of Breastmilk Substitutes (WHO, 1981), and standards are recognised and maintained through assessment and accreditation. Midwifery training courses are also accredited through University Best Practice Standards (UNICEF, 2011c) and community facilities through the Seven Point Plan for sustaining breastfeeding in the community (UNICEF, 2011d). During the period in which this research took place, NHS Bristol achieved community accreditation, Bristol became the first UK 'Baby Friendly City' and both maternity units had 'Baby Friendly' status. This illustrates the context for the women in this work who received support and advice before this enhanced community support and training was introduced. Achieving and maintaining BFI accreditation involves a range of activities, including training health visitors and maternity support workers, and developing other ways to support women breastfeeding in their communities.

2.5.3 How many women breastfeed in the UK and for how long?

The best UK information about how many women start breastfeeding and how long they continue breastfeeding comes from the quinquennial Infant Feeding Survey (IFS). The IFS gives information on breastfeeding initiation and duration measuring incidence and prevalence up to nine months as well as looking at other feeding practices during the first eight to ten months. It provides estimates of exclusive breastfeeding and examines breastfeeding outside the home, breastfeeding and work, problems with breastfeeding and smoking and drinking during pregnancy. The data are derived from a series of questionnaires given to a representative sample of women who gave birth

between two fixed dates. The IFS provides a wealth of useful information about breastfeeding during the early months. I give here some of the relevant contextual detail in which long-term breastfeeding women begin their breastfeeding journey.

From the 2010 survey results we know that UK initiation rates are high although lower than other European countries and the US, falling rapidly in the first few weeks - 81% of UK mothers initiated breastfeeding in 2010 (McAndrew *et al*, 2012), up from 76% in 2005 (Bolling *et al.*, 2007). In 2010, 55% were still breastfeeding at six weeks, 34% at six months; these rates were higher than in the 2005 survey indicating that mothers in the UK are breastfeeding for longer than previously. 69% of mothers were exclusively breastfeeding at birth, 17% at three months but less than 1% at six months. Data is available separately for all four UK countries: England has the highest initial breastfeeding rates and Northern Ireland the lowest. Just over 25% of mothers in England were still breastfeeding at nine months in the 2005 survey (Bolling *et al.*, 2007); although data was collected on breastfeeding up to nine months in the 2010 survey it is not presented in the final report. It is not known how many carry on breastfeeding beyond this time.

The IFS also gives information about which mothers are more likely to breastfeed, with:

..the highest incidences of breastfeeding...found amongst mothers from managerial and professional occupations, those with the highest educational levels, those aged 30 and over and first time mothers...

(Bolling *et al.*, 2007:viii). This applies to all ages up to nine months. At six months, white mothers breastfeed less than mothers from all minority ethnic groups. Mothers who breastfeed for longer are more likely to be feeding their second or subsequent baby, be from higher socio-economic groups, have higher levels of education, be older and not working outside the home; women in the South of England also breastfeed for longer than women in the North. The findings from the 2010 survey in relation to socio-economic factors and incidence of breastfeeding were consistent with previous surveys (McAndrew *et al.*, 2012). In this thesis I do not analyse or discuss women's experiences in relation to their social class or economic situation and this is acknowledged as a limitation.

Little is known about how many women breastfeed beyond nine months and we have no information about how many breastfeed at two years. Several opportunistic surveys have been carried out (Sinnott, 2010) which demonstrate that some women breastfeed children up to age 11, although the numbers are very small. Breastfeeding women are in a minority by the time their babies are six weeks old and this continues as time goes on, leading to a paradox. Breastfeeding mothers follow guidance to do the best for their babies and yet are unusual; women feeding their babies formula milk go against guidance but are the majority very early on (Lee and Bristow, 2009; Faircloth, 2010b). This position of 'good mothering' is dependent on who observes, who breastfeeds and the situation. It may reverse if

breastfeeding women continue for 'too long' and breastfeeding then becomes a signifier of bad mothering (Stearns, 2011).

2.6 Individual level influences: women's experiences

This final section focuses on breastfeeding women's experiences, including a brief consideration of cultural and historical variations, highlighting research which examines long-term breastfeeding and the ways this PhD complements existing research.

2.6.1 The range of women's experiences

Women's breastfeeding practice and experiences vary according to social and cultural circumstances (Maher, 1992). Some of these are within women's control, but many are determined by their social position and associated constraints, especially if they are in patriarchal societies. Maher's work demonstrates the difficulties of comparing western long-term breastfeeding experiences with those in developing countries due to cultural variations. An example is the way co-sleeping and night-time breastfeeding is more common in some cultures. This might be explained because women work during the day, and through cultural taboos about sexual intercourse post-partum and/or during breastfeeding, not just because it is more 'natural' (Maher, 1992).

Dettwyler's work combines knowledge about breastfeeding across time, cultures and species, and demonstrates that if allowed to self-wean children breastfeed for two and a half to seven years (Dettwyler, 1995). This is known as the 'hominid' blueprint for breastfeeding and is sometimes referred to by women breastfeeding long-term (Faircloth, 2009) although not mentioned by

women in this study. In other work Dettwyler (2004) shows how the duration of breastfeeding in many societies is modified by a range of beliefs. These may be about many aspects of cultural and social life and include religious beliefs, as well as those about the behaviour of children and parents and women's roles in relation to work and childcare. Dettwyler relates cultural perceptions about the appropriate duration of breastfeeding to negative responses to long-term breastfeeding, specifically in the contemporary U.S.

In a more recent study Sellen (2007) echoes some of Dettwyler's earlier findings, using evolutionary anthropological and ethnographic studies to study human lactation at different times and in different places, historically and culturally. Reviewing a wide range of evidence he concludes that breastfeeding beyond two years was normal in the majority of 'small-scale societies' although does not agree with the age range for weaning suggested by Dettwyler (discussed above). Without further knowledge of the disciplines drawn on by Dettwyler and Sellen it is difficult to assess the relative merits of the conclusions they reach. One of the key points from Sellen's paper, drawing from an evolutionary perspective in relation to human behaviour around complementary feeding, lactation and birth spacing, is that there is:

...a strong behavioral tendency among humans to reduce the length of exclusive breastfeeding beyond the lower bounds consistent with optimal infant outcomes...

(Sellen, 2007:136); he identifies this as a public health challenge.

There is also a wider body of work which looks at cross-cultural and historical patterns of infant feeding, demonstrating that breastfeeding for longer than

six months is normative in other cultures and at other times. This work focuses more on cultural issues than on the biological and evolutionary evidence discussed by Dettwyler and Sellen. The decline of breastfeeding as the usual way to feed a baby, alongside the medicalisation of infant feeding, has been well documented (see, for example, Palmer, 2009; Wolf, J.H., 2001; Van Esterik, 1989). At some points, historically, this has had dramatic consequences. Wolf (2001) shows, for example, how a change in practice - which was culturally driven - from prolonged breastfeeding to the use of cow's milk or other foods led to a dramatic increase in infant mortality in Chicago in the early twentieth century.

More recently others have considered the changes in cultural norms around breastfeeding that are brought about in contemporary societies by an interplay of traditional cultural norms and external influences. Palmer (2009) has written about this specifically in relation to artificial milk feeding and the market created for this in developing countries. Hashimoto and McCourt (2009) discuss it in relation to breastfeeding in Japan, where traditional infant feeding and weaning practices have been affected by Western social and cultural influences, shown both in reduced rates of exclusive breastfeeding and in a reduction in the overall duration of breastfeeding (where previously a cultural commitment to breastfeeding for long periods was seen). In their study, Hashimoto and McCourt show how features of Japanese beliefs about breastfeeding have been maintained (discussed particularly in relation to 'embodied knowledge'):

...despite rapid social change and modernisation and the impact of medical approaches which have effectively undermined exclusive breastfeeding...

(Hashimoto and McCourt, 2009:74). Others have also considered influences on breastfeeding rates and duration within specific cultural and socio-economic settings, placing these within the context of the implementation of the WHO's Global Strategy (see, for example, Groleau and Rodríguez, 2009; Thairu, 2009). In these examples variations on optimal breastfeeding rates are discussed within the context of poverty and disease, highlighting the some of the many factors which may impact on breastfeeding duration within different cultural milieu.

2.6.2 Understanding women's experiences of breastfeeding

Despite the large body of research on breastfeeding (particularly biomedical research), there has been little work until recently exploring women's breastfeeding experiences and the meaning breastfeeding has for them (Spencer, 2008; Ryan *et al.*, 2010). Recent work examines how women manage their experiences in hostile cultures to breastfeeding, how women construct narratives in relation to their experiences (Ryan *et al.*, 2010), and the relationship between breastfeeding and maternal identity (Murphy, 1999; Lee, 2007; Faircloth, 2009).

There has also been an increased discussion of breastfeeding issues in the media, often in relation to the journalist's personal experience (for example, Barbieri, 15 November, 2007; Groksop, 18th July, 2009), a proliferation of

internet discussion groups and web pages, and publications from LLL and the ABM.

2.6.3 Breastfeeding babies: early experiences

UK literature examining breastfeeding women's experiences usually addresses particular issues which are used to support policy and practice, for example the importance of support, the role played by partners and other family members, the physical difficulties faced by many women, the challenges of breastfeeding in public places and of breastfeeding and returning to paid work.

Breastfeeding in public is a particular issue for early and long-term breastfeeders. Stearns (1999) identifies the difficulties for women in reconciling the sexual and the maternal body, the work involved in breastfeeding (Stearns 2009) and the role of this 'body work' within families. Of particular interest in relation to this project are her findings that women feel 'touched out' by the constant contact they have with their children and the difference that breastfeeding can make to the relationship between the baby/child and the father. In her study mothers:

...portray the demands on their body and their time posed by the body work of breastfeeding as simultaneously amazing, enjoyable, exhausting and demanding...

(Stearns, 2009:76).

Stearns notes that breastfeeding in public involves considerable 'body work', particularly when breastfeeding young babies – dressing differently and

managing breastfeeding timing and the potential for leakage. Sheeshka *et al.* (2001) echo this by describing the steps taken to manage breastfeeding in public, including wearing specific clothing, going out with friends and choosing specific locations. Interestingly Sheeshka *et al.* note that long-term breastfeeders identify the importance of:

...having the mental strength to overcome the social stigma...

(2001:32). Recent work has considered other ways that women manage breastfeeding in public through 'lactation advocacy' or 'lactivism' (Boyer, 2011) and shared experiences such as breastfeeding picnics. A more detailed discussion of issues relating to breastfeeding in public is given in Dowling *et al.* (2012 – see Appendix I).

Other research demonstrates that early breastfeeding causes specific difficulties for women when breastfeeding in front of others, particularly some categories of men (Pain *et al.*, 2001), or in specific spaces. Breastfeeding women may reinterpret private spaces as public when breastfeeding in front of others (Stearns, 1999; Smyth, 2008). While some women do not breastfeed young babies outside their homes (Sheeshka *et al.*, 2001), others restrict their movement within their homes, breastfeeding in their bedrooms or bathrooms if other people are in the house (Smyth, 2008). Other women choose to formula feed in these situations, or switch to formula altogether.

A useful UK resource is the set of healthtalkonline interviews on breastfeeding experiences. Drawing on interviews with 49 women and 2 men carried out in 2005/2006, they are categorised thematically: deciding to

breastfeed, getting started, managing breastfeeding, breastfeeding in special circumstances, weaning the baby from the breast and reflecting on breastfeeding (healthtalkonline, 2011). Each theme also contains a number of sub-themes. 'Managing breastfeeding' has interviews about breastfeeding older babies/children; this data is discussed further below (2.6.4). The data has been further analysed to explore the embodied experiences of breastfeeding by examining moral work in women's breastfeeding narratives (Ryan *et al.*, 2010), the ways women make sense of their experiences through examining the '*private, internal moral work that they undertake*' (Ryan *et al.*, 2010:957), and the inter-embodied experience of breastfeeding (Ryan *et al.*, 2011). This latter paper particularly focuses on looking at how women:

...make sense of their experiences through language, but...(also)...through body language and description, a prereflective or embodied/emotional way of knowing...

(Ryan *et al.*, 2011:731). This work is important because of its contribution to furthering understanding of women's breastfeeding experiences and how they are made sense of by women within their cultural and social contexts.

2.6.4 Experiences of long-term breastfeeding

Very little work has examined the experiences of women breastfeeding long-term. Research published in the 1980s and 1990s examines North American women's experiences. Most used surveys and drew samples from US women: although dated, these papers are frequently cited in discussions about long-term breastfeeding in the absence of more recent work. They are considered important as they contribute to a body of work that has been

developed more recently by academics in North America (Rempel, 2004; Buckley, 2001; Stearns, 2011) and Australia (Gribble, 2007, 2008). The limited UK work has been undertaken by Britton (2000), Faircloth (2009, 2010a, 2010b, 2011) and Sinnott (2010), with a small number of healthtalkonline interviews (carried out in 2005/2006) also addressing long-term breastfeeding.

Early work on breastfeeding long-term

Early work on long-term breastfeeding focused particularly on the difficulties experienced by women carrying out a socially unacceptable practice, how this required women to have strength of character (Hills-Bonczyk *et al.*, 1994), and the pressure to wean beyond certain ages. Morse and Harrison (1987) report that women experienced a withdrawal of support when their babies were 6 – 8 months old, receiving comments such as '*Are you still nursing?*' at 9/10 months, with increasing pressure/coercion to wean if they were still breastfeeding at 12 months, or beyond. Consequently, longer-term breastfeeders withdrew from unsupportive friendships and sought out other support, including LLL. The importance of LLL support is mentioned in many early papers. Longer-term breastfeeding may become secret, concealed from health professionals and wider family (Wrigley and Hutchinson, 1990; Sugarman and Kendall-Tackett, 1995).

Other important early findings include the importance of bonding and the close relationship experienced by long-term breastfeeders and their children

(Wrigley and Hutchinson, 1990; Hills-Bonczyk *et al.*, 1994), emotional benefits to children (Reamer and Sugarman, 1987) and acknowledgement of social stigma (Reamer and Sugarman, 1987). Also noted were women feeling tied to breastfeeding, and interference with other activities (Reamer and Sugarman, 1987). Women described being very tired and many were co-sleeping (Hills-Bonczyk *et al.*, 1994). In these studies women referred to the 'naturalness' of long-term breastfeeding, and the importance of child-led weaning (Hills-Bonczyk *et al.*, 1994) with many believing that their children were physically healthier as a result of continuing to breastfeed (Hills-Bonczyk *et al.*, 1994; Reamer and Sugarman, 1987).

Recent work on breastfeeding long-term: North America and Australia

Later North American papers built on this work. Buckley (2001) found that long-term breastfeeding women consider it to be primarily about nurture, despite the limited evidence: the paper identified the need for further research to ascertain whether long-term breastfeeding also played a role in nutrition. Buckley (2001) also commented on stigma associated with long-term breastfeeding and its hidden nature. Rempel (2004) examined factors influencing long-term breastfeeders' decisions. She noted the importance of closeness and relationship, connecting this with '*natural mothering*' (Rempel, 2004:307). Her research reinforces previous work identifying the importance of societal attitudes, family and wider social support.

Stearns explored women's:

...cautionary tales about the potential social perils of extended breastfeeding... (Stearns, 2011:539). She noted the unsupportive cultural and social contexts and how women manage their breastfeeding. Of particular interest is participants' identification of the '*stigma potential*' of long-term breastfeeding (Stearns, 2011:544) and the strong cultural pressure to wean after a few months of breastfeeding. Stearns identified the ways breastfeeding mothers and others talk about children's behaviours (walking, talking and asking) in the context of long-term breastfeeding and how they are associated with:

...breastfeeding extend(ing) beyond the boundaries of appropriate public behavior... (Stearns, 2011:525). Finally, it is noteworthy that Stearns' research participants identify the space of LLL meetings as normalising.

Gribble (2007, 2008) is unusual in considering the experiences of long-term breastfeeding women and their children's experiences. The children described how breastfeeding made them feel and what it tasted like; the study showed the active part that children played in continuing to breastfeed. Gribble found that continuing to breastfeed was associated with both nutrition and nurture, especially calming children and helping them sleep. Gribble also notes the stigmatised nature of long-term breastfeeding and the associated social pressure to wean. Most mothers in Gribble's 2008 study did not intend to breastfeed long-term, or initially found the idea '*repulsive*' (2008:11). Participants faced challenges by continuing to breastfeed, they restricted contact with mothers making different infant feeding choices and sought support from groups and from:

...sub-cultures within which breastfeeding beyond infancy was normal and expected...

(Gribble, 2008: 12).

Recent work on long-term breastfeeding: the UK

Only two UK academics from the UK have recently considered long-term breastfeeding: Britton (2000) and Faircloth (2009, 2010a, 2010b, 2011) - both are anthropologists. The small number of healthtalkonline interviews (carried out in 2005/2006) which look at long-term breastfeeding are also of interest here as they consider relatively recent experiences. The health journalist Sinnott (2010) makes a contribution too: although she is UK based her work draws on a survey of women worldwide.

Britton's PhD thesis looked at women's experiences of breastfeeding 'early and long-term'. She is overt about her personal as well as professional interest in breastfeeding. She found that women who breastfeed long-term are likely to keep it secret and associate it with being 'natural' and being a 'good mother' (Britton, 2000:1). A large part of her thesis, however, deals with early breastfeeding, specifically let-down reflex experiences and this is the focus of post-doctoral publications. She does, however, briefly refer to her doctoral work in a discussion on cultural and societal influences on duration of breastfeeding and how this impacts on women's experiences (Britton, 2009). A weakness of the thesis is felt to be the dual focus on let-down and on long-term breastfeeding (as these two issues represent very different aspects of women's experiences but are at times discussed

together) but there are some findings in relation to the latter which are interesting in the context of my study; these are briefly outlined here.

Britton explores women's reasons for continuing to breastfeed with some similarities in findings to this study (see Chapter 7). She found some relationship between continuing to breastfeed and previous breastfeeding experiences (which was not found in this work as all but one of those interviewed in my study were breastfeeding their first child). She also found that women draw both on science and emotion when identifying the benefits of continuing to breastfeed (these findings are echoed in Faircloth's work and I also discuss them in Chapter 7). Britton's participants talked about focusing on their own needs when deciding to stop breastfeeding – this is not a theme which emerged in my work, although the difficulties experienced when breastfeeding long-term are discussed at length (see Chapter 9). Other themes of interest which also arose in my work are of a strong belief in the benefits of continuing to breastfeed, particularly in relation to the relationship with the child, and of the importance of support from others who had made similar decisions. Britton also found that women sometimes experienced health professionals views on parenting and breastfeeding as in opposition to their own and as unsupportive (particularly health visitors).

Finally, although Britton's data collection was carried out some time before my own, there were similarities in findings in relation to women's experiences of breastfeeding in public and private (although her discussion of this is in relation to both early and long-term breastfeeding). These include the use of

these spaces when breastfeeding and developing strategies in order to breastfeed in public more comfortably.

Faircloth's work was carried out at the same time as my study and has some similarities of methodological approach. Participant observation and interviews (both semi-structured and via questionnaire) were carried out with LLL attendees in London and Paris (journal publications from the research draw only on the data from London). There is little further detail given about methodology and data collection in publications. Our work is different in approach as I am as explicit about my insider status as Faircloth is about hers as an outsider. This has a range of impacts on our work, providing both of us with advantages and disadvantages in relation to analytical insight and distance (these issues are further discussed in Chapters 4 and 5). Faircloth can be seen to be using her outsider status to provide an open and critical perspective on long-term breastfeeding. She has however received some negative feedback from breastfeeding women about this, in particular following an early presentation of her doctoral work (Faircloth, 2007) which led to some negative online discussion (no longer available); Faircloth acknowledges this explicitly:

...there was a suggestion that I had disappointed LLLI and the attachment parenting community by not advocating their practices more strongly (if at all). In fact, what irritated one of the commentators most was that she couldn't work out if I was 'for or against breastfeeding'...

(Faircloth, 2010a).

Faircloth's work differs from my study in the focus given to interpretation of the findings. Less emphasis is given to experiences and more to understanding the relationship between women's decision to breastfeed long-term and how this is justified in relation both to wider society and to internal factors. In her post-doctoral writing, Faircloth specifically relates long-term breastfeeding to maternal identity and risk: she examines the 'accountability strategies' of women who breastfeed long-term (Faircloth, 2010a; 2011), and the relationship between attachment parenting and long-term breastfeeding, with many of her participants specifically identifying as attachment parents (2010b). Her participants draw on 'science' to support their decisions (Faircloth, 2010a), and they reason that what they are doing 'feels right' (Faircloth, 2011). Extensive reference is made both to explanations for, and interpretations of, the benefits of breastfeeding and attachment parenting (drawing both on the literature and on her data). This is contextualised within discussion about contemporary motherhood, particularly ideas about 'intensive motherhood' (Douglas and Michaels, 2004; Hays 1996). In Faircloth's work the importance of LLL is emphasised – both in the validation of women's decisions and in a recognition of an alternative way of being ('*I have met my tribe*' – Faircloth, 2010b:363) but also, for some, as a source of pressure (to continue breastfeeding). This latter point is not one that was made by participants in my study. As her fieldwork was carried out with LLL attendees and Leaders Faircloth does not address issues of support for long-term breastfeeding from other sources.

A small number (8) of healthtalkonline (2011) interviews (carried out in 2005/2006) also address long-term breastfeeding in the section entitled 'Managing breastfeeding: breastfeeding an older baby'. These add to the body of knowledge about how women decide to breastfeed long-term, with several women saying that they had not planned to breastfeed an older baby at the outset and that it 'just happened' (this issue is further discussed in relation to this study in Chapter 7). In these interviews participants also talk about issues relating to breastfeeding in public, and the emotional and practical benefits of continuing to breastfeed. In common with participants in this study (see Chapter 9) they also talked about conflicting feelings when breastfeeding an older baby, including the idea of 'having their body back'. Breastfeeding during pregnancy and tandem feeding are also raised and discussed in relation both to practical and emotional issues. Support from partners, families and support groups is acknowledged as important with recognition from this group of women that long-term breastfeeding is more likely to take place in private (with approval for breastfeeding changing to surprise or disapproval the older the baby became). Findings in relation to experiences of long-term breastfeeding are not specifically drawn on in publications from this work (Ryan *et al.*, 2010; Ryan *et al.*, 2011).

2.6.5 Attachment parenting

Literature on attachment parenting is briefly considered here; this is both because of its association with long-term breastfeeding and in order to add context to the discussion of the findings (specifically, Chapter 8).

Attachment parenting (AP), sometimes also known as 'natural' or 'instinctive' parenting or 'natural nurturing', is a style of child-rearing which emphasises:

...utmost sensitivity to the child's innate emotional and physical needs, resulting in extended breastfeeding on demand, extensive infant carrying on the caregiver's body, and cosleeping of infant and parents...

(Schön and Silvén, 2007:103) as well as other aspects such as elimination communication. Parents who identify as 'attachment parents' may choose to adopt some or all of these practices (Etelson, 2007). Although drawing on attachment theory, most notably developed by John Bowlby and Mary Ainsworth in the 1960's (Stevenson-Hynde, 2007), AP as practised by parents in Western industrialised countries is particularly associated with the writing and publications of William and Martha Sears (see, for example, Sears and Sears, 2001) and draws on understanding of a baby's bio-evolutionary need for very close physical contact (Etelson, 2007). To a lesser extent, but also influential, are the writings of authors such as Liedloff (1975) and Jackson (1989). AP is often referred to in the grey literature on long-term breastfeeding, with numerous websites and online discussion groups either directly supporting AP or associated issues, such as baby wearing/sling use or co-sleeping.

AP is addressed by academics from a range of disciplines, including evolutionary psychology, biological anthropology and those writing from a feminist perspective. Schön and Silvén's thorough review (2007) considers a wide-range of research, examining AP from historical and cross-cultural perspectives and placing this within the context of a discussion of contemporary Western parenting practices. They conclude that there is

‘supportive evidence’ that parenting in this way is beneficial and that it is likely to have positive outcomes in relation to psychological development. Furthermore, they suggest that some currently conventional Western child-rearing practices may be less than optimal in relation to child development.

Other psychologists have particularly focused on the issue of breastfeeding and attachment but with a range of conclusions. In their review of 41 papers Jansen *et al.* (2008) looked at the relationship between breastfeeding and the maternal bond, concluding that there was insufficient evidence of a relationship between breastfeeding and improved quality of relationships between mothers and children. They acknowledge that there are difficulties in assessing breastfeeding and maternal bond and that there are a limited number of research studies in this area. One paper included in this review, Britton *et al.* (2006), examined a specific area of the mother-child relationship, maternal sensitivity, and concluded that enhanced sensitivity could be seen in breastfeeding mothers, particularly in those who breastfed for longer. They suggested that this was evidence of a link between breastfeeding and attachment security, although this was disputed by Jensen *et al.* In a study which examined maternal time-use data, Smith and Ellwood (2011) found that breastfeeding mothers spent more time in ‘emotional care’ than mothers who were formula feeding. They concluded that this had positive implications both for attachment and for developmental outcomes.

Although not specifically focusing on AP, the work of the biological anthropologists Ball, McKenna and Tully (née Klingaman) in relation to infant

sleep (specifically the benefits of co-sleeping, its relationship to breastfeeding and cross-cultural differences in approaches to infant sleep) has been influential (see for example, Ball, 2003; Ball and Klingaman, 2007; McKenna *et al.*, 2007). They are referred to in many breastfeeding publications and drawn on in advice given by UNICEF and others in relation to safety and infant sleep; their work can be seen as providing evidence supportive of many of the beliefs and practices of AP parents.

AP has been discussed by feminist commentators and noted to be considered both feminist and non-feminist (Liss and Erchull, 2012). In their study Liss and Erchull investigated self-identified feminist and non-feminist women's views on parenting styles (both mothers and non-mothers). They found that both mothers and feminists were more in favour of AP practices than non-mothers and non-feminists. They acknowledge that, despite these findings, AP can be seen as disempowering for women and recognise the need for further research in relation to feminist child-rearing practices, the role of fathers and the issue of breastfeeding, concluding that:

...the question arises whether attachment parenting is an explicitly feminist way to parent or whether it is simply a way of parenting that happens to be used by feminist-identified women...

(Liss and Erchull, 2012;139). Etelson (2007) specifically asks the question '*Do real feminists attachment parent?*'. Her paper reviews the literature on attachment theory and discusses this in relation to AP and feminism. In particular she considers men's role in AP (concluding that the only aspect of AP that men cannot practice is breastfeeding and that this may be problematic) and the relationship of AP to contemporary ideas about

'intensive parenting' (see for example Hays, 1998; Douglas and Meredith, 2004). I concur with her perspective in not seeing AP as an oppressive aspect of modern parenting, and agree rather that:

...many parents' choice of attachment-promoting techniques is a reflection of their psychological freedom to do things differently from their parents and from mainstream society and to appreciate the uniqueness of their child's first year of life..

(Etelson, 2007:14).

2.6.6 Summary/Gaps in the literature

The majority of work exploring long-term breastfeeding is dated and from outside the UK. Recent UK work has a different focus to mine although with some similarities noted in findings. Despite these limitations there are themes of interest: these are explored in Chapter 3 and the discussion of the findings (Chapter 11), and relevant to consider whilst reading the findings (Chapters 7-10). Of interest is the way stigma is referred to in the literature, and how lack of support for long-term breastfeeding and the challenge in finding support are identified.

Gaps in the literature are evident in the paucity of recent UK research exploring women's experiences of long-term breastfeeding. It is important to identify whether issues discussed in the 80's and 90's are still relevant to women's experiences today. More recent work such as Stearns (2011) and Gribble (2008) focuses on the experiences of women in the US and in Australia. My study, looking at UK women's experiences, adds to this body of work. In addition, further research into the experiences of women who breastfeed long-term adds to the knowledge about social and cultural

constraints on long-term breastfeeding identified in other research, and the ways in which women manage and make sense of these.

2.7 Conclusion

This chapter outlines a number of areas of literature to provide a context to the thesis. The intention is to give some background to the UK cultural and social milieu within which women breastfeed and to the intellectual context for the PhD. A large amount of literature has been reviewed and difficult decisions made about what to include or exclude in order to produce a reasonably comprehensive review. The next chapter looks at a different area of literature, providing background to the theoretical concepts used to think about the work and to work with the findings.

Chapter 3: Conceptual models (liminality, stigma and taboo)

3.1 Introduction

This chapter provides an overview of the major theoretical influences on the thesis by reviewing and discussing the key concepts of liminality, stigma and taboo. The term 'conceptual models' rather than 'theoretical models' is used because, as noted by Phelan *et al.* (2008:258), not all the ideas discussed can be accurately described as theories. The different concepts reviewed in this chapter are later used in Chapter 11 to discuss long-term breastfeeding. Some of the concepts were familiar (mostly those which relate to stigma), although not understood in sufficient depth. Some were not so well understood, although I had previously come across the concept of liminality and thought that it might be useful.

The literature search on which this discussion is based had three main aims. The first was to look for material which would increase my understanding of the concepts. This led me to several original classic texts from anthropology and sociology. The second aim was to understand how these ideas had subsequently been used. Most of the papers chosen included explanations of liminality, stigma or taboo (or combinations) and discussed how each concept had been used in research. This helped in furthering understanding of the original texts. Papers were selected that used these approaches to develop knowledge about health care issues, although literature from other fields was also included if it helped to increase understanding.

I was also interested in the extent to which these ideas had been used to look at breastfeeding (including long-term breastfeeding) experiences.

Comprehensive literature searching revealed little material that discussed these issues in relation to breastfeeding. The literature on liminality, stigma and taboo is wide-ranging and so material from sociology, medical sociology, anthropology, social and health psychology and medical and social geography was searched. Some topics were more widely researched than others – there was plentiful relevant work on stigma for example, but finding useful material on taboo was more difficult. These difficulties are reflected in the different lengths of the relevant sections in this chapter.

In the following sections I will consider each conceptual area separately, focusing on research that has applied the concepts to health-related issues and to breastfeeding. The use of these three concepts to deepen understanding of the experiences of women who breastfeed long-term is discussed further in Chapter 11.

Three key texts have been identified which consider specifically the issues of liminality, stigma and taboo in relation to breastfeeding. A critique of each will be offered. This small body of literature is also significant because it demonstrates both links to particular theoretical perspectives, as well as to an historical body of classical anthropological and sociological work. Mahon-Daly and Andrews (2002) draw particularly on the anthropological work of van Gennep (1909) and Turner (1969) and on later discussion of their ideas by Davis-Floyd (1993) and Teather (1999), but place these within current

perspectives drawn from post-medical geography. Smale (2001) structures her discussion using the sociological work of Jones *et al.* (1984), who themselves elaborated on the work of Goffman (1963). Battersby's work (2007), whilst not specifically drawing on the work of anthropologist Douglas (1966), uses ideas about pollution and taboo and appears to be strongly influenced by her work, whilst also making reference to Mahon-Daly and Andrews. There are also other links – Turner's discussion of liminality draws on the work of his contemporary Douglas. Douglas' work builds on the ideas of Durkheim (Jackson, 2005:333), Goffman and other early sociologists and anthropologists. In the foreword to the 2009 re-print of Turner's classic *The Ritual Process* (1969), Abrahams discusses the influence on Turner's work of sociologists and anthropologists Weber, Durkheim, Evans-Pritchard and Malinowski (2009:x).

The three key concepts – liminality, stigma and taboo – are linked and inter-related, both conceptually and in the literature; this will be discussed both in this chapter and in Chapter 11 in relation to the findings of this study. Some of these links are shown diagrammatically towards the end of this chapter. Although it has been necessary to omit some important influences, this is believed to be a simplified and helpful way of showing how the three issues connect with each other. These connections are cross-disciplinary and across time and are shown to have contributed to current thinking about breastfeeding experiences.

3.2 Liminality

3.2.1 Introduction

This section explains and discusses the concept of liminality, using both the work of those with whom its origins are associated and those who have used it more recently, particularly in research focused on health issues. It concludes with a brief discussion of the use of liminality to look specifically at breastfeeding experiences.

3.2.2 The concept

The term liminality comes from the Latin '*limen*', meaning a threshold or a period of transition. The concept was originally used by social anthropologists - most associated with the work of van Gennep (1909) - to look at rites of passage, such as marriage or coming of age, in tribespeople. This work was later developed by Turner (1969). Liminality refers to one or both of two related ideas (Jackson, 2005). The first is the concept of being 'betwixt and between' (Turner, 1969:95); the second - associated more with the work of Douglas - focuses on the meanings attached to 'matter out of place' and ideas of pollution (Douglas, 1966). I will show later how liminality has been used in both these ways to think about breastfeeding experiences, also focusing on the original meaning of liminality as:

...a term denoting a time and a space...

(Czarniawska and Mazza, 2003:269). The work of Douglas will be discussed both in the context of liminality (this section) and of taboo (section

3.4); it is seen as important as she is frequently referred to in the literature, particularly by scholars writing about breastfeeding and work on bodily fluids, and to breastfeeding in public (see Dowling *et al.*, 2012, for further discussion of these issues).

In his early anthropological work on rites of passage van Gennep identified three main stages/phases – separation (pre-liminal), transition (liminal) and incorporation (reassimilation/aggregation – post-liminal), each associated with particular rituals (van Gennep, 1909; Turner, 1969). During *separation* people move from their previous existence and way of life into the *transition* or liminal state (Madge and O'Connor, 2005). Here they exist in limbo, neither how they were before nor how they will be afterwards. This stage in the change process introduces:

...the possibility of moving to a new structure or back into the old...

(Jackson, 2005:333). *Incorporation* takes the person back into the 'secular' world again (Teather, 1999), but usually in a different social state to how they were before (Turner, 1979). In other words, in the usual use of the concept, people move from their 'old' situation through a passage of time/place in which they are different, into their 'new' situation or way of being. In different types of social passage, one or other of these stages/phases might be more important than the others (Czarniawska and Mazza, 2003).

These ideas have been developed and used in a number of different ways over time; their application to health issues is considered further below. One example of the development of the concept is that the liminal phase is usually

held to be a relatively short period of time, but it can be prolonged: in some circumstances people may remain in a liminal state for the rest of their lives. Liminality can thus have both acute and sustained phases (Little *et al.*, 1998). In addition, the idea of liminality has also been used without the three phases being as clearly defined as might be suggested from the outline of van Gennep's ideas above (Little *et al.*, 1998).

Turner (1969) – a social anthropologist who conducted much of his research on ritual with sub-Saharan African tribespeople – adapted and developed van Gennep's model, with most of his work focusing on the liminal stage. He argued that culturally prescribed and shared rites of passage are important in order to be able to move through the phases of separation, transition and incorporation. Without this movement new identities may be constructed outside of social norms (Schouten, 1991, cited in Teather, 1999:14). Turner argued that in many societies today there are fewer shared rites of passage than previously, and so movement is not always straightforward, with people occasionally in a liminal state for some time. He explained the ambiguous position of people in this state:

...these persons elude or slip through the network of classifications that normally locate states and positions in cultural space. Liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremonial...

(Turner, 1969:95).

The liminal state is often seen as potentially dangerous with the previous identity of liminal people replaced by ambiguity, separation and a different sense of order. Navon and Morag explain this as:

...declassification without reclassification...

(2004:2338). Liminal states are therefore sometimes seen as threatening; culturally acceptable when their duration can be controlled (as in rituals) but not otherwise (Navon and Morag, 2004). Turner (1967) points out that this threat/danger is also in relation to the way in which liminal people are seen as polluting to others (who have not gone through the liminal period), referring to Douglas' work on pollution in *Purity and Danger* (1966). Douglas in turn noted that Van Gennep:

...saw society as a house with rooms and corridors in which passage from one to another is dangerous. Danger lies in transitional states, simply because transition is neither one state nor the next, it is undefinable. The person who must pass from one to another is himself in danger and emanates danger to others...

(Douglas, 1966:119). Douglas' work focuses in particular on the social consequences of crossing boundaries and of being in liminal states/places. The association of liminality with 'threat or unease' has also been noted in relation to a number of works which use the concept to examine health issues (Warner and Gabe, 2004).

Although Turner's original research was with one specific group of people (the Ndembu) he applied insights from this to Western cultures. These ideas have since been used by others to look at rites of passage in industrialised societies in relation to stages in the life-course (Teather, 1999). Mahon-Daly and Andrews outline the issues:

...the life course is a journey which all individuals must pass through...we

encounter difficult periods in our lives which challenge us in learning about our bodies and the places we frequent...the more predictable include adolescence, puberty, childbirth, menopause and death and the more unpredictable include illness and sudden disability. These potential 'crisis points' may also be considered as 'rites of passage'...

(2002:64). Some of these life events have rituals associated with them, although ritual is minimised in modern Western society (Taylor, 2008).

Turner's ideas about the attributes of liminal entities (1969:102-106) and the magico-religious properties of liminal situations (1969:108-111) are interesting, but their relevance to thinking about breastfeeding experience is limited (for further detail see Turner, 1969:94-130). There is, however, one element of the way in which the concept of liminality developed that is important. This is the idea of *communitas*, used by Turner to describe the common space inhabited by those in the liminal phase (a way of living rather than a common place), an 'unstructured egalitarian social world' (Madge and O'Connor, 2005:93). Turner used the example of the 'hippy' to illustrate his discussion of *communitas* (1969). Czarniawksa and Mazza note that this shared sense of community is not so much to do with identity as with 'a *shared sense of alterity*' (2003: 273). *Communitas* consists of three areas - liminality, marginality and inferiority - with their relationship to each other expressed as:

...in between (liminality), on the edges (marginality), and beneath (inferiority)...

(La Shure, 2005). This has relevance to the notion of stigma, which is discussed below.

Liminality and *communitas* are also importantly associated with the concepts of structure and anti-structure, key elements of structural anthropology.

Turner (1969) used the term 'anti-structure' to describe the way that social groupings who were outside the mainstream were yet dependant on the mainstream for their position/impact. Turner noted that *communitas* exists because of its relationship with (and outside) social structures. Marginal people are also seen to draw on symbols of 'otherness', emphasising individualism.

3.2.3 The use of liminality in understanding health issues, including breastfeeding

The anthropological concept of liminality has been applied to a range of health issues. Jackson shows how both the 'betwixt and between' and 'matter out of place' meanings have been used to look at the sick role (Lewis, 1975), gender liminality (Besnier, 1994) and refugees' status (Malkki, 1992 and 1995 – all cited by Jackson, 2005:333). Jackson's own work uses the idea of liminality to examine the experience of living with chronic pain (2005); importantly for this discussion she also makes explicit links between liminality, stigma and taboo (discussed further in relation to this study in Chapter 11). Jackson (2005) points out that although there are often negative associations with liminal states, sometimes (if given a special status by society) liminality has a positive value. Jackson makes links between chronic pain sufferers and liminality to argue that they are felt to have threatening powers:

...By profoundly challenging mind-body dualism [they] present(s) a dilemma that turns the person embodying that dilemma into a sublimely liminal creature whose uncertain ontological status produces stigmatizing reactions in others...

(2005:333). This link between liminal people and stigma is explored further later on in this chapter.

Allen uses liminality to examine the role of the fertility clinic (2007), employing the concept to think about being between two social identities (not pregnant/pregnant or not pregnant/infertile). She talks about the way in which liminality be seen as both '*space*' and '*time*' (in this example both being exemplified by the fertility clinic). Liminality originally denoted both time and space (Czarniawksa and Mazza 2003); some researchers have looked at how this time and space is used by those in transitional states, seen as 'a "*time out of time*"' Madge and O'Connor, 2005:84) – for example by new mothers exploring their new role and responsibilities. Warner and Gabe also use the association of liminality with place in their discussion of risk and liminality in mental health social work (2004). In this context (specifically, mental health in inner cities) they talk about how liminal people (who may be relatively powerless) can be 'banished' to:

...marginal spaces and unloved places...

(Wolch and Philo, 2000:144, quoted in Warner and Gabe, 2004:389).

Liminality has also been used to think about other women's health issues, such as cervical cancer screening (Forss *et al.*, 2004) and historical childbirth rituals (Hogan, 2008). Forss *et al.* point out that the transition to liminality can be unintentional, and how difference is not always visible (in their

example, having an abnormal cervical smear). They build on Turner's idea of being:

...at once no longer classified and not yet classified...

(Turner, 1967, quoted in Forss *et al.*, 2004:318). Hogan discusses both liminality and taboo in relation to childbirth and breastfeeding, taking a cultural historical perspective:

...Liminal events can be deeply disturbing...that which cannot be easily categorised leads to social anxiety and from there to suppression or avoidance: that which cannot be clearly classified, or that which falls between classificatory confines, may be regarded as 'polluting' or 'dangerous'. Ambiguous things can seem very threatening...

(Hogan, 2008:142). This is discussed further in Chapter 11. Others have talked about the powerlessness of people in liminal states, when they cannot go back to what they were, nor see how they can evolve into a new identity. Navon and Morag talk about this in relation to men having hormonal therapy for advanced prostate cancer, who believe themselves to be:

...not temporarily unclassified but permanently unclassifiable...

(2003:2344). Taylor (2008) uses liminality to think about families' experiences of premature birth; of particular interest to this work she notes both how the liminal period can be an extended one, and how there are societal expectations about the length of rites of passage:

...deeply entrenched psychological expectations surround Rites of Passage i.e. we internalise a set pattern which we believe will be standard to all concerned within a particular group...

(Taylor, 2008:57).

Little *et al.* (1998) use liminality to consider the experience of cancer patients. Their work develops the original concept – liminality is not necessarily a short

phase as survivors of serious illness enter and remain in this state in some form for the rest of their lives. Little *et al.* refer to liminality as an:

...enduring and variable state...

(1998:1490). They also consider that the three stages described by van Gennep (1909) are not always clearly defined – and that, in some situations, such as those experienced by people with serious illness, they will not be passed through ‘neatly’. Of particular interest is the way in which Little *et al.* use liminality to consider subjective experiences, and their acknowledgement of the unsettling nature of liminality. Others, as noted above, have written about how disturbing others find those in the liminal state; Little *et al.* consider how unsettling liminality is for those experiencing it. Of particular interest here again is the way in which they note that:

...family and friendships are so important and so deeply challenged by liminality...

(2008:1491). This idea is returned to later in Chapter 11.

Liminality is often referred to in the breastfeeding and early motherhood literature, although as a contributing idea rather than as a central concept. McCourt notes that the work of early anthropologists such as Van Gennep have:

...had enduring resonance and value...

(2009:44). She discusses this specifically in relation to concepts with which to think about time and childbirth, also making reference to Douglas (1966), and ideas of purity and danger in relation to the liminal status of the foetus. Elsewhere, McCourt uses liminality to think about birth and the transition to parenthood (Mccourt, 2006). Other earlier influential work on pregnancy and

childbirth also considers these issues both in relation to rites of passage (Longhurst, 1999) and ideas of space and time (Sharpe, 1999).

Liminality is used very little elsewhere in the literature in relation to long-term breastfeeding. Bartlett (2010), in her discussion of time in relation to breastfeeding, briefly considers liminality and long-term breastfeeding, but finds it an unhelpful concept:

...breastfeeding cannot just be a liminal time or space which women occupy while waiting for 'normal' time to be returned. To understand breastfeeding as such is to devalue and constrain it to a nether-land outside of normal life. For women who breastfeed multiple children for months or years at a time, breastfeeding can be more 'normal' than not breastfeeding...

(2010:126). In other work Bartlett (2005) considers social and cultural constraints to women's freedom to breastfeed as and where they like. Here, however, she does not appear to recognise these influences on women who breastfeed long-term – where, however 'normal' it becomes for individual women, it remains far from normal for those around them.

Mahon-Daly and Andrews' paper (2002, discussed in detail below) is frequently referred to, although in relation to their findings as much as their use of the concept of liminality. In their discussion of Vietnamese immigrant women's experiences of breastfeeding, Groleau *et al.*, (2006) talk about how Mahon-Daly and Andrews demonstrated the importance of rites of passage in '*abandoning*' breastfeeding. In a number of publications Dykes refers to breastfeeding in many communities as a:

...marginal and liminal activity, rarely seen and barely spoken about...

(2006:206, also 2003; 2009). She makes several references to Mahon-Daly and Andrews but does not explore liminality in any depth. Sachs *et al.* (2006) also refer to Mahon-Daly and Andrews in relation to the early weighing of babies and focus on common findings, with little discussion of liminality; Boyer (2010; 2011; 2012) uses Mahon-Daly and Andrews too but again primarily in relation to findings rather than to liminality.

3.2.4 Mahon-Daly and Andrews: liminality and breastfeeding

Mahon-Daly and Andrews (2002) take a geographical perspective and use the concept of liminality to think about space and place in relation to women's experiences of breastfeeding. Despite the paper's shortcomings (it is now quite dated, discusses the results of one small study, and contains a number of flaws) it is well cited and therefore considered a seminal work in this area. The paper gives a thorough explanation of liminality and relates the idea of 'rites of passage' to contemporary experiences. The ways in which geographers have used rites of passage as a theoretical framework to look at maternal and child health issues are also considered, particularly in relation to pregnancy (Longhurst, 1999) and childbirth (Sharpe, 1999).

Mahon-Daly and Andrews cite Davis-Floyd and Sargent (1997) as introducing the idea of liminality to breastfeeding research (from an anthropological perspective). I was unable to find any mention of the ideas they refer to in the given reference, even though the way that Davis-Floyd and Sargent identify ritual phases in relation to breastfeeding is specifically

discussed (Mahon-Daly and Andrews, 2002:65). Personal communication with Mahon-Daly (2011) clarified that the reference was in fact to Davis-Floyd (1992) and that the Davis-Floyd and Sargent reference was an error. However, although the ritual phases of *hazing*, *strange-making* and *symbolic inversion* are discussed by Davis-Floyd (1992) they are not applied specifically to breastfeeding. I have therefore concluded that the breastfeeding link is an interpretive one by Mahon-Daly and Andrews and, as such, still useful.

Since the publication of Mahon-Daly and Andrews' (2002) seminal work a number of geographers have undertaken important work using ideas of space and place to think about women's breastfeeding experiences (Pain et al., 2001; Smyth, 2008; Boyer, 2010; Boyer, 2012). None of these authors specifically use the concept of liminality in their work (although some refer to Mahon-Daly and Andrews' paper).

Mahon-Daly and Andrews (2002) carried out participant observation in breastfeeding support groups and face-to-face interviews. Mahon-Daly was breastfeeding during data collection. Mahon-Daly and Andrews discuss breastfeeding in relation to three levels of liminal experience. The first level relates to the post-natal period, during which a woman is neither pregnant, nor returned to her 'normal' bodily state. This liminal phase lasts until the woman stops lactating and reintegration can occur. For most women, who choose not to breastfeed or who stop breastfeeding in the early weeks, this liminal phase is very brief and the woman soon returns to what is seen as a

'normal' bodily state. The second level relates to the way in which, during this transitional stage, women are changed for life (through experiences of breastfeeding) and so do not return to the way they were before, reaching:

...a new understanding of themselves and their bodies...

(2002:65). The third level considers the act of breastfeeding itself, theorising that this takes place in particular spaces, which women move in and out of ('*behavioural rituals*'). In this way, Mahon-Daly and Andrews consider breastfeeding to be liminal both in terms of time and space, and that this makes the liminal state very temporary because breastfeeding is not viewed as a 'normal' activity, and women wanted to return to a 'normal' life.

Breastfeeding as pollution is also considered and discussed in relation to both taboo and liminality. Breastmilk is described as:

...a potentially impure body fluid...

(Mahon-Daly and Andrews 2002:69) and interesting points are made about breastmilk leakage. Their participants discussed both the leakage and stains of breastfeeding (in relation to '*perceived dirtiness*') but also, interestingly, they note different reactions to spilt breast- and formula milk. Mahon-Daly and Andrews argue that if breastmilk is viewed as polluting, this supports the idea of a liminal state of breastfeeding.

Mahon-Daly and Andrews (2002) give examples of women's experiences in the three levels of liminality. Although their work does not consider issues of long-term breastfeeding, it does provide a useful conceptual framework which can be further developed to encompass the experiences of women

breastfeeding long-term. The conclusions from this paper are discussed in more depth in Chapter 11.

3.3 Stigma

3.3.1 Introduction

This section explains and discusses the concept of stigma. It uses both classic texts and more recent work, particularly research focused on health issues. There is now a very large body of literature in this area; my focus (as in the liminality section above) is on that which has helped to further my understanding of the concept and experience of long-term breastfeeding. Much of the research on stigma comes from sociologists and social psychologists; others, including social geographers and anthropologists, have also contributed to the debates (Link and Phelan, 2001). Stigma is often linked to deviance, prejudice and discrimination (Phelan *et al.*, 2008); these concepts will also be considered because of their relevance to breastfeeding.

The development of ideas about stigma is primarily associated with Goffman (1963). I also look closely at the work of Jones *et al.* (1984), both here and in Chapter 11, both because they made an important contribution to developing understanding of stigma and its effects, and as their work has been applied to the experience of breastfeeding (Smale, 2001). I will also consider ideas from others who have developed and used the theories of Goffman (1963) and Jones *et al.* (1984). Phelan *et al.* provide a synopsis of stigma models (2008:366) which shows the development of the concept from Goffman (1963), via Jones *et al.* (1984), through to more contemporary work including that which looks at an evolutionary model of stigma (Kurzban and Leary,

2001), introduces and investigates issues of stigma in relation to power and control (Link and Phelan, 2001; Parker and Aggleton, 2003) and considers moral experience and stigma (Yang *et al.*, 2007). The work of Link and Phelan (2001) is also considered particularly helpful as they have added to and used the definition developed by Jones *et al.* (1984).

The second part of the section will discuss the use of stigma more specifically as a concept in understanding and explaining health issues and in thinking about breastfeeding. This links directly to the discussion in Chapter 11 in which the issues of liminality, stigma and taboo will be brought together to consider long-term breastfeeding.

3.3.2 The concept

Defining stigma is not straightforward with wide variation in the literature (Link and Phelan, 2001; Deacon, 2006). The definition of stigma has been described as:

...vague and highly variable...

(Parker and Aggleton, 2003:15). The word stigma originates from the Greek word for a tattoo mark, used to brand people, originally to mark them as servants of the temple, and later as slaves or criminals - people to be avoided (Whitehead *et al.*, 2001a; Breitkopf, 2004). Over time usage of the word has changed although the concept is still influenced by cultural and social contexts. Recent definitions of stigma combine both sociological

perspectives (building on Goffman) as well as recognising the psychological experience of the person who is stigmatised (Breitkopf, 2004).

Goffman's work has been very influential in framing understanding about stigma. Many of the specific examples he uses, however, can be seen to be very much grounded in the historical context within which he was working, particularly in relation to the language used. He wrote about stigma in terms of the social understanding of difference – both in relation to how people *become* socially different and how some people in society *choose* to stigmatise others as different (Whitehead *et al.*, 2001a) - and linked this to attributes held by the stigmatised person. Goffman's definition of stigma is often cited:

...possessing an attribute that makes him [sic] different from others in the category of persons available for him to be [reduced] from a whole and usual person to a tainted, discounted one...

(Goffman, 1963:12).

Goffman distinguished between visible, easily perceived difference (such as a physical disability, skin colour or a scar) and difference that is not immediately known about or evident. People with visible differences are '*discredited*'; people with differences that are not evident are '*discreditable*' (Goffman, 1963:14). Those who are discredited have to manage their social encounters (and any ensuing tension) with '*normals*', whereas discreditable people have to manage information about themselves, deciding what to disclose, when and to whom (Jacoby, 2002). A stigmatised person has '*an undesired differentness*' (Goffman, 1963:15), with this difference being

culturally and socially constructed (Parker and Aggleton, 2003). As a result of sanctions applied by society, the stigmatised person has a '*spoiled identity*' (Goffman, 1963). Parker and Aggleton note that Goffman's work has been interpreted in ways that perhaps do not represent his intention, encouraging:

...Highly individualized analyses in which words come to characterize people in relatively unmediated fashion. Thus stigma, understood as a negative attribute, is mapped onto people, who in turn by virtue of their difference, are understood to be negatively valued in society...

(2003:14). The consequence of this has been that stigma has been framed as a 'static attitude' as opposed to a variable social process (Parker and Aggleton, 2003).

Goffman identified three types of stigma: '*physical deformities*', '*blemishes of individual character perceived as weak will*' and '*the tribal stigma of race, nation and religion*' (Goffman, 1963:14). Goffman also made the link between stigma and deviance, particularly in relation to the idea of '*moral behaviour*'. Others have more recently used and developed alternative definitions, including Jones *et al.* (see below); these have included factors such as beliefs about behaviour, the possession of devalued attributes and components such as stereotypes and discrimination (Link and Phelan, 2001; Pescosolido *et al.*, 2008).

Goffman's stated focus was on the '*language of relationships, not attributes*' (1963:13) although more recent research has shifted focus (Scambler, 2009):

...the stigma or mark is seen as something *in the person* rather than a designation or tag that others affix to the person...

(Link and Phelan, 2001:366). Goffman's work centres on the idea that stigma comes about through social interactions and is thus socially constructed through relationships. Pescosolido *et al.* (2008) note that, since Goffman, advances in theory have increased understanding of the range of influences on, and context of, social interactions. The current variation in definitions of stigma may result from the concept being applied to a wide range of issues, and because much research on stigma is multidisciplinary (Link and Phelan, 2001). Link and Phelan have also shown how work building on Goffman's original concept has helped increase our understanding about how human differences are distinguished, labelled and linked to negative stereotypes (for example, people being categorised as '*us*' and '*them*').

Another useful and influential model of stigma is that developed by Jones *et al.* (1984). They used a social psychological perspective (specifically, affective psychology – Whitehead *et al.*, 2001a) to develop Goffman's ideas to look at what they called the '*psychology of marked relationships*' (Jones *et al.*, 1984). Their interest was in developing an analysis of the relationships between those who are 'deviant' (who bear a 'mark' of some kind) and those who are 'normal' (1984:1) from a psychological perspective. Their focus was on the psychological impact of the stigmatising condition on the person with the condition, but also on how this affected their ability to function in society – on the relationship between the 'mark' and stereotyped undesirable characteristics (Link and Phelan, 2001). As in Goffman's analysis, the 'mark'

of stigma may or may not be physical or visible (Jones *et al.*, 1984). The 'mark' may refer to a range of factors that together begin the process of being stigmatised.

According to this model the process of stigmatisation results in the development of strategies which help the stigmatised person deal with the ensuing social implications (Whitehead *et al.*, 2001a). Jones *et al.* identified 'six dimensions' of stigma (1984:24), outlined by Jacoby:

...Concealability (the extent to which the stigmatizing characteristic is visible to others; course of the mark (whether the characteristic becomes more salient over time); disruptiveness (the degree to which it interferes in interactions with others); aesthetics (subjective reactions to the unattractiveness of the stigmatizing characteristic); origin (congenital, accidental or intentional); and peril (the perceived danger of the condition to others)...

(2002:S11). Link and Phelan, in their discussion of stigma in relation to mental illness, later added another dimension – *discrimination* – to the six outlined by Jones *et al.* (Link and Phelan, 2001). Others have taken Jones *et al.*'s six dimensions and collapsed them into two – visibility and controllability, with visibility relating primarily to 'concealability' and controllability to 'course of the mark' (Breitkopf, 2004).

Since Goffman (1963) and Jones *et al.* (1984), sociologists and psychologists have written about stigma and considered ways in which it could be reconceptualised, in particular by integrating issues of power (for example, Link and Phelan, 2001; Parker and Aggleton, 2003) to create a:

...more holistic theory of stigma...

(Deacon, 2006:420). Parker and Aggleton describe their framework as showing how:

...stigma and stigmatization function (...) at the point of intersection between *culture*, *power* and *difference*' (...) central to the constitution of the social order...

(2003:17), drawing on the studies of Foucault and Bourdieu in relation to power to construct their concept.

This is, by necessity, a fairly broad overview of a number of complicated ideas. Before leaving the concept of stigma it is important to also briefly recognise other related issues. Stigma is connected, in the literature, to a number of concepts that have relevance to thinking about breastfeeding experience. Ideas about deviance, prejudice and discrimination are also important. In Goffman's work stigma and deviance are heavily linked although this is felt to be of less relevance to contemporary theorists: Whitehead *et al.* (2001b) point out that, since Goffman's time, deviance now has different connotations (with sex and with perversion).

A number of authors have considered the relationship between stigma and prejudice. Phelan *et al.* conclude that, although there are

...some differences in emphasis and focus [they] describe a single animal...

(2008:365). They suggest that there are three functions of stigma/prejudice: exploitation and domination; enforcement of social norms; and avoidance of disease. Colloquially these may be summed up as '*keeping people down*', '*keeping people in*' and '*keeping people away*' (2008:365). Thornicroft *et al.* link stigma with prejudice ('*attitudes*') but also with ignorance ('*problems of knowledge*') and discrimination ('*behaviour*') (2007:192). Thornicroft *et al.* suggest, in relation to behaviour towards people with mental illness, that

refocusing on discrimination (rather than stigma) is appropriate. This echoes the view of Sayce (1998) who also argues that a focus on discrimination is important for behaviour change. These authors (in reviewing the work of others) consider how behaviour towards people with stigmatising conditions affects experience in a range of areas of social and economic life (Thorncroft *et al.*, 2007).

3.3.3 The use of stigma in understanding health issues, including breastfeeding

Stigma has been used as a concept to understand a wide range of health issues, including urinary incontinence, leprosy, cancer and mental illness (reviewed by Link and Phelan, 2001), genital herpes (Breitkopf, 2004), HIV/AIDS (by many, including Parker and Aggleton, 2003; Deacon, 2006) and epilepsy (Jacoby, 2002). These are but some examples: the range of issues examined using the concept of stigma is vast. As noted above, many writers have drawn on Goffman and on later developments of his work; some specifically use Jones *et al.*'s six dimensions (for example, Breitkopf in her discussion of genital herpes, 2004).

The work of medical sociologist Scambler (2008; 2009) has been particularly influential in health-related stigma research, introducing the idea of the '*sick role*' (from Talcott Parsons) into an examination of stigma, and bringing together the concepts of illness, deviance and stigma to consider conditions such as AIDS, burns, epilepsy and psoriasis (Whitehead *et al.*, 2001a).

Scambler has focused specifically on the social processes involved in health-

related stigma – on the judgements made about people and the effects that these have. He builds on Goffman's work, considering how stigma is a:

...mark of disapproval..

(2009:443) and the implications of the labelling that ensues from this (with consequences, for example, for mental health).

The concept of stigma has also been used more recently to look at social exclusion in relation to health and healthcare (Mason *et al.*, 2001). Some, as outlined above, have specifically linked the ideas of stigma and discrimination in relation to health issues, particularly to look at HIV/AIDS (for example, Parker and Aggleton, 2003) and mental health (for example, Sayce, 1998). Goffman's idea of '*undesirable difference*' has been used in a range of health-related work on stigma (Jacoby, 2002; Parker and Aggleton, 2003). In her work on stigma and epilepsy, Jacoby (2002) notes the importance of how individuals with a stigmatised characteristic manage information about themselves; how, whether and to whom they disclose information about their condition. This has relevance for other issues too, including long-term breastfeeding.

Stigma has been used to examine issues of particular relevance to women's health, including abortion (Kumara *et al.*, 2009), obstetric fistula (Bangser, 2006), involuntary childlessness (Blyth and Moore, 2001) and teenage pregnancy (Jacono and Jacono, 2001). Although there is little work that specifically addresses the issue of stigma and breastfeeding the concept is frequently referred to in discussions of breastfeeding. It is particularly noted

in relation to breastfeeding in public (Sheeshka *et al.*, 2001; Lavender *et al.*, 2006; Condon *et al.*, 2010). As was noted in Chapter 2, in the small body of work that considers experiences of long-term breastfeeding there is often an assumption of the associated stigma rather than a detailed examination of it (for example in Reamer and Sugarman, 1987; Buckley, 2001; Stearns, 2011).

3.3.4 Smale: the stigmatisation of breastfeeding

Smale (2001) is clearly not the only author to address the issue of the stigmatisation of breastfeeding; her work is considered particularly useful here because of the specific way in which she applies the concepts developed by Jones *et al.* (1984). She uses the concepts of 'origin' and 'peril' to consider the ways in which breastfeeding is constructed in Western culture and how it may be seen, not as disfiguring, but as a '*degrading affliction*' (Jones *et al.*, 1984:58). Smale does not justify her decision to focus on 'origin' and 'peril' and exclude the other dimensions of stigma outlined by Jones *et al.*: this appears to be a weakness in her discussion.

Smale's discussion (2001) is particularly focused around the issue of breastfeeding in public and includes illustrations of some difficulties surrounding this at the time it was written (not thought to be significantly different now, despite legislative change). She also draws attention to cultural differences in attitudes to breastfeeding in different parts of the UK, which is also thought to be a current issue.

Smale (2001) considers Jones *et al.*'s idea of the origin of the 'mark' of stigma and discusses this in relation to two issues – the leaking of breastmilk (stains and smells), and the noises of breastfeeding. A full discussion of issues relating to leaking breastmilk and breastfeeding in public can be found in Dowling *et al.* (2012). Smale refers to the bearer's responsibility for:

...creating his or her own mark...

(Jones *et al.*, 1984:56) – that women are encouraged, through public health campaigns, to breastfeed their babies and then stigmatised for doing so (Smale, 2001); this issue was noted in Chapter 2. She also relates the way in which women are often held responsible for any feeding difficulties they may have to the idea of the mark (stigma) being evidence of some earlier:

...mistake, indiscretion or evil act...

(Jones *et al.*, 1984:60). This is discussed further in Chapter 11.

The other main focus in this chapter is the idea of 'peril'. Smale notes that breastfeeding does not clearly 'fit' with the concept as outlined by Jones *et al.* but focuses instead on the idea that:

...breastfeeding is constructed culturally as a threat to order...

(Smale, 2001: 236). She develops this idea in relation to cultural disquiet about breastmilk, particularly in close proximity to other forms of eating. Ideas about the sexual nature of breasts and the cultural ambiguity about women's bodily fluids are raised but without reference to some of the other interesting work in this area (discussed further below). Smale also considers the sexual nature of breasts and the cultural confusion about breasts/nipples in relation to breastfeeding – again relating this to the idea of peril (although I

feel that the argument here is more tenuous). Smale does not draw on any of the feminist literature which discusses these issues (for example, Stearns, 1999), instead referencing two research papers on women's experiences of breastfeeding, which were fairly dated even when the chapter was written (although interestingly one reference relates to long-term breastfeeding - Wrigley and Hutchinson, 1990).

Smale's discussion concludes with consideration of specific places where breastfeeding is problematic (in church, in Parliament and at work) and can be seen here to resonate with the ideas discussed above in relation to time and liminality. She ends her chapter (whose stated audience is health professionals) with some detailed suggestions as to how women might be helped to destigmatise breastfeeding.

3.4 Taboo

3.4.1 Introduction

This section will explain the concept of taboo and then look at how this has been used in relation to health issues in general and breastfeeding experiences in particular. Searching for literature with which to increase understanding of taboo has been more difficult than with liminality and stigma. I have chosen to focus particularly on the contribution made by two texts – *Taboo* (Steiner, 1956) and *Purity and Danger* (Douglas, 1966).

Steiner's work is considered particularly useful as he discusses the origins of the term and its definition and critically reviews theories of taboo in the century before he was writing (particularly Smith, 1869 onwards; Frazer, 1875; Wundt, 1906; Freud, 1913, Mead, 1937 and Radcliffe-Brown, 1939,1952; the majority of these texts have not been examined for this review). Douglas' work has been particularly influential: I have come across many references to her work in relation to both liminality and taboo.

The relationship between taboo and health is more abstract than those between liminality and stigma and health, and it was harder to find examples of the current use of the concept of taboo in health research. The discussion in the second part of this section therefore focuses more on illustrating how taboo has been used to look at a variety of issues which can be seen to be health-related in a broad sense.

3.4.2 The concept

Steiner noted that the term 'taboo' has been used in a number of different ways, being concerned with:

...(1) All the social mechanisms of obedience which have ritual significance; (2) with specific and restrictive behaviour in dangerous situations (...) (3) with the protection of individuals who are in danger, and (4) with the protection of society from those endangered – and therefore dangerous – persons...

(1956:21), and therefore with '*a number of diverse social mechanisms*'.

Steiner comprehensively explains and discusses taboo, beginning with the introduction of the word into European languages by Captain Cook after visiting the South Sea Islands. The word's origins are commonly believed to be in Polynesian languages (Freud, 1913; Steiner, 1956), with the most common form being *tapu*, although other variants include *tabu*, *kapu* and *tafu* (Steiner, 1956:33). Steiner refers to the taboos that are connected to different phases in rites of passage:

...concerned with the various delimitations of our spheres and boundaries, our time spans and our experiences...

(Steiner, 1956:116). In this way Steiner relates taboo to the liminal phase, saying that taboo is clearly related to transgression, '*of passing...from inside-outside*' (1956:116). Of particular interest here, discussed further below, is his comment that:

...Taboos are concerned with the passings of things into the body and out of it; they guard the body's orifices...

(1956:116).

Radcliffe-Brown considered one of the functions of social beliefs such as taboos to be the expression of social values (Radcliffe-Brown, 1939, cited in

Steiner, 1956:118, also Radcliffe Brown, 1952). Other anthropologists and sociologists have also looked at the function of taboos, suggesting a psychological purpose or a way of noting power or status (Colding and Falke, 2001). Taboo has come to mean the ways in which certain actions or ideas are considered offensive in society (or more specifically, in a group or community). Although much of the work drawn on here is from the 1950s and 1960s, Freud and others wrote about taboo much earlier in the century. Freud notes that taboo can mean both:

...on the one hand 'sacred', 'consecrated', and on the other 'uncanny', 'dangerous', 'forbidden', 'unclean'...

(1913:21); the result of taboo can be *'prohibitions and restrictions'*.

According to Freud, taboos can be either temporary or permanent, attached to specific states (his examples are menstruation and childbirth) or to activities (for example, incest).

Douglas reviews anthropological and sociological ideas about taboo and notes that, prior to the time that she was writing, it was traditional for anthropology to view taboo as having a protective function. Douglas develops this idea, writing about taboos in relation to social and moral codes, and how these are organised in society – with taboos therefore used to support morality or propriety. Sanctions or dangers are associated with taboos if the accepted moral code is not respected; in relation to this, ambiguous things are seen as threatening.

Her work is frequently referred to in writing about cultural unease with bodily fluids. She focused in particular on ideas about dirt and pollution, on how these are interpreted as 'disorder' and on how ideas about pollution are used to influence behaviour. She is particularly well known for her consideration of 'matter out of place', noting that dirt and bodily functions lead to expressions of disgust – but that things are only dirty if they are in the 'wrong' place. Dirt, according to Douglas, is associated both with hygiene and with respect for convention. Of particular relevance here is the way in which she focuses on ritual behaviour in relation to pollution, noting examples of this in a range of cultures. She includes ideas about pollution that are associated with menstruation and childbirth; this can also be seen in beliefs in some cultures about colostrum (Hogan, 2008; Rogers *et al.*, 2011). Her ideas about '*marginal stuff*' (1966:150) are also interesting. She talks about the symbolic importance of body orifices (the margins of the body) and how particular types of pollution linked with them are seen as dangerous. The examples she gives include milk (as well as urine, blood, tears etc.). This is clearly related to Steiner's comments, noted above, about the liminal nature, and taboos, associated with things that pass through bodily orifices.

3.4.3 The use of taboo in understanding health issues, including breastfeeding

Taboo has been used to understand a range of social and cultural issues, including health issues. Taboo is discussed in relation to, for example, death/dying (Lee, 2008), food (Meyer-Rochow, 2009), menstruation (McPherson and Korfine, 2004), stillbirth and miscarriage (Frøen *et al.*,

2011), as well as to a range of issues connected with sexuality; these are merely some out of many examples.

Taboo is often related to specific areas of women's lives – including menstruation (as above), childbirth and early breastfeeding, perhaps more clearly seen at different times historically (Hogan, 2008) and in different cultures (Rogers *et al.*, 2011). A range of taboos around breastfeeding in different cultures are noted in the literature – from those relating to the eating of specific foods (Bandyopadhyay, 2009) to the taboo on sexual contact during breastfeeding (Yovsi and Keller, 2003). Cultural taboos about aspects of breastfeeding are recognised as a barrier to increasing breastfeeding rates in many communities (Dykes and Flacking, 2010).

A small body of research examining women's experiences of breastfeeding also draws on ideas about pollution and taboo (often with reference to Douglas). Schmied and Lupton (2001) discuss cultural taboos in relation to breastfeeding and breastfeeding mothers, both in terms of the ambiguity of breastfeeding bodies and the incest taboo. They also pay particular attention to the meanings attached to breastmilk – as an inside-outside symbol, with leaking milk seen as '*messy*' and '*dirty*' (2001:242), clearly '*matter out of place*' as in Douglas' theory. They specifically refer to Douglas when discussing the danger associated with:

...that which is marginal or different...

(2001:245), as well as in relation to the cultural discomfort felt when boundaries are blurred.

Other work seen as relevant here is that which draws on ideas about taboo to discuss women's bodily fluids, including breastmilk, highlighting the cultural confusion concerning fluids seen as pure but also contaminated by association with sexual orifices (see, for example, Grosz, 1994; Bramwell, 2001; Shaw, 2004 – also Dowling, *et al.*, 2012, for further discussion of this point).

3.4.4 Battersby: breastfeeding and taboo

The book chapter by Battersby (2007) differs from the chapter by Smale (2001) and journal paper by Mahon-Daly and Andrews (2002), discussed above. Battersby does not explicitly state that she is considering the issue of breastfeeding and taboo. However, in her opening paragraph she makes clear links between breastfeeding in public and issues of pollution and disgust. Although she does not refer to Douglas' (1966) work on taboo (discussed above), the idea of dirt and pollution, of breastfeeding being unclean and of invoking sanctions runs throughout the chapter, and it can be seen to have strong theoretical links with notions of taboo; it is therefore considered relevant in this context.

The chapter considers issues of sanctions including the ways in which women are asked to leave public places when breastfeeding, relating these both to the ways in which breastfeeding is seen to be 'dirty and polluted' (Battersby, 2007:102) and to the cultural connotations of the sexual nature of the breast. Battersby reviews the literature which looks at the ways in which

women's bodily fluids are perceived as dirty and out of control, and makes links between this and the way in which a breastfeeding mother may also be seen as out of control, her leaking breastmilk as dirty and disgusting.

Battersby relates her discussion to other literature that also considers these issues (Morse, 1989; Britton, 1997; Bramwell, 2001) although this work is quite dated and there is no reference to theoretical discussions of taboo.

Battersby also reviews the literature on the sexual and cultural constructions of the breast and relates this to breastfeeding in public; these sections of the chapter, whilst interesting, do not discuss taboo so clearly. It is apparent however, that some taboos exist around the appropriateness of the use and function of the breast, with conflicts arising between the sexual and maternal uses (Stearns, 1999). Battersby also makes reference to Mahon-Daly and Andrews (2002) in the context of this discussion.

The remainder of her chapter is a more focussed discussion around breastfeeding in public, looking at issues of embarrassment, modesty and discretion. Battersby returns to the issue of pollution and taboo when she refers to the noises of breastfeeding; this is resonant of Smale's (2001) discussion of this noise as a 'mark' of the stigma of breastfeeding. Battersby notes that noisy feeding draws attention to the act of breastfeeding:

...if a baby feeds noisily and is demonstrative whilst feeding this may be perceived as breaching the normal bounds of modesty and may attract critical attention...

(2007:109). She refers to other work - including Smale - which has recognised the social difficulty that occurs when a mother and baby are seen to be enjoying breastfeeding, physically and emotionally (Kitzinger, 2000, and

Pugliese, 2000, cited in Battersby, 2007:209). This issue will be returned to in Chapter 11. At this point in the chapter Battersby explicitly refers to taboo and relates this to long-term breastfeeding:

...mothers are expected to breastfeed their infants in a quiet and detached manner, with any emotional display being regarded as taboo. This will be particularly evident if the mother is nursing an older child...

(2007:210). She concludes her discussion by returning to the idea of sanctions.

The diagram that follows (Figure 2) shows some of the relationships between the different conceptual models in the literature, also showing how they link with the breastfeeding literature discussed in this chapter. Figure 3 shows some of the ideas discussed in breastfeeding research and how they link with the conceptual models.

Figure 2: Relationships between different conceptual models in the literature

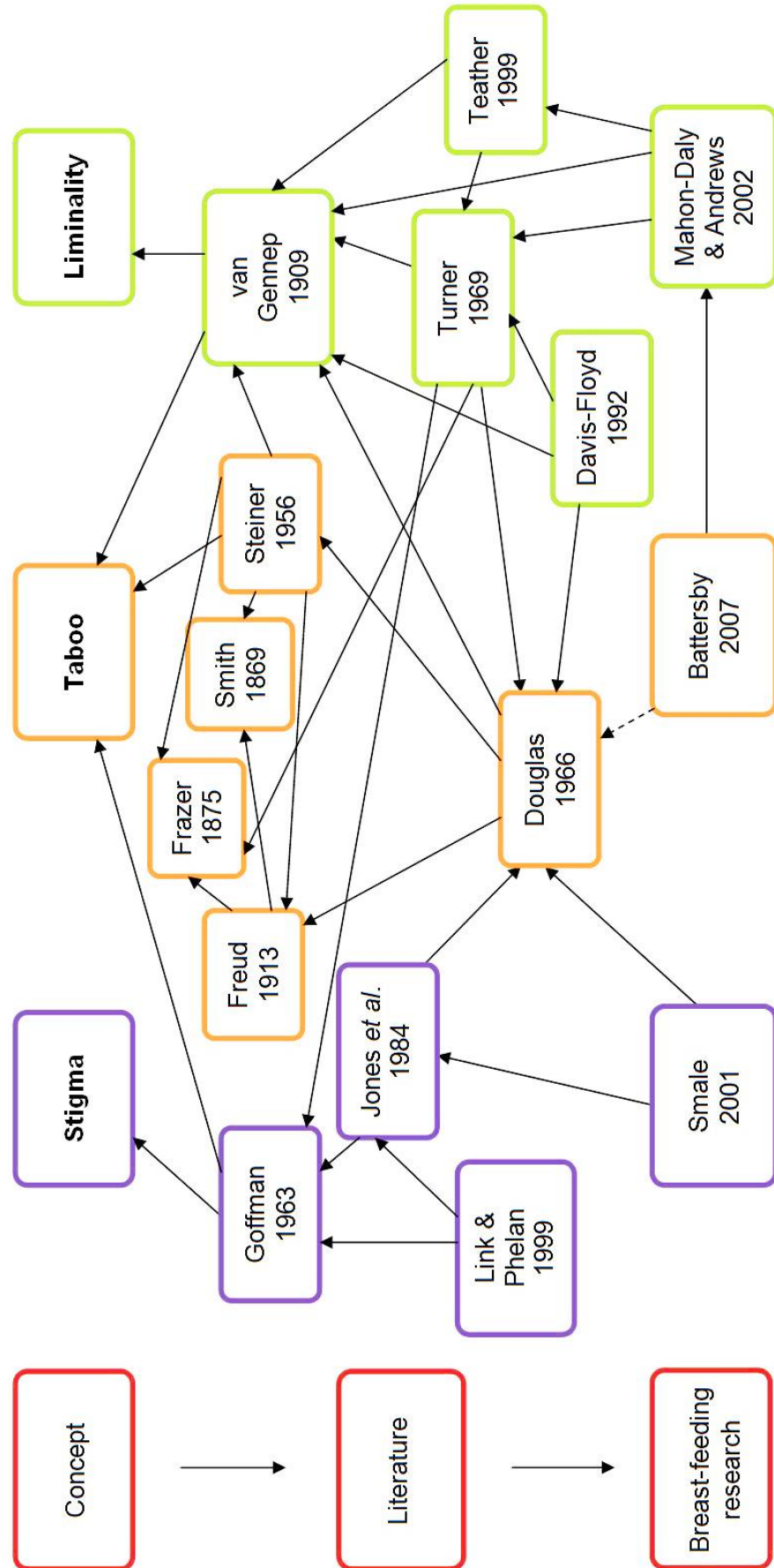
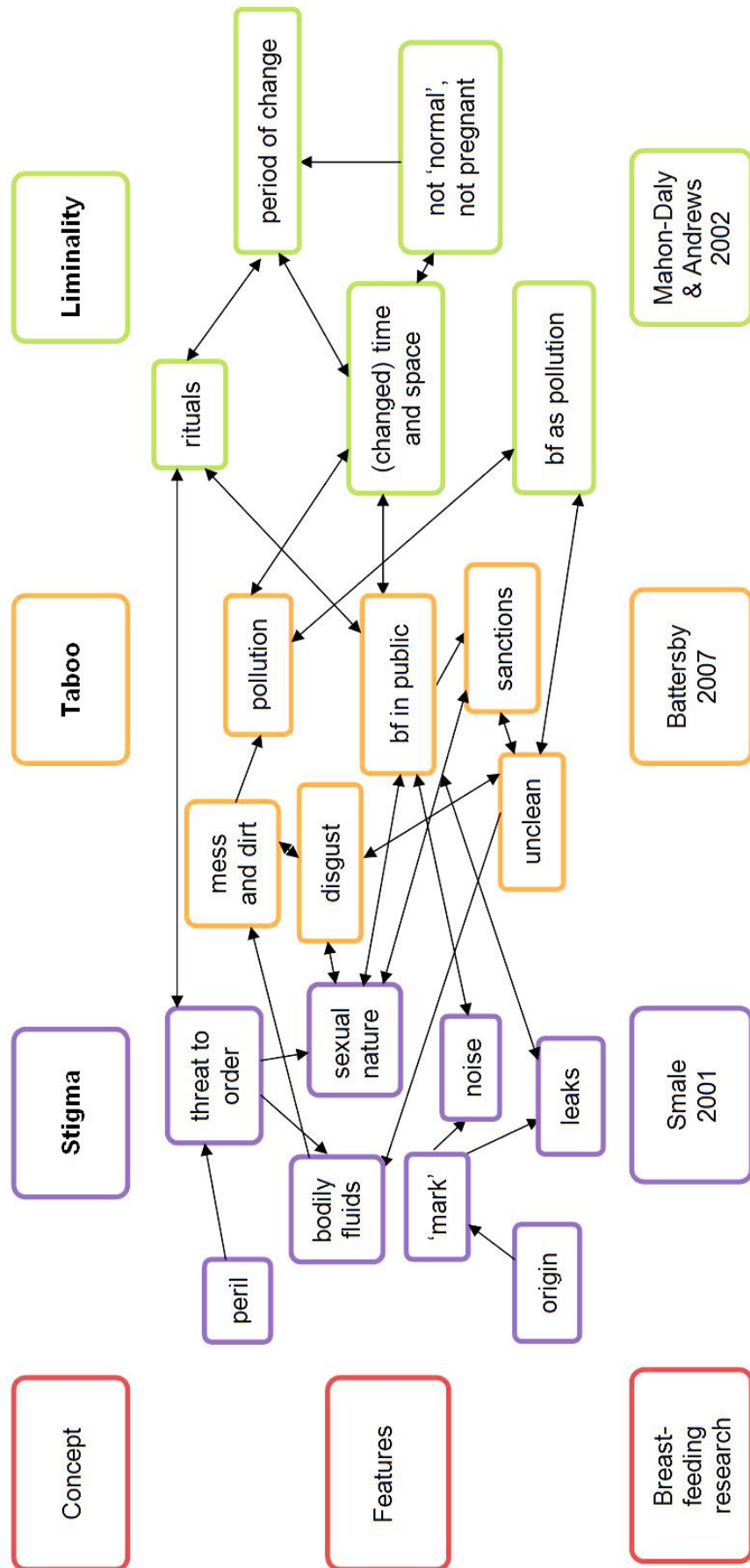


Figure 3: The relationship between breastfeeding research and the conceptual models



3.5 Conclusion

This chapter has outlined and discussed the key theoretical concepts used to think about the findings in this work. I have introduced the ways in which these concepts can be used, both generally in health research and specifically in relation to breastfeeding. The following two chapters address issues of methodology and methods before the focus narrows to a detailed and thorough explanation and discussion of findings (Chapters 6 – 10). The concepts introduced here are returned to in Chapter 11 where they are used to understand the experiences of women who breastfeed long-term.

Chapter 4: Methods used in the research I - perspectives and techniques

4.1 Introduction

The previous three chapters discussed contextual and background issues whereas this and the next address methodological issues and methods. In this chapter I discuss methodological principles, the rationale for specific methods, and application issues. In this thesis I follow Letherby's distinction between methodology and methods, that is method:

...is a technique...(and)...methodology entails a perspective or framework...

(Letherby 2003:5), and draw on Madden in considering that:

...methods are what tools you use; a methodology is an explanation of why you use those tools...

(Madden 2010:25). I address these aspects below through a structured discussion of techniques/tools and perspectives in relation to data generation and analysis.

Section 4.2 outlines the justification for methodological choice, highlights specific issues in relation to carrying out research using ethnographic methods, and discusses feminist methods and other issues of perspective. This section focuses on cross-cutting themes including quality, consent, bias and other ethical issues. Section 4.3 discusses the specific methods (tools) used, opening with an overview of data collection and related issues. The methods are discussed in detail, focusing on the rationale for use and their complementarity. Sampling, recruitment, access and entering and leaving the

field are considered in relation to each method. I use a timeline showing data collection strands in relation to the months of the year and to each other. My aim is for the timeline to help relate the discussion of the methods to the cross-cutting themes discussed in section 4.2. Section 4.4 addresses data analysis and arising issues. Section 4.5 draws together the main points discussed.

Three different methods were used to collect data - participant observation, face-to-face (FTF) interviews and asynchronous online interviews. Data was collected over nineteen months, generating a large amount of material (see also Chapter 6 and Appendices A-G).

Throughout the project I have tried to remain as open and honest as possible to myself, my supervisors and the research participants. I include a reflective strand running throughout this discussion to demonstrate my methodological thinking (Letherby, 2003), my consideration of how the methodological processes and choice of methods has affected participants, the production of data and the shape of the thesis. It is a crucial element in using ethnographic methods (Madden, 2010) and one way to mitigate against the potential for bias. Reflexive practice is illustrated using research diary/ field note excerpts and quotes from different elements of the data to illustrate the use of my '*sociological imagination*' (Mills, 1959) by:

...connect(ing) biography and history, to join the personal with the public...

(Denzin, 2008). The following chapter addresses reflexivity, issues of carrying out insider research and the place of reflection in data collection and

analysis. The two chapters together demonstrate the approaches and techniques used in this research.

4.2 Methodological issues

4.2.1 Methodological choice

Choice of methodology and selection of methods are important elements of research in determining the kinds of data produced and how they may be used (Flick, 2009). Methodological choice is determined by the research questions posed: these shape research design and consideration of the best way to address them. Linked to this are the researcher's philosophical assumptions, beliefs about the world and the nature of knowledge (Creswell, 2007). Research practice is informed by ontology, epistemology, axiology, rhetoric and methodology. The assumptions made by researchers when choosing qualitative research methods include beliefs about the nature of reality, the relationship between the researcher and the researched, the role of values and acknowledgement of biases, the language used in writing and the processes (methods) used (Creswell, 2007). In this discussion I reflect on, and am explicit about, these issues.

In this study I selected methods to enable an in-depth understanding of women's breastfeeding experiences and how they make sense of them. These methods focus on participants' perspectives (Flick, 2009), turning them into:

...a series of representations...

(Denzin and Lincoln, 2008:4). I chose methods grounded in a methodology where my intimate involvement with my subject matter was acceptable and understood as a central part of the research process (Denzin and Lincoln,

2008). It was also attractive to be part of a research tradition with established/multiple methods which also encourages innovation and freedom to use little used/new methods (Denzin and Lincoln, 2008).

Qualitative research uses a range of techniques, for example, observation, focus groups, interviews and textual analysis, built on a variety of traditions but also responsive to cultural and social change (for example, the use of internet based methods). These are used alone or combined to understand the viewpoints, experiences or behaviour of people or groups in the context in which social life takes place. Particular types of research questions lend themselves to qualitative approaches (Creswell, 2007) and generate data amenable to different types of analysis. An underpinning belief is that researchers are not seeking to find 'the truth' as positivist research might be. There is an acknowledgement that there are multiple truths representing the experience of the people studied (Hammersley and Atkinson, 2007). Participants are not chosen for their representativeness as research findings are not intended to be generalisable to other similar groups. Findings may be transferable and may increase our understanding of others in similar situations or add to a body of knowledge about an issue.

There are a number of different approaches to qualitative inquiry, for example, narrative research, phenomenology, grounded theory, ethnography and case studies (Creswell 2007), with associated methods for data collection and analytical techniques, although distinctions are sometimes blurred. Choice of approach is related to the research questions and

researcher experience, background and epistemological and ontological beliefs. The application or generation of theory is also closely linked to choice of approach with some researchers using existing theory to view data gathered whilst others use data collection and analysis processes to develop new theory, as in grounded theory (Flick, 2009).

Ethnography is associated with classical anthropology and sociology (Hammersley and Atkinson, 2007) and refers to methods where data is collected in 'natural' settings usually using participant observation. The term 'ethnography' has been debated, with various methods used by different disciplines and over time. In particular anthropologists and sociologists may apply different criteria to their understanding of what constitutes 'ethnography' (Hammersley, 2006). Traditionally, in anthropology, ethnography is holistic in its approach and in analysis and writing takes into account the social and cultural context of the setting being studied. Participant observation, with relatively long periods of fieldwork, is therefore seen as a central method in anthropological ethnography. Others, however, have argued that ethnography can be more issue specific, known as 'micro-ethnography' (Lutz, 1981; Erikson, 1992). Increasingly there are ethnographers who undertake detailed analysis of specific instances (with perhaps relatively short periods of fieldwork), although others continue to argue for a more holistic approach that takes into account the social and cultural location of what is being observed.

In this study I drew on ethnographic methods, but as I was interested in a very specific phenomenon (and in investigating it using my insider status) my work does not examine in detail the social contexts within which the women I met were living and breastfeeding. Although I chose to undertake my research in this way this approach could also be seen as a limitation and as having constrained the data available for final analysis. My choice of approach therefore has more in common with the ethnographies of the symbolic interactionist approach of American sociologists (for example, Howard Becker) than with classical anthropology and can be seen as a micro-ethnography.

Present day ethnographers draw on a range of methods and perspectives (Atkinson *et al.*, 2001) but essential elements of ethnography include reflexivity and:

...the thoughtful, indeed artful, presentation of the material as an ethnographic story...

(Madden, 2010:24). These elements influence the discussion focus of this chapter, the following one and the thesis presentation. The approach taken in this study is therefore a qualitative one, using participant observation as a key method, in conjunction with interviews (FTF and asynchronous on-line methods).

4.2.2 Feminism and qualitative research

This work is also underpinned by feminist beliefs about research, the appropriateness of methods and conduct, and how findings are used and

disseminated. Feminist methodology is associated with the use of qualitative methods and with a critique of positivist methods that emphasise objectivity (Flick, 2009; Im, 2010). Recently there has been a move to consider '*feminist knowledge*' more important than '*feminist methods*' (Olesen, 2005).

Early feminist research emphasises the importance of exploring women's (often invisible) experiences and of using this knowledge to challenge positivist claims about knowledge (Brooks & Hess-Biber, 2007). The political dimension to such research is emphasised, as feminist research often addresses issues of empowerment and social justice, and is associated with activism (Brooks and Hesse-Biber, 2007). Feminist researchers have focused on power in gender issues: recently this has extended to consider the place of race and class in women's lives (Skeggs, 2001).

Methods that recognise the importance of participants' and researcher's experience are highlighted in feminist research (Oakley, 1981). The encouragement for researchers to be open about and use their own perspectives in research (Brooks and Hesse-Biber, 2007) drew me to feminist approaches to methodology. Feminism and ethnographic methods are suited to each other, as:

...they do not lose sight of context...

(Skeggs, 2001:426).

My interest in researching women's lives is influenced by my identification throughout my adult life as a feminist. It is part of my world-view. These

beliefs about the ways experience is mediated by gender are also important influences on my behaviour in the world and how I interpret others' behaviour (Stanley and Wise, 1993). I am interested in research that makes women's lives visible, particularly aspects that may be misunderstood or considered unimportant. Feminist research recognises that choice of subject and conduct of data collection and analysis are influenced by researchers':

...perspective on reality...

(Brooks and Hesse-Biber, 2007:4-5). Feminist researchers recognise issues of power and reciprocity in knowledge production and dissemination (Skeggs, 2001; Buch and Staller, 2007). I retain an awareness of these factors alongside a realistic and honest account of how difficult this can be in practice.

Feminists use many different approaches to research and investigate a wide range of topics (Maynard, 1994) and their influence may be seen at all stages of research – epistemological assumptions, choice of issue, data collection and analysis and representation of findings (Flick, 2009). My interest is in using a feminist approach to methods (choice, application and ethics) rather than exploring the specific influence of feminist theories. A feminist approach to breastfeeding research:

...(goes) beyond the surface content of women's accounts and explicitly (explores) the social processes that can make breastfeeding oppressive...

(Johnson *et al.*, 2009:90). This is feminist research, that is, research by women for women, which includes awareness and understanding of power

issues in research relationships, emphasises researcher-participant relationships and ideas about the mutual creation of data.

Finally, this study does not set out to exclude male perspectives, as feminist research does not exclude men and male behaviour (Stanley and Wise, 1993). It focuses on women's experiences. Data collection is carried out in predominantly women-only settings and so male viewpoints are not prominent. Women's views on male partners' perspectives and experiences were discussed during data collection and these are represented in the findings where relevant. A deeper understanding of fathers' perspectives of long-term breastfed children would be interesting - adding to the body of knowledge about the contexts in which it takes place - but this is outside the scope of this research.

4.2.3 Assessing quality in qualitative research

The quality of research focuses on the demonstration of rigour in research practice. Davies and Dodd argue that criteria for assessing rigour in research must be:

...appropriate to the research and the type of research methods used...

(2002:280). Criteria traditionally used to assess quantitative research are not necessarily appropriate for assessing qualitative work (Rolfe, 2006). If a thoughtful and systematic approach is taken to the different stages of research, then:

...ethnography need not worry itself with narrow 'scientific' assessments of validity...

(Madden, 2010:24).

Rigour is:

...the means by which we demonstrate integrity and competence...

(Aroni *et al.*, 1999, cited in Tobin and Begley, 2004:390) and is closely linked with ethical conduct (Tobin and Begley, 2004). It is as important to consider rigour in qualitative as in quantitative research and there are well established, different methods available (Silverman, 2011). Some argue that by shifting attention away from reliability and validity in qualitative research, the focus has moved from research to readers' abilities to evaluate the quality of completed research (Morse *et al.*, 2002; Rolfe, 2006). I wish to demonstrate attention both to the quality of data **and** to the judgements that may be made about it.

There are a number of strategies for ensuring quality in qualitative research. Criteria suggested by Guba and Lincoln (1985) are often cited as appropriate although much debated in the literature. They developed the idea of 'trustworthiness' to replace quantitative concepts of reliability and validity (Morse *et al.*, 2002). Trustworthiness consists of credibility, transferability, dependability and confirmability (Guba and Lincoln, 1985). They also include transparency, having an audit trail, methods triangulation and member checking (showing transcripts to participants and having other researchers check coding) – but these are contested (Rolfe, 2006). Examples of how I demonstrate research trustworthiness are given in the following discussion.

I recognise the importance of demonstrating the quality of my work at all stages. The work of Miles and Huberman offers practical standards to answer the question:

...How will you, or anyone else, know whether the finally emerging findings are *good*?...

(1994:277). They suggest a structure based on Guba and Lincoln's - *confirmability, reliability/dependability/auditability, credibility/authenticity, transferability/fittingness and utilisation/application*. Although Miles and Huberman retain a focus on quantitative issues by using 'internal validity' alongside credibility and 'external validity' with transferability (1994:278-279), the basic framework is useful to structure considerations of quality and standards in my research.

Confirmability refers to how clearly and explicitly the conduct of research is explained, whether auditability is established through a 'decision trail' (Sandelowski, 1986), and the clarity about influences, personal biases or assumptions (Miles and Huberman, 1994). I show this through detailed explanation of decisions and processes, excerpts from field notes, my research journal, interview and observation transcripts and emails, and including relevant documents in Appendices. A date reference has been given for all quotes to source original documents if necessary. All data - audio files, documents, notes - have been retained and are available for reanalysis. Bias is addressed through reflexivity, an awareness of insider research issues and openness to be transparent at all stages with all people and about all processes.

Reliability and auditability is addressing the question:

...have things been done with reasonable care?...

(Miles and Huberman, 1994:278) and is evidenced through clear research questions, appropriate research design, methodical data collection, relationship to theory and evidence of peer review. These are demonstrated in this work through detailed examination of methods (this chapter), the relationship between the findings and literature (Chapters 2, 3 and 11), and analysis and subsequent discussion (Chapters 6 – 11). Peer review took place throughout, with data and findings discussed regularly with my supervision team, doctoral student peers and via conference presentations and publications throughout the PhD (see Appendices H and I).

Miles and Huberman refer to credibility and authenticity as the ‘truth value’ (1994:278) when considering whether research findings make sense. This is partly about the plausibility of the research account, and cogency between methods used and results obtained, and includes evidence of uncertainty, attempts to find negative cases and consideration of alternative explanations for findings. These are evident in this study through the story clarity, ‘thick’ description throughout (Geertz, 1973; Ponterotto, 2006) and coherent explanations of methods, analysis and findings. I have looked for and identified examples that do not fit with the other findings (negative cases) and am explicit when I consider alternative explanations (see Chapters 6-10).

Study transferability is the extent to which conclusions can be applied to other contexts (Miles and Huberman, 1994). Transferability can be assessed

by the sampling description, population and settings studied. Thick description is important for the reader to have enough information to have a good sense of the data and to see how findings might transfer. This is shown here through discussion of findings and identification of necessary and appropriate future work (see Chapter 12).

Finally, research application refers to how useful it is for the researchers, participants and potential users of findings. Miles and Huberman also discuss accessibility of findings and dissemination – I want to make my research findings accessible to a wide audience of breastfeeding women, professional and lay breastfeeding workers and educators. I also want to reach an academic audience of breastfeeding researchers and sociological or health-related researchers. I have presented my work at conferences for breastfeeding women, their supporters and academics (see Appendix H), and published papers and book chapters for different audiences (see Appendix I). Specific applications for practice and future research identified are discussed in Chapter 12.

4.2.4 Ethical considerations, including consent

Research ethics decisions are made at all stages of the process (Edwards and Mauthner, 2002), not just at the application point for ethical approval. I remained aware of research ethics issues throughout, considering it an on-going process. Research ethics approval was initially granted on 27th November 2007 (see Appendix A), later reconfirmed to carry out online

interviews. Consent forms were designed for use with each interview group (see Appendix B). The three methods generated different ethical considerations, especially gaining informed consent for participant observation; these are considered in general first and then separately below.

Other research ethics issues are also important. Pseudonyms are used to maintain confidentiality; participant and gatekeeper contact details stored in a password protected computer file and specific geographical locations are not named. Researchers cannot ensure complete anonymity (Murphy and Dingwall, 2001); some participants may identify themselves or each other in future writing from this research despite best efforts to protect individual identities.

Informed consent in qualitative research

Obtaining informed consent for research participation is now considered a fundamental tenet of good practice. In social research there are a number of professional codes of conduct (for example, the Association of Social Anthropologists of the UK and Commonwealth, 2011; and the British Sociological Association, 2002) and the emphasis is on the:

... 'moral' discourse of research ethics, concentrating on individual agency and the personal responsibility of the researcher for his/her relationship with participants and their well-being...

(Ashcroft, 2003, cited in Miller and Boulton, 2007:2203).

Three key principles underpin informed consent – people are competent to give consent, they have sufficient information for decision making and they

act under their own free will (Flick, 2009:41). These are associated with ideas of non-maleficence, beneficence, autonomy/self-determination and justice (Beauchamp *et al.*, 1982, quoted in Murphy and Dingwall, 2001:339). These principles of informed consent are inextricably linked with access to participants, management and storage of data, appropriateness of research methods, analysis and reporting of research outputs.

Gaining consent in qualitative research is different from other forms of research. Operating to ethical 'rules' agreed beforehand is often difficult and does not always resolve ethical dilemmas (Flick, 2009). Qualitative research projects evolve and information about potential risks may not be known at the outset (Byrne, 2001). Participants' understanding of risks involved may change as time passes and as their relationships with researchers develop. Qualitative interviews may result in participants revealing more than they intended or exploring areas not considered in the original agreement (Miller and Boulton 2007).

Consent in qualitative research may be seen as an on-going process rather than a single event (Corrigan, 2003), which suggests that the most appropriate point to request informed consent should be re-considered (Mattingly, 2005). It may not be clear when research takes place and there may be risk of involuntary disclosure or unwitting covert investigation, particularly with insider research (Byrne, 2001; Shaw, 2008). Gaining consent implies that researchers know the risks beforehand. There are also risks in the way qualitative research encourages pseudo-intimacy making

disengagement difficult and undermining genuine voluntary consent. As an insider researcher I was particularly aware of this and drew on feminist contributions to research ethics on researcher role, shared experiences with interviewees, and being both interviewer and resource (Im, 2010).

Consent about researchers' personal information is also an issue in qualitative research. Time is spent building relationships with participants, and personal information may be revealed without discussion about how it might be used by others (see online interviewing below). Technological developments mean that researchers' own privacy is harder to control, despite benefits such as increased ease for documenting consent giving (Miller and Boulton, 2007).

Consent: participant observation

Participant observation raises specific issues about gaining informed consent, particularly covert observation. Participants may not be able to give written consent before observation, or be given the opportunity to refuse to take part (Lee, 2000). Issues arise when studying vulnerable populations and where researchers need to be aware of exploitation risk (Mulhall, 2003). Even in overt observation it is difficult to obtain consent – contact is often protracted and those observed may not remain aware that they are subjects of research (Moore and Savage, 2002). In complex social situations it may also be difficult to ensure that everyone involved has the same information or knows exactly to what they are consenting.

Gaining research ethics approval to carry out participant observation can be problematic, particularly if a local Research Ethics Committee (REC) has a biomedical focus or is unused to this methodology (Moore and Savage, 2002). Participant observation in this work raised issues for the REC about gaining consent (see Appendix A). In the three local breastfeeding support groups, observation access was negotiated via the group co-ordinators; in one case I was already known to the group as a member and in each setting I was open about being a breastfeeding mother (Dowling, 2009b).

Each group had fluid membership which made gaining consent challenging if required from every group member on each occasion. This has been recognised in research in other social settings where participants come and go and gaining consent from each person is problematic (Mulhall, 2003; Moore and Savage, 2002). Gaining fully informed consent for participant observation in advance may not be feasible as researchers need to be responsive to field circumstances (Moore and Savage, 2002). Although researchers may be explicit about their intentions, this may be forgotten as time passes and they become known to participants (Hammersley and Atkinson, 2007). Having worked hard to build rapport and be accepted, it would be disruptive to continually remind participants of the research in order to seek consent (Miller and Bell, 2002). There may be cogent reasons for not giving participants full information at the outset. Researchers may not know all the consequences of participation when negotiating access. In some

projects, giving partial information is preferable to avoid influencing research results.

In my research ethics application I stated I was not seeking written consent from each group participant. Approval was not granted initially and I had to address this to gain approval (see Appendix A). To seek written consent from each participant would be detrimental to group dynamics and to my position as participant and researcher. I resolved this by using a number of strategies to regularly inform participants about my presence and offering opportunities to withdraw consent. Project details were circulated via an email newsletter (LLL), and paper copies were available at all three group meetings. This is a similar approach to other researchers' actions, though for some gaining written consent is an important aspect of on-going consent (see Moore and Savage, 2002).

Consent: online asynchronous interviews

There are specific ethical issues when using the internet in qualitative research (James and Busher, 2009) regarding data collection, gaining consent (a signature might not be possible) and data use. Risks to participants from other participants needs to be considered (particularly an issue in on-line focus groups or chat room research) as confidentiality and anonymity may be different; participants may not be who they say they are (for example, different gender or age). Distinct ethical issues arise about

observation online (particularly covert) and for confidentiality and privacy when using talk generated in on-line settings (Brownlow and O'Dell, 2002).

Despite the increased interest in qualitative research ethical issues and of internet based methods, formal guidelines to structure practice are absent (Mann and Stewart, 2000; Brownlow and O'Dell, 2002). However, literature is available which reports online qualitative research results and acts to guide good practice (Hine, 2005; James and Busher, 2009; Salmons, 2010). The same principles apply for gaining consent on-line as in other research. Differences include giving information about the use and storage of texts, how texts taken out of context will be used and how identities will be protected (James and Busher, 2009). Good ethical practice about informing potential participants on how data will be collected and used will support freely given informed consent.

Researchers must provide information about projects to obtain consent for online interviewing. This can be via email attachment or a website from which consent forms may be downloaded (Mann and Stewart 2000). One point of debate has been whether to gain a physical signature as indicator of consent (Mann and Stewart, 2000). This has sometimes been problematic for RECs who are unfamiliar with this medium (Meho, 2006). Salmons has addressed this by collating guidance for RECs/Institutional Review Boards (IRBs) based on case studies of internet based qualitative research (Salmons, 2011).

Online research participation provides opportunities for participants to deceive researchers through identity change or assuming multiple identities (James and Busher, 2009). Participant freedom to choose when they participate in asynchronous interviews may leave researchers unsure if consent has been withdrawn - in this study one regular participant did not respond for several weeks, despite reminders.

Internet research often uses online methods to recruit participants. This raises important issues about consent as a number of contacts (often emails) are usually made before consent is formally given and personal information may be exchanged before the project has properly begun. A well-designed research project should protect both participants and researcher from harm (Miller and Boulton, 2007) but researchers may not always consider what they are consenting to themselves when starting research relationships. The confidentiality of researchers' views or personal information may not be considered beforehand, giving rise to difficulties (Watts, 2006). In this study I revealed personal information in email contacts to a greater extent than in FTF interviews or during participant observation (Dowling, 2011c). I did not consider that this might be a problem and although the potential was there it did not cause difficulties. However, this is something I will consider carefully in future projects. Project information sheets were emailed as attachments to the four women recruited, and consent forms were posted to me by three and via email by one.

Consent: FTF interviews

Gaining consent for FTF interviews was more straightforward than for the other strands of data collection. Four of the women initiated contact by email or telephone after reading project information in the LLL newsletter or distributed at meetings. One FTF interviewee contacted me after talking to an online interviewee, the other was recruited following participant observation. All had read the participant information when we met for interview. Consent forms were signed before starting audio recording.

4.2.5 Subjectivity and bias

Subjectivity and bias are often discussed in relation to ethnography and interviewing (Hammersley and Atkinson, 2007; May, 2011), and are inter-related but distinct concepts. Subjectivity refers to the way the interviewer (or informant/interviewee) draws from their identity and social experience. Bias refers to researcher influence on the account produced from interviews (or other data collection methods), including ways that the data may be selected to fit expectations.

People's accounts of experiences are by their nature subjective; this is important for naturalism (although debated) but problematic for positivism (Hammersley and Atkinson, 2007). Subjectivity is often discussed in relation to researchers and accounts. Informants' accounts are based in their subjective experience but are a product of relationships with researchers (who have their own experiences). This inter-subjectivity is important as the

subjective experiences of interviewers and informants influence final accounts. Accounts produced in this way are still valid, there is no reason:

...to deny (or for that matter to affirm) the validity of accounts on the grounds that they are subjective...

(Hammersley and Atkinson, 2007:98). Bias and subjectivity are related: through their subjective experiences interviewers affect what happens in interviews and on data production.

Some qualitative researchers consider it important that researchers remain detached, minimising the influence of their subjectivity (and relationship) on interviews and traditionally favour non-directive interviewing. Interviewers were taught to avoid answering interviewees' questions to minimise bias (Oakley, 1981). For many (particularly feminist researchers) the importance of reflexivity in qualitative research means that subjectivity is essential. To consider otherwise would be to:

...strip 'ourselves' from descriptions, or describe our involvements in particular kinds of ways – as somehow 'removed' rather than full-blown members of the events and processes we describe...

(Stanley and Wise, 1993:155). Maintaining reflexivity through field notes production/processing and supervision may be more productive than trying to minimise researcher effect on data collection (Hammersley and Atkinson, 2007). I was aware of the project's bias potential but reassured by the literature which suggests that bias is inevitable but not necessarily problematic, that:

...ethnographic accounts will always be selective reproductions, influenced by the researcher's own bias...

(Ward, 1999:3). This may account, however, for my discomfort in some interviews and observations.

It is not easy to balance using one's own subjective experience and being aware/critical of assumptions that might be made. I drew on my own identity and experience to gain access to participant settings and interviewees, and to establish rapport. After interviewing Tina I noted:

...It would be impossible to be objective!..

(Interview with Tina, field notes; 5th July 2007). I was struck by the way she used words that I use to describe my experience and wrote:

...could have been my words at times...

I was aware I needed to critique the effect my experience and strongly held views might have on my interpretation of accounts given and observations made. There is a difference between:

...'when we are experiencing things as a researcher' and 'when we are experiencing them as a person'...

(Stanley and Wise, 1993:156). Initially it was hard to draw on my subjectivity and also maintain criticism of my assumptions during an interview. In time, reflecting on interviews and observations became easier. Insights gained this way are productive for analysis and future interviews (Hammersley and Atkinson, 2007).

Researcher bias and prejudice can affect interviews in many ways.

Researchers may make assumptions about others' behaviour based on their own experiences (particularly important if the experiences are similar). I wanted to present long-term breastfeeding positively but did not want to

minimise the difficulties or hard work involved. I was aware I wanted my informants to demonstrate this. Although interviewees voiced many of my views the interviews could be emotionally difficult for me if different views were expressed. This was sometimes an issue in observations and is discussed further in Chapter 6.

Other issues include key informant bias – using atypical informants – and over-rapport (particular where informants are known to interviewers). I sought women from different areas and organisations to get diverse experiences and opinions hoping to mitigate against key informant bias.

During interviews I was very aware of over-rapport as outlined by

Hammersley and Atkinson:

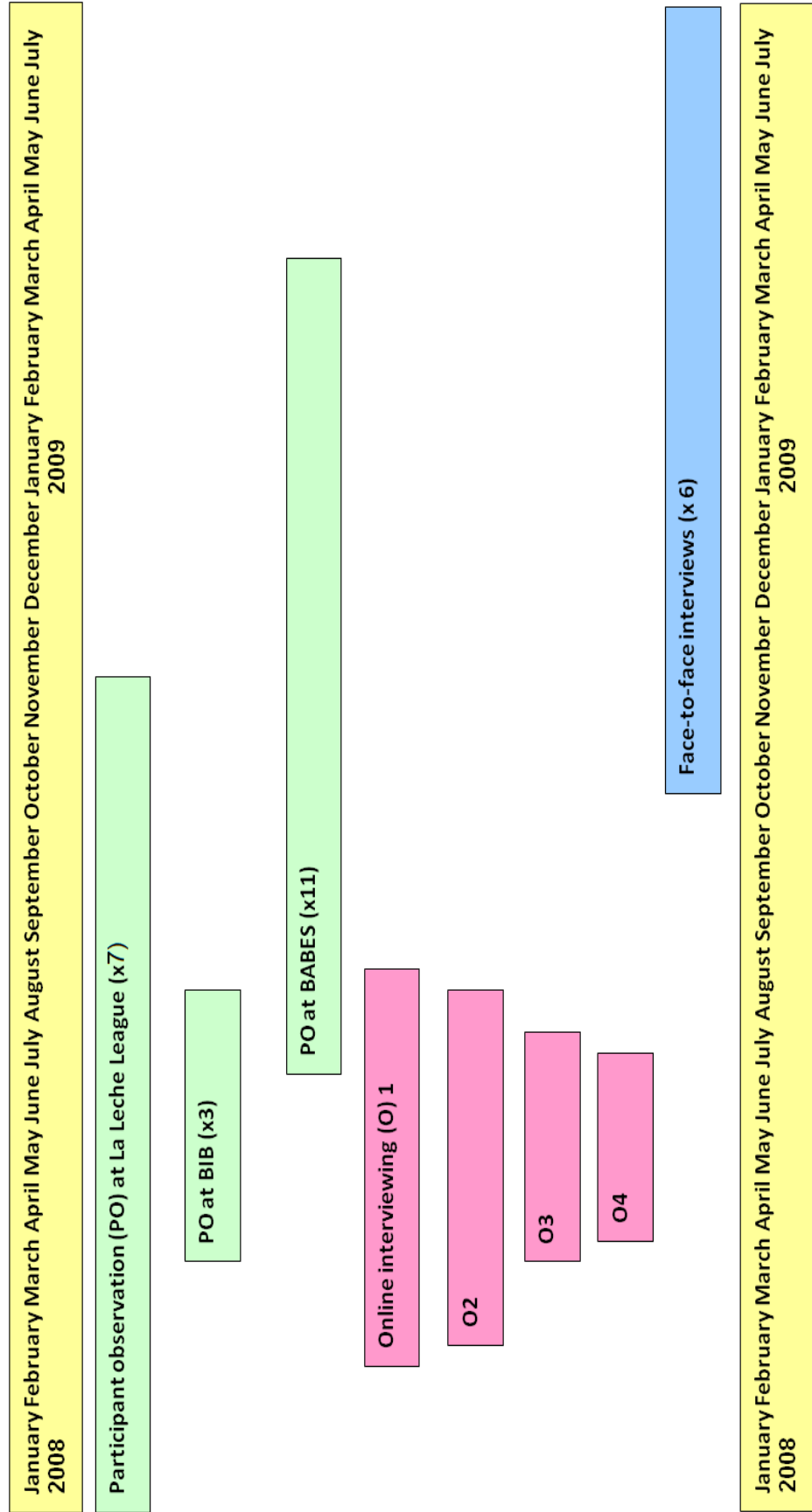
...a particular problem was the tendency of respondents to invite her to draw on her background knowledge rather than spelling out what they were saying...

(2007:118); this was coupled with an on-going awareness of the need for analytical distance. There were multiple contact points between myself and research participants. For example, 'Tina' mentioned a breastfeeding counsellor who had helped both of us, but only used her first name knowing I knew her. She also made comments about knowledge I had about her, such as:

...at that time I had a *superb* midwife, as you know...

(Tina, interview; 5th July 2007). Further discussion on the challenges and possible disadvantages of insider research is given in the following chapter (Chapter 5).

Figure 4: Timeline showing different elements of data collection, January 2008 – April 2009



4.3 Methods used in data collection

4.3.1 Overview and timeline

[See timeline during the following discussion sections].

Issues relating to participant observation in breastfeeding support groups, FTF and online asynchronous interviews with breastfeeding women are examined here. The rationale for using the methods and their inter-relationship and overall research contribution is presented.

My relationships with research participants differed: sometimes we had contact in multiple settings during the different data collection elements and in other parts of my life. This was further complicated because some women in LLL meetings, online interviews and FTF interviews referred to each other and other people I knew from elsewhere. This illustrates the complicated nature of insider research and associated complex research relationships (May, 2011), and emphasises the need for researcher openness and honesty through reflection (Hammersley and Atkinson, 2007).

Complementarity of methods (relationship to each other and to the data produced)

The three data collection methods complemented each other, generating a large amount of rich data about women's long-term breastfeeding experiences. Participant observation helped me understand more about how women support each other when long-term breastfeeding. Online

interviewing allowed in-depth exploration of women's experiences and helped me reflect on my experiences of the issues raised. FTF interviews explored similar issues with less focus on my experiences, helping participants reflect on their breastfeeding in a different way from support groups. Using three methods allowed for triangulation (Flick, 2009; Denzin and Lincoln, 2008) and increased the richness and variety of data.

Participant observation was the first data collection strand, lasting fourteen months (see timeline). During this time all online interviews and most FTF interviews took place. There was no overlap between online interviews and FTF interviews. Issues from early observations were discussed with women interviewed online and online interview themes and observations informed FTF interviews. This iteration became clearer as transcribing, early data analysis and later observations influenced the subsequent interviews.

I also generated data through the writing of research journals and field notes which supported reflection (Hammersley and Atkinson, 2007; Flick, 2009). Observations and interviews took place until I was satisfied that I was not observing, listening to or being told anything significantly new or different, known as data saturation (Creswell, 2007), staying alert for negative/deviant cases for data verification.

All the data collection methods made a valuable contribution to meeting the research aims and objectives and there were interesting and unexpected results. The fullest and richest data were generated using online interviews,

which differs from other researchers' experience (Mann and Stewart, 2000). The prolonged contact possibly helped explore issues differently because we could return to them over a period of time and because a relationship was developed with each woman. Women interviewed online were more negative or critical, perhaps more reflective, when talking about their breastfeeding experiences than those interviewed FTF.

Since completing field work I have reflected on differences between online and FTF methods and the data produced and have noted specific issues (Dowling, 2011c). The differences between them were partly due to inexperience. Each FTF interview happened once only and in retrospect additional interviews to clarify/further explore issues would be useful. Some women had talked about their experience in other settings (support groups) and a single interview was considered sufficient, though with hindsight this was probably not long enough. The online interviews took place over a protracted time period and I was able to refine my practice. Some exchanges with this group felt close to friendship because of our similar lives and the repeated contact.

A final point about the difference between these two methods and data collection relates to quality and content. Exploring breastfeeding experiences requires women to think and talk about their bodies and bodily actions but the fullest, most interesting data was obtained using disembodied email. Interviewing FTF requires body use to put interviewees at ease and non-verbal language/social cues create useful information exchange (Flick, 2009;

Hesse-Biber, 2007). Online interviews use texts to create and maintain situations where people feel comfortable in disclosing details of their lives. I found that I made most use of information about my body and my life as a breastfeeding woman using a medium where my physical body was absent from the exchange. The women interviewed using text-based communication explored issues about their bodies, the milk in their bodies and associated relationships with others in private and in public. They did this to a greater extent than FTF participants, confirming that it is a good medium for carrying out sensitive research (Mann and Stewart, 2000).

4.3.2 Participant observation

Participant observation as a method

Participant observation is the 'classic' ethnographic method (Delamont, 2004) with roots in nineteenth century anthropology; now one of many methods used by qualitative researchers (Sánchez-Janowski, 2002). It originally described researcher immersion in the culture under study, 'in the field', to develop deep understandings of how people experience their lives. The term is often used more widely (Hammersley, 2006), with participant observation, ethnography and fieldwork often used interchangeably (Delamont, 2004).

Sánchez-Janowski distinguishes between '*research that utilises participant observation methodology*' and '*ethnography*' (2002:144). As discussed earlier in this chapter I view my work as belonging to the ethnographic tradition, using participant observation as a tool used alongside other

qualitative methods, to deepen understanding of breastfeeding women's experience. Denzin describes the breadth of the approach:

...a field strategy that simultaneously combines document analysis, interviewing of respondents and informants, direct participation and observation, and introspection...

(1989:157-158, quoted in Flick, 2009:226) which I have found useful. Being an observer while balancing the need to gain an insider perspective but simultaneously retaining an external one is a key difficulty of participant observation (Flick, 2009; Hammersley and Atkinson, 2007) and I reflected on this throughout my observations (see Chapters 5 and 6). Creswell (2007) suggests that a pre-requisite for observation is being an outsider but this is not a consensus view. Important contributions have been made by feminist insider researchers (Taylor, 2011). Participant observation in a group where you are known adds additional layers of insight and interpretation, but also the potential for bias (Labaree, 2002).

Junker and Gold delineate the roles of '*complete participant*', '*participant-as-observer*', '*observer-as-participant*' and '*complete observer*' (1960 and 1958, cited in Hammersley and Atkinson, 2007:82). In my field notes I acknowledge finding it hard to know how to behave because at different times and in different groups my role was 'participant-as-observer' and 'observer-as-participant'.

Participant observation in this project

Spending time with women where they felt comfortable talking about their experiences of breastfeeding was an important way to increase my

understanding of their experiences. Breastfeeding support groups give women space and time to talk about what is happening to them in a safe, non-judgmental setting. Groups take different forms including those that are predominantly peer-led or health professional facilitated (NHS, third sector or joint arrangement). My intention was to be a part of the group and always be open that I was a breastfeeding mother, to listen to and observe women, and to think about their discussion topics, the way they talked about them and how they behaved with each other.

Participant observation took part in three different groups from January 2008 to March 2009, overlapping with FTF and online interviews. Through fieldwork I had contact with over eighty women who breastfed newborns to four year olds. Participants included women in lesbian and heterosexual relationships and women parenting alone. Their age ranged from early twenties to late forties and included first-time, experienced, pregnant and tandem breastfeeders. There are key differences between the three fieldwork groups, discussed further in Chapter 6. My original intention was to carry out fieldwork in LLL meetings because I knew I would meet long-term breastfeeders there. Accessing other groups added to the richness of the final data set. Through other groups I met younger women, more women parenting alone or combining breastfeeding with paid work, and breastfeeding without partner/wider family support. I also met women long-term breastfeeding in low breastfeeding areas.

Before starting this study I was a member of LLL and attended many local meetings when pregnant with my third child (see Chapter 1). When fieldwork started I was an infrequent attendee, my youngest was still breastfeeding and I had returned to work. During field work I met women at LLL meetings that I had met previously in other settings (such as the local home birth support group) or that I knew personally as friends. I interviewed three women from LLL meetings FTF (although one only attended once during fieldwork). I met one woman in all three groups on several occasions, and one other woman once at both the other groups (BIB and Babes).

Access

LLL seemed a good place to start participant observation in breastfeeding support groups as my previous attendance and the literature suggested the likelihood of meeting women breastfeeding for longer than six months was high. Access seemed relatively straightforward. Recent changes combining toddler and baby meetings meant that long-term breastfeeding women might not attend every meeting. This was also the case in the other breastfeeding groups, and seemed less important as time went on.

Negotiating access to research settings can present difficulties (Hammersley and Atkinson, 2007) but in this project there were no problems. Access was obtained quickly and easily, facilitated by my knowledge of, and connections with, the local LLL group. I was known to four of the five local Leaders who acted as gatekeepers and sponsors (Hammersley and Atkinson, 2007) and

negotiated access to meetings (see Appendix C). I emailed them in December 2007, outlining my study and asking permission to observe local meetings. I wrote to the local group via their e-letter so that members had the opportunity to see it in advance of fieldwork. As non-members would not see it, participant information sheets were available at all meetings (see Appendix B - information sheets and consent forms; Appendix C - copies of letters to/from LLL Leaders).

Access to this first observation setting was made easier by my existing relationship with the group. Personal networks may positively and negatively influence data quality (Hammersley and Atkinson 2007). Problems may arise when theoretical positions could alienate gatekeepers or participants. Hey writes about the hostility she experienced as a feminist researcher (Hey, 2002). I approached my observations with an interest in feminist research methods as well as a growing knowledge about feminist critiques of breastfeeding, and of LLL. Some LLL members might interpret a feminist viewpoint as unsympathetic because LLL has been seen as an anti-feminist organisation (see Blum, 1999). From my previous local group knowledge I anticipated meeting women with a range of opinions.

Gatekeepers may have concerns about how the organisation will be presented when considering granting access and will want to be shown favourably (Hammersley and Atkinson, 2007). Many researchers have experienced access problems arising from gatekeeper expectations and suspicions. My personal breastfeeding biography enabled me to 'fit in' at LLL

meetings, gain trust and be seen as a person with honourable motives (Hammersley and Atkinson, 2007). I was aware from the outset I needed to be open and reflexive about my group role and the research, and to vigilantly maintain good research relationships.

There are also difficulties negotiating access when gatekeepers are sponsors too, influencing the range of opinions accessible via FTF interviews (Creswell, 2007). I thought LLL Leaders may act as sponsors. Although I planned to recruit women myself, the Leaders could introduce me to others, either because they thought they would be interesting interviewees but also for a particular view/type of experience to be put forward. It transpired that interviewees were recruited via information given to LLL members, or by snowballing. I was concerned I might feel obligated to present LLL in a particular way due to my existing connection and gratitude for allowing me fieldwork access. I tried to be aware of the potential for this. In one poorly attended meeting the Leader expressed concern about the material I needed:

...The topic... was 'Siblings...' ...Jenny stuck to the usual format even though there were so few of us. I recorded the meeting as usual – it was interesting that Jenny commented on how she wished she'd been better prepared as I was recording – I think if there had been more of us present she wouldn't have done this...'

(LLL observation, field notes; 10th October 2008).

Access to other groups came through meeting 'Fran' at an LLL meeting, shortly after starting fieldwork. Fran became a key informant as well as gatekeeper for the other groups because she attended other breastfeeding support groups as a peer supporter. These groups were in socio-

economically deprived areas of the city and were supported by ABM trained breastfeeding counsellors. Through Fran I negotiated attendance at two groups (BIB and Babes) and observed three meetings of one and eleven of the other over a twelve month period (see timeline) in order to broaden contact with breastfeeding women. My relationship with Fran both facilitated access and, at times, made me feel ill at ease within these other groups. This illustrates the way maintaining gatekeeper/key informant relationships can be a complicated factor when researching.

Leaving the field

Leaving the field when data collection is finished can be difficult, especially when successful relationships exist with participants (Hammersley and Atkinson, 2007). Although relatively straightforward, it was different in each group. Six of the seven LLL observations took place from January to July 2008. The last was October 2008. Before the summer break I contemplated stopping fieldwork because changes had happened in the group and data saturation had probably occurred. The October meeting was different from others – of the few women there, two were LLL leaders and two were long-term breastfeeders I knew (I had interviewed one). After this meeting I decided to stop fieldwork. I emailed the leaders to let them know and thank them, and said I would keep in touch. I went to one other meeting several months later at the request of a friend. I tried to be clear with myself, and with women at the meeting who knew me, that I was there as a breastfeeding mother and not as a researcher. It was difficult and I decided not to go to any

more meetings while still working on this study. I only attended three meetings of BIB, leaving because attending Babes was more straightforward and it introduced me to a similar range of women. Babes was the hardest of all the groups to leave. I stopped fieldwork when data saturation was reached.

4.3.3 Online interviewing

During the project I referred to this data collection method as 'email correspondence' and, as my knowledge and thinking developed, as 'online asynchronous interviews'. I corresponded with these participants using an open-ended asynchronous interview via email. These issues, and my developing thinking, have been explored in publications and in conference presentations (Dowling, 2009a, 2009b, 2011b, 2011c); the main points are outlined below.

Using the internet in social and healthcare research

The rapid rise in personal computer use and recognition of their potential for research has increased the use of the internet for conducting focus groups, administering questionnaires (particularly to large samples), participant observation in chat rooms, analysing email discussion groups and interviewing (Mann and Stewart, 2000). It is particularly useful for investigating sensitive issues with hard to reach groups (Brownlow and O'Dell, 2002), where the sample is hard to access, or because the subject matter is internet-related (Kivits, 2005; Kanayama, 2003). Topics include

internet support groups for breast cancer (Eysenbach and Till, 2001), using the internet for healthcare information (Kivits, 2005; Kivits 2006), living with chronic illness (Kralik *et al.*, 2006) and exploring gay men's use of the internet to seek sex (Davis *et al.*, 2004). Recent developments include new web technologies such as Skype, VOIP technology, videophones, Web 2.0 and mobile technologies, social networking sites and 'Second Life' (Salmons, 2011). Increasingly the internet is used in ethnographic research by anthropologists, sociologists and other social researchers, using a range of methods as identified above (see Hine, 2005, and Kozinets, 2010, for further discussion).

Using online interviews; using correspondence

Interviews are widely used in internet research, either synchronous (interview takes place in real time) or asynchronous (usually using email). In asynchronous interviews, interviewers and interviewees may be physically and temporally distant. In most early work on internet use in qualitative research little is written about asynchronous online interviewing; it is discussed alongside other methods of computer mediated communication (CMC) such as focus groups, online surveys or participant observation in virtual communities (Kanayama, 2003; Meho, 2006). Correspondence has rarely been used in qualitative research. I came to it by chance on reading Kralik *et al.*'s work (2000) when I wanted to keep in touch with some potential interviewees while I began fieldwork. My desire to 'get going' on collecting data in January 2008 was tempered by a realistic understanding of the

amount of work that would be generated. A number of women had come forward offering to be interviewed in response to my letter to the local LLL group (see Appendix C) and I was concerned about generating too much work by interviewing and observing simultaneously. Asking some women to write to me about their experiences gave me a chance to get to know them before FTF interviewing. The experience was positive and I decided to correspond via email rather than interview FTF. I mistakenly thought it would be time-saving and corresponded with four women for between three and six months (see timeline). Our communication was valuable in itself and was not followed by FTF interviews. Later I reframed this as a form of unstructured interviewing.

I was influenced initially by Kralik *et al.*'s work (2000) as it gave valuable insights into using correspondence and a set of principles from which to work. Kivits' work (2005; 2006) is also useful as she demonstrates the value of using email for in-depth interviewing. I found little other work on correspondence but found others using email for interviewing (for example, Curasi, 2001; Kanayama, 2003; Meho, 2006; James and Busher, 2006; James, 2007) or using letters in their research (James and Owens, 2005), albeit in a very limited way. During the project, publications on internet research increased rapidly (for example, Hine, 2005; James and Busher, 2009; Salmons, 2010; Salmons, 2011) and internet use for qualitative interviewing became visible.

I became interested in whether there was a difference between 'correspondence' and 'interviewing'. Kralik *et al.*'s description of 'corresponding' with 80 women over a year and Kivits' in-depth 'interviewing' with 31 people for a similar time contain similarities of approach and process. During my data collection I noticed some differences - I wanted to 'correspond' with my participants about our shared experience to create a narrative, a:

...critical reflective conversation...

(Kralik *et al.*, 2000:911), different from interviewing. Building on others' online interviewing experience, the distinction is less important to me now than at the time (I reflected on this in conference presentations shortly after completing this aspect of data collection – see Appendix H). Kralik *et al.* point out that correspondence is not asking people to keep diaries – a response is expected. I knew I was entering into a relationship where I would respond to what was said and expected a response in return, and so on. My respondents did not always see it the same way as me, or each other, and this caused some difficulties. The method has underpinning ideas influenced by feminism – about sharing, disclosure, collaboration and reciprocity (Letherby, 2004; Kralik *et al.*, 2000) - crucial aspects of how I want to work and behave as a researcher.

Sampling and recruitment

Four women were recruited for online interviews by purposive sampling and snowballing. Three responded to the LLL letter and approached me. One

passed on information to a friend who then contacted me to be involved (see Appendix D for information about participants). These women are different from other participants (particularly women at Babes and BIB groups) but as far as we know from the little research in this area they are not atypical of long-term breastfeeders and their experiences add richness to the data. None of these women were known personally to me. One of them had never been an LLL attendee, the other three had various degrees of contact with LLL but none were currently attending meetings.

Methods

Each woman was sent an introductory email (see Appendix E); when they replied I responded. This happened at a different pace and in a slightly different way for each woman – ‘Sarah’ wrote very frequently at first, whereas ‘Judith’ was slower. Other researchers started contact very slowly, building the relationship over time (Kivits, 2005; 2006) or sent photos of themselves to build trust and rapport (Kralik *et al.*, 2000). I did not send photos but gave information about myself and my breastfeeding experience to build rapport.

Before interviewing started I constructed a set of guiding key principles (adapted from Kralik *et al.*, 2000). I wanted to correspond promptly, or give a reason if I was unable to do so. This meant I told women when I was ill, going on holiday or if there was another reason why correspondence would be delayed. I sent short emails, thanking them for theirs and letting them know I would reply fully at a later date, giving some idea of when this might

be. Responses were thoughtful and respectful as well as prompt. I thought about how to gain trust and how to use information about myself.

I consider my responses to be data and analysed my emails to the women as well as theirs to me. My aim was to keep my responses personal – although I sometimes asked each woman similar questions when I wanted to know something from all of them, I contextualised it within our correspondence. From the outset, I also thought about how the correspondence would end. With two women, it came to a natural conclusion; with the other two I ended it before taking an extended summer break. I gave them plenty of notice of my intention, asking permission to re-contact them if I needed to follow anything up (one woman was re-contacted, once).

Some women responded to contact promptly, others took longer. Some saw it as correspondence as I originally intended, others responded as if in an interview, answering questions but giving little else, waiting for further questions. One woman, who had recently stopped breastfeeding her sixteen-month old daughter found it hard to participate and our correspondence was sporadic and short:

...I'm sorry it has taken so long to reply about your research. I really do want to do it, I've just been tired with this pregnancy and to be honest I keep forgetting about it...

(Judith, email; 1st March, 2008).

Each email was copied into a Word document and pseudonyms given to all people mentioned; the key was kept in a password protected file. There are

about sixty emails and they have been imported into NVivo along with the other data.

Advantages of asynchronous online interviewing by email

Many of the advantages of using email identified in the literature were also apparent to me. My correspondents came from a narrow geographical area but could have been from anywhere in the world. For most people email is an unobtrusive friendly medium, and for some may be less stressful than FTF interviews (Bampton and Cowton, 2002). Response can be almost instantaneous but women can also take time to respond, allowing reflection on experiences within and between emails (Kanayama, 2003). All participants talked about being able to stop and start communication to fit in with their lives:

...I'm not sure how far I will get. Janie is sick yet again and is tossing about a bit in sleep. I might have to run off...

(Sarah, email; 6th February 2008);

...I am starting this email at 10 at night, while waiting for John to get to a point in his computer game that he can leave and go to bed. So I will probably finish it tomorrow (note, it is now the day after tomorrow)...

(Christine, email; 12th March 2008). Asynchronous interviewing is particularly suited to reflexive, qualitative practice (Kivits 2005), and supports rigour by allowing researchers to return to fully explore issues (James and Busher, 2006).

Working like this supports rich data collection on sensitive issues or with hard to reach groups (James and Busher, 2009). It is on-going and dynamic and

a product of the relationship between the people involved. Data processing can be cheaper and less time-consuming as there is no transcription but I found it very time consuming when emails reached a peak of frequency.

This data was part of an iterative data collection process where each data collection method contributed to the others. I was observing at the same time and issues raised were used in some online interviews. For example women in LLL discussed feeling tied to their babies/children through breastfeeding and I asked my online interviewees about their feelings and experiences of this. Similarly I reflected on comments from online interviewees about home education and breastfeeding with other, FTF, interviewees.

Some participants reflected on what was happening and how they felt about it during the process:

...I enjoyed reading about your experiences...

...I'm rather enjoying this. I haven't reflected that much on what has brought us to this place...

(emails from Sarah, 14th and 27th February 2008). When I concluded the online interviewing I asked each participant what the experience had been like for them. All were positive, identifying a number of important issues:

...I think this is an excellent way to get information about a woman's breastfeeding experience. It has helped me that I don't know you...I probably would have edited myself if I have known you. I have been very open and it strikes me that you know more about my breastfeeding experience and how I have felt about it than any other person!...

(Sarah, email; 29th July 2008);

...thank you for the conversation! It has clarified quite a lot of my thoughts about breastfeeding....I suppose it has also made me increasingly aware of my

responsibility, as a long term breastfeeder, for making that possibility open to other women. Not by preaching at them, but just by example and openness...

(Jess, email; 11th June 2008).

Disadvantages of online interviewing

Unlike FTF interviews or synchronous CMC, there is a lack of spontaneity. No cues are available from body language or voice tone. I expressed myself carefully to avoid misunderstanding and clarified with correspondents any doubt about meaning. It excludes people without or who are uncomfortable using computers, although this is becoming less of an issue (Mann and Stewart, 2000). Participants must also have a reasonable level of literacy. Anonymity may be an issue; participants can choose to be truly anonymous by their choice of email address. Other issues include adapting to respondents' communication style: although mine did not use emoticons to compensate for absent conversational cues, I would review my use of them if any had.

Respondent response time may be an issue from the researcher's position as it can take hours or days; researchers may have to manage anxiety when responses take longer than usual. I found it hard, when a prompt responder suddenly took a long time to reply. I worried I had upset her or she was withdrawing from the project. I learnt to wait although my urge was to dash off an email asking what was wrong. Sometimes I sent short emails saying that I would like to hear from the woman when she had time. Kivits has described using email interviews as an:

...unusual, even sometimes troubling, research relationship...

(2005:35); this was at times also my experience.

The openness of some of my correspondents made me wonder whether emails were being used as 'therapy', whether this was appropriate and if I was responding appropriately. Because of my mental health nursing and counselling background I had to remind myself of my researcher role. Some participants defined the process as therapeutic:

...I started out being open because I wanted you to have the information and data you would need and then I think it took a turn as I started working through my breastfeeding relationship...This whole process has been interesting for me. We started our correspondence at a time when I was reaching breaking point and felt that something had to change. Writing about my experience was quite therapeutic...

(Sarah, email; 29th July 2008). For others it was too big a commitment:

... so sorry that I haven't replied earlier...I really am very interested in your research, I just don't have much energy in the evenings to reply (if I think of it I say to myself "I'll do it tomorrow")...

(Judith, email; 15th May 2008).

Sometimes technical problems interrupted the communication flow, frustrating the corresponding women and me:

...Sorry this has taken so long. And it has taken even longer because I accidentally erased my first reply! Or so I thought! After typing it up a second time the first one magically reappeared!...

(Christine, email; 30th March 2008). And:

...I'm finally getting round to doing this! It's a shame I lost the other email because I was in a much more positive frame of mind...

(Sarah, email; 2nd July 2008).

Online interviewing in this project

Asynchronous online interviewing took place with four women over six months for different lengths of time with each woman (see timeline above). These women were similar to the typical profile of LLL members (two had some previous contact with LLL before the fieldwork period, and one trained as a LLL leader); their recruitment is discussed further below. Three of the women were unknown to me, and I met one very briefly once before although we had not spoken. The four women were very different compared to the Babes and BIB groups attendees, being highly educated (all were graduates, three had doctorates, and two were in paid work), older (mean age forty, range 35-47) and very articulate. Three were North American and some discussions were about cultural differences they had observed in relation to breastfeeding.

They had four children between them; one was pregnant at the start and one by the end. Their children ranged from 16 months to 11 years and were breastfed for fourteen months to six-and-a-half years (two were still breastfeeding). During fieldwork, I was breastfeeding my three/four year old daughter. I was closer in age to these women than to those interviewed FTF. This strand of data collection includes more information about, and reflection on, my own breastfeeding experience partly because my interaction with the four women was an on-going shared narrative and less of an interviewer-interviewee relationship.

4.3.4 Face-to-face interviews

The use of interviews in qualitative research

In-depth interviewing is a classic qualitative and ethnographic method (Hammersley and Atkinson, 2007). Interviews are considered to enable researchers to:

..elicit authentic accounts of subjective experience...

(Silverman, 2004:125). Qualitative interviewing has developed over time. Originally seen as objective and scientific, assumptions were made about roles and power (Letherby, 2003). Oakley (1981) was influential in raising issues of power in research relationships and considering interviews as generating reciprocal data. Interviews are associated with feminist research, with feminist interviews often considered as 'conversations', shaped by interviewers and interviewees (Heyl, 2001). Some, however, critique the assumption that they are the 'best' method for feminist inquiry (Letherby, 2004). A number of principles were important to me as all interviews took place in participants' homes - being respectful, mindful of time-keeping and being responsive to individual circumstances (Creswell, 2007).

Face-to-face interviews in this project

FTF interviews occurred with six individual women. Four women lived in my home city, one in a nearby town and one in a neighbouring city. Women were recruited in various ways as they contacted me or I met them as the research progressed (through LLL or Babes). They had breastfed eleven

children between eighteen months and four-and-a-half years and had experience of breastfeeding while pregnant and tandem feeding. Many references were made during interviews to people I had met either in LLL, or Babes meetings or elsewhere (for example, having the same independent midwife).

One woman was interviewed before the main fieldwork period (July 2007) as part of an Open University Ethnography course and was treated as a pilot for the PhD. The data was useful and following discussion with my supervisors I re-contacted this woman and secured consent to include her interview in my data set. On the timeline this interview is shown alongside the others as this is when consent was gained for inclusion.

Access, recruitment and sampling

The six FTF interviewees were recruited using purposive and snowball sampling. My initial e-newsletter contact with LLL attendees resulted in five direct contacts (I interviewed two FTF and three online). Two others were approached after LLL fieldwork was established and one at Babes. The sixth interviewee was introduced to me by an online interviewee. Although, as noted, we had many common contacts, I did not rely on these to recruit participants.

Three out of six participants were graduates and only one was in paid work. They were younger than online interviewees with a mean age of 33 (range 27-42).

The process

All FTF interviews took place in interviewees' homes. These interviews were often challenging: four took place with other people present – babies, children, mothers and sisters. They were noisy; I was frequently distracted and often very tired which affected my concentration and the interview quality. I worked hard to maintain the interaction and remain focused. Interviews lasted for between 50 and 70 minutes, all were digitally recorded and transcribed in full as Word documents and imported into NVivo. With five of the women I had email contact before we met to set up meetings and to tell me a little about their breastfeeding experience. Usually the interview format was a conversation, using a topic guide, about the woman's breastfeeding experience; I explored areas of interest as they arose.

All the FTF interviewees knew I was also breastfeeding, and when appropriate I talked about my experiences. Reflecting on this afterwards I was surprised I found this difficult and that I did not exchange as much personal information with them as the online interviewees (Dowling, 2011c). Each participant was interviewed only once as I had heard a number talk about their breastfeeding experience in support groups. On reflection, it might have been advantageous to talk to some women again. Although

similar issues were addressed by FTF interviewees as online interviewees, greater depth and exploration was possible with the latter.

4.4 Methods used in data analysis

Analysis in qualitative research is not a one-off process, carried out after data collection is complete (Richards, 2009). Data collection, analysis and interpretation often take place alongside each other (Creswell, 2007).

Qualitative data analysis is considered a demanding aspect of the research process (Miles, 1979, cited in Basit, 2003). The idea of analysis as an iterative process and the notion that many research activities are also elements of analysis were useful (Creswell, 2007). However, analysis takes on another form once data collection is complete and the data set is viewed as a whole.

The three data methods and the reflective materials added along the way produced a large amount of material. LLL meetings were digitally recorded and all but one partially transcribed. Notes were made immediately after all BIB meetings and then word processed. The same technique was initially used for Babes meetings but I then decided to dictate my notes into a voice recorder as I travelled home and transcribed the recording later. This is a freer method which enabled me to remember and reflect on events. Dictation also helped me to make analytical links between these and other data, immediately after the event. Participants who came regularly to meetings were given pseudonyms; others were referred to as 'Woman A', 'Woman B' and so on, and where possible, ages and sexes of babies and children were recorded alongside details about their mother's contributions. All FTF interviews were digitally recorded and transcribed in full. All emails, including

my own, were copied into Word documents. All names were changed. A password protected data key was kept separately with details of all pseudonyms and real names, across the data set.

All documents were imported into NVivo (initially NVivo 7 then later, NVivo 8). In addition some emails and other documents sent to me by interviewees were also imported. One correspondent sent me a letter she had written to a friend, another sent copies of pieces she had written for newsletters and other information she thought might be useful. Paper copies of all documents were kept. Once imported, folders were set up in order to manage the data collection strands separately: sub-folders for each correspondent, interviewee and observation were created. A total of 96 separate documents were imported into NVivo.

There were a number of reasons why I chose to use a Computer Assisted Qualitative Data Analysis Software (CAQDAS) package like NVivo. Qualitative researchers use whichever techniques best suit their approach and project. Regardless of approach, whether more 'traditional' methods are used, a CAQDAS approach or a mixture of the two, data analysis is time consuming, and involves careful thought and deliberation. Claims for CAQDAS superiority centre on its sorting and search functionality, allowing researchers to search across complex data sets to find similar instances, combinations or patterns (Richards, 2009). One disadvantage is that it forces researchers to think of data in hierarchies (Bazeley, 2007).

NVivo was used to manage my data, store and retrieve it straightforwardly, which was useful when writing up findings. It assisted with coding and identification of themes at a fairly basic level. I took a broad thematic approach to analysis (Braun and Clarke, 2006), interrogating data to identify common responses. Analysis involved a number of stages. All documents were read and a first stage of coding applied. Sections of text were identified and a code applied to noteworthy sections about women's experiences, or in relation to research questions. This generated 182 codes, some of which were similar to each other. Stage 2 involved re-viewing coding and merging similar ones.

Stage 3 involved creating broader codes in which to group first level codes. Examples included 'influences on breastfeeding and decision to breastfeed', 'breastfeeding as a way of life' and 'tensions and conflicts'. This stage created 27 higher codes, from which themes emerged. Many interesting themes were identified but peripheral ones were discarded in favour of those addressing the research questions.

Finally, four main themes were identified – 'Deciding', 'Living with the commitment', 'Challenges' and 'Being supported'. As the research progressed, I used concepts of liminality, stigma and taboo to understand these emerging themes. Chapters 7-11 examine the findings about women's experiences in the context of the four themes and then consider them specifically in relation to liminality, stigma and taboo. These theoretical concepts became of increasing interest as the research developed and so

later coding looked at women's experiences in relation to them as well as to other factors.

4.5 Conclusion

This chapter looked in detail at methodology and methods, perspectives and techniques to provide readers with an understanding of how the research was conducted and of choices made about research approach and conduct. It provides contextual information for reading the findings and discussion. The following chapter discusses issues of reflexivity and insider research.

Chapter 5: Methods used in the research II - Reflexivity and insider research

5.1 Introduction

This chapter continues with issues of methodology and of method. I have separated the discussion for clarity and because the issues merit independent consideration. I want to demonstrate the centrality of reflexivity and avoid making it:

...a marginal note in ethnographic writing...

as sometimes occurs (Madden, 2010: 21). The chapter focuses on ideas about reflexivity and on the practice of being reflexive because the study addresses women's experiences of breastfeeding long-term and what it has been like for me exploring those experiences.

Two main sections follow, the first discusses reflexivity and highlights its importance qualitative research and in this project . This is linked to a reflective discussion on the emotional impact of carrying out qualitative research, focusing on relevant issues and methods. The second section addresses my role in the research and writing about it, autoethnography and its relationship to the work. Finally, I discuss insider research, and include a reflexive discussion on the experience of carrying out insider research in this context. The discussion in this chapter is felt to be particularly important as I was aware throughout of the potential difficulties relating to my role as an insider and of the importance of strategies for maintaining analytical distance.

5.2 Reflexivity in qualitative research

5.2.1 The role of reflexivity

Reflexivity is an essential feature of qualitative research (Finlay, 2002; Flick, 2009) as social researchers do not work in isolation from wider society, their personal experiences and characteristics or their biography (Hammersley and Atkinson, 2007). The subjectivity of researchers and participants is an important part of the research process. Ethnographers are the central 'tool' in their research and care has to be taken in assessing their influence on the process as well as their power and position in relation to the research (Madden, 2010; Buch and Staller, 2007). There are a number of questions for reflexive researchers to consider:

...How does your biography affect the research process; what shapes the questions you chose to study and your approach to studying them? How does the specific social, economic, and political context in which you reside affect the research process at all levels?...

(Hesse-Biber, 2007:129).

Reflexivity is one way of assessing validity and its ethical significance is seen through its relationship with accountability, honesty and transparency (Doucet and Mauthner, 2002). This transparency is seen as a way of auditing the research process although this is challenged concerning power relationships in research practice (Finlay, 2002). Feminist researchers pay attention to reflexivity, believing in the need to:

...be aware of their own positions and interests and to explicitly situate themselves within the research...

(Hertz, 1997, cited in Finlay, 2002:211). There is an emphasis on 'power, position and influence' in research practice and relationships (Buch and Staller, 2007:211; Sampson et al., 2008). Reflexive discussion is a way of demonstrating the extent to which the product of research is a result of the relationship between participants and researchers (Finlay, 2002), and is therefore an integral aspect of ethical research practice (Davies and Dodd, 2002).

Reflexivity is important because it highlights the influence of relationships, beliefs and other factors in the methods chosen, their application, the conduct of research and presentation of findings. Reflexivity allows researchers to reassess their place in the research and the relationship between themselves, participants and methods chosen (Bott, 2010). One result may be researchers changing how they feel about participants as the work progresses:

...As we get to know the people we are researching, our investments in them change. Inevitably we begin to identify/disidentify, like/dislike, familiarize/otherize and this impacts our representations of them in relation to ourselves when we write up our ethical worries and interview data...

(Bott, 2010:160). Although reflexivity is important to analysis it is usually related more to the methods used with the consequence that:

...there is an assumption built into many data analysis methods that the researcher, the method and the data are separate entities rather than reflexively interdependent and connected...

(Mauthner and Doucet, 2003:414). Reflexivity in feminist research makes women's concerns more visible (May, with Perry, 2011). This is of interest to me as my work highlights a largely invisible experience.

Reflective practice has been central in carrying out and writing up this research project. During the time I developed my ideas and research proposal, collected and analysed data and wrote about it, I was also a breastfeeding mother. Being an insider influenced my research practice but it was clear from the outset that I needed to remain aware of bias issues. I interviewed women with whom I shared a particular experience and, with many, a similar world view. We also shared other things such as experience of home birth, the same independent midwives and some friends and acquaintances. With some women I also shared the experience of being in the same support group before starting data collection. Feminist researchers have written about interviewing in these situations and of acknowledging and using the relationships, what Davies and Dodd call:

...a blatant sharing of identities and a common social positioning with our research participants...we encourage a rapport based on a sense of shared understanding and empathy...

(2002:283).

In writing about this research I have been open about my experiences and the connections with my participants. I tried to be aware of my own feelings and prejudices when interviewing and observing, and to notice these when analysing, interpreting and writing. Making field notes, keeping a research journal and maintaining regular research supervision sessions helped me to reflect on situations which were agreeable or disagreeable to me, where I found myself wanting to positively represent participants or avoid difficult things they said or did. To make these issues transparent I include excerpts from all elements of my writing about the research throughout the thesis.

5.2.2 Reflexive writing and ethnography

Writing in general, and reflexive writing in particular, is an important part of qualitative research, including ethnography, and interpretation of findings (Madden, 2010). I have tried to write something that is faithful and respectful to the experiences of women who breastfeed long-term. At the same time I am aware of the need to be open to interpretation and analysis, and recognise an anxiety that some women may not like or understand the reasoning behind the 'end result'. Even though most of the participants may never read what I have written, I feel the need to be open about the data collection process and analysis for this reason.

What Coffey refers to as:

...writing the self into the ethnographic process...

(Coffey, 1999:117) has been a constant preoccupation throughout the project. I have thought about what is appropriate in allowing voices to be heard, both mine and the participants'. Research examining misunderstood or invisible experiences gives voice to its participants and tells their story; being reflexive and open is part of this process.

At the beginning of data collection I was anxious about how much to reveal and remained concerned as time passed:

...I talked about my experience...where it felt relevant; as usual when I listen to the recording I will be able to judge better whether it was too much. It...feels uncomfortable...it doesn't always feel ok...afterwards I think 'was that appropriate/too much/too much disclosure'. I am not sure why this goes on being so difficult...

(Field notes after interviewing Jane; 19th March 2009). I was interested in how my experiences (of breastfeeding and other issues) affected the data collected:

...It is hard to tell how much easier it has made it that I am also breastfeeding and that the women I am interviewing know this. So far I have always mentioned my breastfeeding experience in some way in the interview; once the interview is over we usually have a brief chat about something we have in common – today it was independent midwifery (another interviewee with whom I share the experience of using the same midwives!)

(Field notes after interviewing Mandy; 18th November 2008). At times I was surprised by the role of my experience:

...When I asked Sam about seeing people breastfeeding older toddlers and children ... (my daughter) is the oldest child she's seen breastfed! She talked about her feelings of shock and amazement at that and that was interesting and also another complication in the research relationships...

(Field notes after interviewing Sam; 16th July 2009).

Talking about my experience felt different in each of the groups:

...I have talked more and more about my own breastfeeding in a way that feels very ok and easier than it often is at LLL (I have often debated with myself at LLL meetings about whether to say anything at all). Sometimes at LLL I feel like the 'veteran' bf and that I am held up as (or hold myself up as?) someone who has bf for nearly 6 years, bf through pregnancy, tandem fed etc – I've got all the badges! But at Babes I've been bf for longer than any of the group members (only Helen longer and she's no longer feeding) but they are just really interested in that. It feels there like that is my experience and I'm adding that to their experiences and they want to listen to me like I want to listen to them....

(Babes, observation; 24th July 2008); I continued to reflect on this as time passed:

...I need to reflect some more on my position in this group. I really feel (and I think, behave) like a group member now...I just join in and have to remind myself that I am also an observer. I don't hesitate to offer my opinion or to raise topics for discussion – whereas in LLL meetings I still have this debate over whether I should be saying something or not...I think some of this may be because I have sometimes been very regularly to Babes – every week for a while, whereas LLL is more spaced out (and if I miss a meeting, even more so)...

(Babes, observation; 22nd September 2008). Later in the year there was a change:

...I thought afterwards about how different it feels now – I was late and distracted and there would have been a time when it would have been hard to walk into the group like that. Now, I feel very comfortable and accepted and it's ok...to talk about my breastfeeding experience as well as about theirs...

(Babes, observation; 17th November 2008).

Collecting data in this way caused me also to reflect on the difficult aspects of my experience:

...Every time I interview a woman about her breastfeeding experience it makes me reflect on mine – often I come away feeling sad about my own experience and somewhat envious of others'...

(Field notes after interviewing Mandy; 18th November 2008). There were other ways I found the process difficult. Data collection took place during a time when I was often tired or unwell. This affected my ability to concentrate:

..I wasn't feeling very well and was a bit feverish...room got very hot and stuffy so I ended up feeling very hot and rather out of it. I can't really remember what we talked about...

(Babes, observation; 4th September 2008). I noted the contrast when I felt better:

...I felt less tired in this meeting than I do usually and felt very comfortable....

(Babes, observation; 24th July 2008). Feeling comfortable in the group enabled me to share information about current as well as past experiences:

...I feel very comfortable there and it is very natural to talk about my own breastfeeding. This time I talked about how I have been breastfeeding [daughter] to sleep again, after having stopped this ages ago. Now I'm finding it hard because sometimes I don't want to do this and then she won't go to sleep. Sam is interested – she is always really interested in talking about breastfeeding older children, and in my experiences. We talked about how I might stop feeding her to sleep again...

(Babes, observation; 17th November 2008).

5.2.3 Emotional issues in research

Concern about the impact of qualitative research on participants is an established aspect of ethical review, particularly when exploring an issue not previously talked about. Undertaking qualitative research has also been recognised as having an impact on researchers (Hubbard *et al.*, 2001; Johnson and Macleod Clarke, 2003; Sampson *et al.*, 2008) and there is interest in the role of emotion in research. Previous concern about protecting participants has not developed into a similar focus on protecting researchers (Dickson-Swift *et al.*, 2007, 2009). When seeking ethical approval for my project I was asked to consider issues relating to 'care and protection of research participants and researcher' (Faculty Ethics Sub-Committee application form, see Appendix A); at the time I interpreted this in relation to physical safety. It is not unusual for ethics committees to ignore researcher emotional safety (McCosker *et al.*, 2001; Dickson-Swift *et al.*, 2005); no further questions about this were posed and it appeared not as important as protecting participants.

At the start I did not consider the potential emotional impact of the research on me. I referred in my application to debriefing after individual interviews; it was suggested during supervision that I did this and that I record sessions to use as data. I discussed data collection progress and my feelings about it but did not formally use supervision to debrief. I am not sure why: in an already pressured schedule it felt too time-consuming but perhaps I did not feel it necessary. I reflected on each observation and interview in my field

diary and this was probably sufficient debriefing. It was harder to do this with the correspondence, and my reflections on this in my research journal are probably the closest I came to debriefing during this process. Rager (2005) writes about researcher preparedness for emotional impact/coping and includes supervision and personal relationships (whilst maintaining confidentiality). I talked with my partner about my day to debrief: whilst maintaining confidentiality, I discussed how the research was affecting me. In particular I used him to reflect on my own breastfeeding and parenting experience – experiences we shared. There is the risk of preparing methodologically but not emotionally and this may be because each researcher considers her experience is unique. Like Rager, I probably did not use PhD supervision enough to discuss the impact my research was having on me and I take responsibility for this.

My thinking about this as an issue came later in the process and is evidence of the project's reflective nature and the inter-relationship between its stages. Reflecting on the personal impact of carrying out the research has been on-going throughout - gaining participant access, data collection, analysing data and writing up. Emotional impact is considered when research is about a sensitive issue (Johnson and Macleod Clarke, 2003, Dickson-Swift *et al.*, 2006; Renzetti and Lee, 1993) and/or when it is conducted from a feminist viewpoint (Holland, 2007). The increased focus on reflexivity and power relationships in research (particularly in qualitative research) comes from feminist researchers and these concerns plus a focus on sensitive or difficult

topics make feminist researchers vulnerable to emotional risk in their research (Sampson *et al.* 2008; Wincup 2001). Potential emotional issues include being upset, getting angry and over-empathising, as data collection and subsequent processes are researchers' emotional labour (Hubbard *et al.* 2001).

Transcribing has been recognised as having the potential for emotional distress (Etherington, 2007). It was important for me to transcribe interviews and fieldwork notes myself to remain close to the data for analysis. This was not traumatic or upsetting but was nevertheless interesting to reflect on and I noted that re-listening to the interviews fed my occasional sense of inadequacy as a novice researcher (did I do it right?), a parent (this woman has done it better) and as a breastfeeder (in numerous ways).

5.3 Autoethnography

Autoethnography was considered for this project in recognition of my intimate involvement with the topic. It is used by researchers when their subject is themselves or they are centrally involved; personal experiences are used as a primary source of data (Buch and Staller, 2007). Recent theoretical developments are associated with Reed-Danahay (1997), Ellis and Bochner (2000) and Ellis (2004). Autoethnography is:

...usually written in first-person voice...texts appear in a variety of forms – short stories, poetry, fiction, novels, photographic essays, personal essays, journals, fragmented and layered writing, and social science prose...

(Ellis, 1999:673). Although autoethnography has been considered to be lazy, hard to conduct ethically, lacking in analytical outcome and focusing on the powerful in society (Delamont, 2007), it is also described as 'critical autobiography' (Crossley, 2009). Autobiography and autoethnography are linked concepts: Reed-Danahay notes that the move towards reflexivity in ethnography has influenced the:

...increasing emphasis on self-disclosure and self-display...

(2001:407). Personal disclosure is present in anthropology and sociology regarding sexuality, intellectual memoirs (discussed by Reed-Danahay, 2001) and autobiography in illness narratives (see Frank, 1991 and Ellis, 1995). Frank (1991, 1995) does not refer to his work as autoethnographic although it is clearly illustrative of this trend. He notes:

...The key to me is remembering that although my own experience is crucial to how I come at an issue, and it may be a very useful example, other people have no reason to be interested in me. Whatever I say about myself should serve as an example of what others should feel they have a stake in. That's where I find the "performance" and "autoethnography" work often falls short. It fails to generalize the researcher's experience; it stops with this experience (refining its articulation in the performance), instead of using it as a point of departure...

(Frank, personal communication, 2007).

In a contribution to literature on how women make sense of 'perceived' pressure to breastfeed, Crossley interviewed herself and her partner about her experience of '*attempting to breastfeed*' her baby (2009:74). Her work has a different focus to this study, but is the only example found of autoethnographic work considering breastfeeding. Others have incorporated personal experience into academic writing about breastfeeding (Hausman, 2003; Giles, 2003; Bartlett, 2000; Bartlett, 2005). These works are of interest, as academics from disparate disciplines (English/Rhetoric, Media and Communications and English/Cultural studies respectively) centralise their stories as part of the process of pursuing academic study on breastfeeding.

Autoethnography raises issues about co-generation of data with participants, maintaining participant trust (for example, whether ethnographers' family members give permission for inclusion) and data analysis (Ellis, 1999).

These were all relevant to my situation. In addition, the importance of 'voice' is recognised, as well what Frank calls '*standpoint*' in relation to the 'story' being told:

...a political and ethical act of self-reflection: To take a standpoint means to privilege certain aspects of what your biography shares with others...

(2000:356). In research where ethnographers and participants have common experiences autoethnography can facilitate rapport (Berger, 2001).

My personal biography expedited access and helped build rapport with participants.

I considered using explicit autoethnographic techniques in this project, including interviewing myself and making my 'story' central to the analysis. As work progressed I decided not to treat this as autoethnography; it has autobiographical elements and I am overt about the role and influence of my experience as a long-term breastfeeder. This is central because the work would not have been conceived without my experience; it informed study design, data collection, analysis and interpretation. However I have decided not to foreground my experience, although the data from my reflections and online interviewing were analysed alongside all other data collected. I present the experience of women who have breastfed long-term; their experiences are also sometimes my experiences but the focus is on them.

5.4 Insider research

This final section addresses insider research: this is linked to the previous discussion of autoethnography as well as raising issues about the importance of reflexivity. Research using ethnographic methods:

...gradually take(s) an insider's perspective...

(Flick, 2009:111) to understand more about a culture different from one's own. However, research may also focus on a group to which one already belongs.

Insider research has advantages and disadvantages for qualitative researchers. For example, whether the insider perspective is unique and could never be achieved by an outsider, versus whether an outsider would bring a:

...broader, unbiased understanding...

(Labaree, 2002:99), producing findings/outcomes that differ significantly from an insider (or vice versa). Insider research may provide rich data not accessible to others (Hewitt-Taylor, 2002) because of access issues and/or the time needed to become familiar with a group/culture. An important feature of insider research is the relationship between depth of information gained versus the potential lack of objectivity, making overt the potential for bias. This emphasises the importance of demonstrating rigour and ethical practice.

Insider status is also considered in relation to interviews. Access in insider research concerns both accessing groups and communities and the types of information available (Labaree, 2002). Insider status is often assumed to facilitate access. De Andrade writes about this and associated risks. She notes:

...because it was advocated as part of a feminist methodological strategy, I did not hesitate to disclose considerable amounts of personal information...because I had a distinct, previous relationship to the community, this disclosure had implications in terms of my privacy and separateness beyond my role as researcher...

(2000:284). During the project I disclosed information about myself and felt comfortable, although there are implications and occasional difficulties arose. As noted in the previous chapter, it was hard for me to return to LLL as a mother or a friend once data collection was over and I consequently did not attend any more meetings during the remainder of the time I was breastfeeding. I noted the risks involved in self-disclosure in internet research and potential for breaches of my privacy. At times my insider status felt confusing, particularly in LLL meetings where some participants knew me previously. Information I shared in pre-study meetings was occasionally used by participants. When discussing difficulties with tandem feeding one woman noted she had more support than me when I was tandem feeding – information she only knew from my previous LLL attendance some years previously. This also happened in some interviews – one interviewee talked about seeing me breastfeed my four-year old daughter and how this was the eldest child she had seen breastfed.

Conducting research as an insider highlights the importance of reflexivity as it is necessary for researchers to critique their stance and assumptions in relation to bias, data and analysis quality. It is also important to reflect on the fluidity of the insider position – however hard researchers try to minimise difference they will always be insider and researcher (outsider) with the potential for power imbalances as well as differences in perspective (Taylor, 2011). In insider research there is the risk researchers will make assumptions about participants based on previous knowledge or experience of their situation. Familiarity may make it easier to miss points of interest: the challenge of ‘making the familiar strange’ (Hammersley and Atkinson, 2007) is increased when the familiar is very familiar. Participants also may make assumptions about researchers’ perspectives, experience or agreement with a viewpoint.

Throughout this study and in the associated writing I have tried to make explicit my insider status and the ways this has influenced the work through careful consideration of methods, through reflective writing and use of doctoral supervision.

5.5 Conclusion

This chapter, with the previous one, gives a full picture of the methods and methodology used in this work. Important issues in qualitative research and how they were managed have been discussed. In particular this chapter addresses my involvement in the work. This project and the findings are intertwined with my personal experiences and perspectives; considerations of reflexivity and reflexive practice, my use of self and of insider research are central. The next chapter continues the reflexive strand by addressing what it was like for me to be in breastfeeding support groups: it acts as a link between the methodological discussion of the previous chapters and the explanation and discussion of the findings which follow.

Chapter 6: Being with women who breastfeed long-term (settings and participants)

6.1 Introduction

This chapter provides:

...the description of 'being there'...

It bridges the previous chapters, which explain:

...the reason for 'being there'...

and the following ones, where I demonstrate my:

...analytic and interpretive engagement...[and then] substantiat[e]...the reason for 'being there'...

(Madden, 2010:157-161). In ethnographic writing it is usual to give a detailed

description of the culture or group who are the focus of the research

(Hammersley and Atkinson, 2007) to give information about settings and

people and what it was like being in those settings, and with those people.

This way progressive focusing (Wolcott, 2009) leads the reader towards

analysis, findings and interpretation.

The chapter focuses on settings with a lesser emphasis on participants. It

includes a detailed description of the groups in which I undertook participant

observation. Using field notes and research journal quotes and transcriptions

from observations it draws out the similarities and differences between the

settings. I focus on what they are like, what happens in the groups and what

it was like for me to be in them. Participants in breastfeeding support groups

are introduced, where appropriate. More detail on interviewees is given in

Appendix D.

6.2 La Leche League (LLL) meetings

...The meeting is held in the front room of a large house [it] is not very big and always feels crowded. Women sit on chairs and a sofa and on the floor. Sitting and crawling babies are usually in the space in the middle of the floor; today someone had brought some unwanted toys to give away and the babies played with these. On a table in the window the 'library' is set out – a collection of LLL approved books and leaflets on breastfeeding and various aspects of parenting which women can borrow. There is a large entrance hall area where toys are laid out for the children present and usually one adult stays out in the hall...Sometimes women with particular feeding issues or who want to talk with more privacy than is afforded by the group speak with the other Leader in the kitchen/breakfast room (leading off the hall)...

(LLL observation, field notes; 9th January, 2008 – written after my first observation).

6.2.1 Background

Participant observation was carried out in three breastfeeding support groups, one of which was the local meeting of LLL. LLL was founded in 1956 in the US by seven Catholic mothers (Ward, 2000) and is the oldest breastfeeding support organisation in the world with a presence in over sixty-eight countries (Bazelon, 2008). Its focus is on 'mother-to-mother' support, believing that the best people to help breastfeeding mothers are other breastfeeding mothers (Wiessinger et al., 2010). The LLL philosophy has been criticised as anti-feminist, with its focus on 'good mothering through breastfeeding' (Weiner, 1994:1357), and on the needs of the child and the family (Ward, 2000). In particular:

...Like maternalist ideologies of past centuries, La Leche League motherhood gave public purpose to the private activities of domestic life; like advocates of those past ideologies, too, the league argued that women subsume their individualism for the greater good of family and society...

(Weiner 1994:1359). Some of these ideas are still evident in the philosophy outlined on the LLL UK website:

...La Leche League believes that breastfeeding, with its many important physical and psychological advantages, is best for both a mother and her baby, and is the ideal way to initiate good parent-child relationships. The loving help and support of the father enables the mother to focus on mothering so that together the parents develop close relationships which strengthen the family and thus the whole fabric of society. La Leche League further believes that mothering through breastfeeding deepens a mother's understanding and acceptance of the responsibilities and rewards of her special role in the family. As a woman grows in mothering she grows as a human being and every other role she may fill in her lifetime is enriched by the insights and humanity she brings to it from her experiences as a mother...

(LLL GB, 2012a). Some of these criticisms have been addressed through recognition of the range of family situations in which breastfeeding women live, fathers' roles and women's need to return to work. This is evident through LLL publications (e.g. Breastfeeding Matters magazine), LLL website material and the discussion format of LLL meetings.

6.2.2 Local meetings

Local meetings are led by LLL 'Leaders' who are experienced breastfeeding mothers. They undergo training (including reflection on their own breastfeeding experience) after which they volunteer as breastfeeding supporters, run local group meetings, and answer calls on the national helpline. Meetings are held monthly and focus on a range of issues which may be breastfeeding-related but include:

...family life with a baby, night-time parenting, infant sleep, returning to work nutrition and weaning...

(La Leche League, 2012b). LLL meetings are often as much about parenting as about breastfeeding. This is one of the biggest differences between LLL and other support groups I attended. In my field diary I noted this:

...LLL meetings are often about parenting – this one definitely felt more about parenting than breastfeeding...

(LLL observation; 13th February 2008). At one time there were possible tensions:

...She also pointedly brought us back to breastfeeding a few times – we talked a lot about general parenting issues and children’s behaviour and she reminded us that it was a breastfeeding support group not a parenting support group. I’m not sure how much this was for my benefit...

(LLL observation, field notes; 8th October 2008). Many of the meetings I observed involved in-depth discussions about a range of parenting issues. One apparent benefit for women attending these meetings was that they were able to discuss and receive support for parenting choices that were to a certain extent counter-cultural, in a space where it was acceptable (this is discussed further in Chapter 10).

Towards the end of the observations period the venue of the LLL meetings changed. It had been in the home of one of the longest serving local Leaders for several years (and when I had attended LLL as a mother). This is a large house in a mixed population area of students in temporary accommodation, young professionals in flats and families in good-sized houses. It is near a busy main road and a local train station, enabling women to travel to the meeting by public transport.

LLL supports pregnant women and women breastfeeding infants, as well as those who breastfeed for longer than the norm, who tandem feed and women following the principle of child-led weaning (Flower, 2003; Bumgarner, 2000; LLLGB, 2012c; Ward, 2000; Weiner, 1994). LLL meetings are therefore a place where you might expect to see toddlers and older children

breastfeeding. Meetings were fortnightly when I attended previously, one once a month for new mothers and the other for mothers breastfeeding older babies and children. I anticipated attending these 'toddler meetings' but when I started field work meetings were once a month in total due to a shortage of local Leaders. I sometimes wondered whether a pregnant woman or a mother with a new-born who happened to attend a meeting where there were lots of established and long-term breastfeeders might feel out of place. Under the new arrangements there was the potential for both groups of mothers to fail to get their needs met. The once-a-month format also meant a long gap if I missed a meeting. LLL meetings were the least frequent of the groups I attended (BIB and Babes met weekly). Mothers seeking breastfeeding support only from LLL might also experience this gap as lengthy.

6.2.3 What is it like in meetings?

Women usually attend LLL meetings with their babies and children and meetings were noisy and conversation interrupted. During the meetings one of the mothers would stay in the large hallway minding the older children and crawling toddlers, hovering near the doorway and joining in the meeting when she could. At the opening of each meeting, mothers were asked to take care of their own child's needs and to come and go as necessary. Mothers brought a range of healthy snacks to share which were available in the kitchen. Everyone was offered a hot/cold drink on arrival by the hosting Leaders or attending mothers who arrived early to help. Women were given

name labels to wear; all were asked to sign in and LLL members were asked to identify themselves. A library of LLL approved books was available on a table in the meeting room – women browsed before or after the meeting, or borrowed them. The books' subject matter included breastfeeding and parenting topics, such as weaning/feeding issues, sleep and discipline. Specific breastfeeding issues included breastfeeding twins or other multiples, tandem feeding and breastfeeding older children. Sometimes the books were referred to in group discussion and recommendations made.

Each meeting opened with a short preamble which emphasised that a range of opinions might be expressed or behaviours witnessed, and that each woman should take from the meeting what was helpful for her. The meetings usually followed the same structure – the opening preamble, followed by an introduction to the meeting topic. A round of introductions was usual with each woman introducing herself and her children in turn. This was usually an opportunity for individuals to identify particular issues they wanted to address (these were often returned to after the main topic discussion but sometimes the leader would talk one-to-one with someone, after the main meeting ended). Occasionally, a woman would leave the main meeting after the introduction if more than one Leader was available, and go into the kitchen for some individual advice:

...J was in the kitchen offering detailed and lengthy advice to one woman about blocked ducts (the woman left the meeting at one point to seek J out), then another about positioning. She came and talked to Claire briefly about one of her twins possible poor latch...

(LLL observation, field notes; 14th May 2008). Sometimes during introductions women were asked to say something about the topic. Unlike the other meetings I attended (see below) there was an expectation that participants took turns speaking, listened to the speaker and joined in a whole group discussion facilitated by the Leader. I introduced myself and my research project during introductions or before the meeting started, offering written information and asking permission to record the meeting.

Meetings were attended by a fluctuating number of mothers and babies. The length of time women had been breastfeeding also varied. I noted this in my field diary and thought about the implications for the support given and received:

...The oldest breastfeeding children there today were two 'nearly three' year olds. Nine of the group were there last time, including me, M and J. Of the remaining five two had been before but not last time (so only two 'new' mothers and one of these had obviously been to LLL meetings before, but from what she said, elsewhere). I realised that twelve out of the fourteen women there (including me, an observer and the Leaders) had breastfed for over a year! Wow! It emphasises how different meetings can be – last time there were eight babies, mostly very young; this time there were two...

(LLL observation, field notes; 11th June 2008).

On reflection, the meetings seemed very busy (although from my notes there were sometimes not so many women and children present). At times there were as many as seventeen women, with babies and young children, some sat on chairs or the sofa, others on the floor or stood in the doorway. I observed meetings from January to October 2008, but in my memory it is usually winter, or raining; women, babies and children arriving wet, discarding winter clothes. In my recordings it is sometimes hard to hear what

is being said over the crying babies, children's noise, or other interruptions.

During the course of one meeting I noted the following:

...she pauses to comment on what's going on with the babies in the room, to disentangle her necklace from a baby's fist...

...two or three babies/children are feeding at any one time. Children cry and are comforted; hurt each other and are separated...

...it all got very noisy for a bit here. A baby sat on the microphone...

...children and baby noise quite loud at this point – the adults have been talking for over half an hour...

...lots of noise here...a pause in the talking while a woman sitting on the floor talks to her toddler and helps her move across the room...

(LLL observation; 9th January 2008).

I often saw the same women at meetings (some had been there when I attended before) and I wondered what it would be like to walk in 'new'. For the regular attenders there was a lovely feeling of solidarity, belonging and of sharing a journey.

...It was a great meeting with lots of really good discussion...a really supportive group of women who listened to each other and gave thoughtful and caring responses. This was particularly evident near the end when one woman talked, and cried, about her difficulties with tandem feeding...The women in the group were lovely to her, really listened and acknowledged what she was saying and feeling as well as offering her practical as well as emotional support. She said that LLL was one of the few places where she could really talk about how she felt about this issue...

(LLL observation, field notes; 11th June 2008).

Despite the opening preamble there seemed to be a strong feeling of agreement about what was acceptable to the group and what was not, although this was never verbalised. There seemed to be some sort of 'LLL orthodoxy' but opinions expressed within the group were rarely challenged and occasionally this felt uncomfortable (the first excerpt is from my

notes/transcript from the first meeting and the second from my field notes about the same meeting):

...the next says "...this is...X who was born eleven weeks early, so he's actually four and a half months old now...he's got a bit of a mixed development. He...looks quite young, because he's so small but he's doing some things that older babies do...like I've started weaning him...because they encourage premature babies to wean earlier rather than later, it actually helps them to gain weight...so I've started him on some baby rice..." [I felt (imagined?) a collective intake of breath here – I felt shocked, looking at the tiny baby she was holding (she went on to say he weighed under a kilo when he was born)...thinking about how a baby born with such disadvantages should surely need breastmilk more, and for longer, than other babies. I wanted to ask, who are 'they' that encourage this? And what's the evidence? I have observed moments like this in LLL meetings before – the disquiet feels almost palpable but no-one says anything/challenges/asks questions. I felt angry...with the nameless health professionals who were presumably advising her. J (leader) didn't comment either]...

(LLL observation; 9th January 2008).

...sometimes someone says something and there is a feeling that the majority don't approve – but the speaker is rarely challenged. There is a feeling that we all know best...we're all aiming for the same thing and then someone comes along who's not – and the group usually lets it go. I can't decide if this is respectful – or the group not being able to deal with it. In this meeting there was one woman who said quite a lot of challenging things but no-one challenged her. I was disturbed by her comment about weaning her baby and her assertion that this was based on health policy and assume/hope that the Leader felt this too...

(LLL observation, field notes; 9th January 2008). On other occasions,

differences were dealt with another way:

...today there were some different opinions expressed that were dealt with very well by the women present...there was talk about routines and breastfeeding by the clock...some group members who have been coming for a long time were very good at dealing with this. They listened and made affirming comments but also offered alternative perspectives and talked about their own experiences and how they came to make the decisions they did...It felt like a very supportive place to be today...

(LLL observation, field notes; 9th July 2008).

LLL can seem to publicly focus support on stay-at-home mums in traditional heterosexual relationships. In the meetings I observed there were women from a range of situations, although most women were not working outside the home, even those with older children. Some mothers discussed practical issues about working or returning to work during LLL meetings but this was

unusual; issues raised included expressing and storing breastmilk. The majority of women were in heterosexual relationships with partners who were in paid work, although I noted after one meeting that:

...There were two women there (not together) whom I knew to be lesbians from their attendance at the Home Birth Group [where I was a facilitator at the time]; their sexuality was not overt in this meeting but it's interesting as LLL is sometimes quite (heterosexually) family-focused...

(LLL observation, field notes; 14th May 2008).

6.2.4 'Being there' in LLL meetings

Attending LLL meetings was both easy and difficult for me. I already knew the format and some of the women so it was easy to move into my new role as researcher as well as a participant. Difficult because I was often concerned about whether I was doing it 'right' and whether I had participated too much; I was aware of feeling part of the group but not part of it:

...The setting, the layout, the structure of the meeting and the sort of discussion were all very familiar and yet it was strange. I was the same and different...I had intended not to speak but found myself contributing three times...Immediately after the first time I thought 'should I have done that?' I felt then, and now, that I don't know whether I did the observation 'right' – is there a right way?...

(LLL observation, field notes; 9th January, 2008). I struggled with making the familiar strange (Hammersley and Atkinson, 2007), a difficult thing to do when conducting insider research (Mannay, 2010) and this continued for the duration of the observations:

...I am not finding it possible to say nothing and have decided that this is ok...

(LLL observation, field notes; 12th March 2008).

...I did find it easier to observe this time – I spoke near the beginning and then again at the end (I couldn't remain silent when the tandem feeding woman was so upset) but in between there were several occasions on which I wanted to say something but thought about it and made a conscious decision not to. I watched a lot more and took more notes...

(LLL observation, field notes; 11th June 2008). Although I monitored the quality and content of my interactions I felt comfortable at the meetings and enjoyed seeing familiar faces over a period of time.

The facilitation of the meetings affected my experience of being in them and, possibly, the participants' experience. When I attended previously the facilitators were very experienced Leaders. During the observation period there were a number of newly trained Leaders. This sometimes affected the quality of the discussion:

...The group was not as well facilitated as last time. M is not as experienced as J and it showed. J came to her rescue at times. The women present were maybe not as talkative as last time...M's lack of experience and this meant that the talk didn't flow as easily and it felt less like a coherent discussion...It was altogether less animated and the formal part of the meeting finished earlier than last time...

(LLL observation, field notes; 13th February 2008), and later:

...M led the meeting in a slightly hesitant way...I think she forgot to do/didn't do some things which might have been helpful...in the introductory round she didn't ask if anyone had any issues they wanted to raise and so did this at the end which resulted in several conversations going on at once and less sharing of experiences...Maybe she doesn't have much experience of facilitating groups...at another point she talked to the two women on either side of her and seemed to find it hard to move the group on...

(LLL observation, field notes; 14th May 2008). On reflection, my discomfort came from my experience of being in groups as a professional and knowing how to run a group well. There were occasions when the group ran better whoever was facilitating, so I might have witnessed the group dynamics of different women attending month on month:

...It was a great meeting with lots of really good discussion – it felt less 'clunky' than last time – M didn't have to do much. A really supportive group of women who listened to each other and gave thoughtful and caring responses...

(LLL observation, field diary; 11th June 2008). I preferred the meetings Jenny facilitated because I already knew her:

...J was facilitating, which I like. She always sounds so knowledgeable and so reasonable...

(LLL observation, field notes; 12th March 2008) and:

...I always miss J when it's not her facilitating...

(LLL observation, field notes; 14 May, 2008).

I was not alone in being at meetings without my child, but was often the only breastfeeder without their child. Sometimes I felt it necessary to justify my presence, to explain that I had personal as well as professional reasons for being in meetings:

...I felt like I needed to emphasise my 'credentials' and opened my introduction by saying that I was still breastfeeding...and had been breastfeeding in total for five and a half years – do I need to do this or am I over-emphasising it because of my anxiety?...

(LLL observation, field notes; 9th January 2008). Being an insider can create difficulties when the group being studied expect a sympathetic portrayal (Hammersley and Atkinson, 2007) but I was always clear that I wanted to be open about my interest in, and experience of, breastfeeding long-term. At times I was concerned that I risked raising expectations by emphasising my breastfeeding experience, or creating false ones about what the research might produce.

In my field diary I reflected on how I felt about being in meetings, recording, taking notes and noticing and listening to what was going on:

...I felt anxious. I was worried that someone was going to object to my presence or to the recording...I felt awkward at times. Taking notes did not feel easy. One woman, sat in a chair next to and over me, could have read what I was writing if she'd wanted to...

(LLL observation, field notes; 9th January 2008). I felt less anxious during the second meeting but still found observing difficult:

...I felt more confident than last time as I knew the recording equipment worked well. I was very tired and felt that I might find it hard to concentrate...I found it hard to concentrate on observing. My tiredness maybe – or maybe because I slipped more into participation....Am worried that I will focus too much on the talk because I have good recordings and miss some of what I might observe when I am there...

(LLL observation, field notes; 13th February 2008). As time went on I found the practicalities of field-work easier:

...I chose to sit next to the table today as I've learnt that where I sit makes a difference. I felt much more relaxed than last time...and put the microphone on the table (on top of the library books). This meant that I didn't have to worry about keeping crawling babies/curious toddlers off it as I have done in previous meetings (and makes me wonder why I didn't put it on the table before!)..

(LLL observation, field notes; 11th June 2008). My management of the environment to facilitate observation and recording improved, but there were always aspects not in my control:

...One woman positioned a chair so that it was slightly to the front and to the side of me. No-one sat there to begin with but when one of the latecomers did it meant she had her back to me. This both helped me to feel like an observer and created problems as I then couldn't see everyone in the room...

(LLL observation, field notes; 9th July 2008). Because the room was often crowded I had little choice in where I sat, or where others sat in relation to me.

6.3 Breast is Best (BIB)

...They meet weekly from 9.30 – 11.30 in a room in (...) and offer 'support, advice, information and friendship' to 'pregnant mums who want to breastfeed and to those already breastfeeding' (from their flyer). Although not an Association of Breastfeeding Mothers (ABM) group, they have an ABM counsellor present and women can train to be ABM 'mother supporters' (5 have just finished this). Most meetings do not have a specific focus although sometimes they have a speaker ('real nappies' for example, recently). Women chat to each other – sometimes lots of conversations going on at once, sometimes only one. They have a library in a pull-out bookcase. More about breastfeeding than parenting (LLL have lots of parenting books) but some about fathers' role and about sleeping/crying. Also videos...

(BIB observation, field notes; 5th March, 2008 – written after observing first meeting).

6.3.1 Background and setting

During the field-work I visited this group on three occasions only (see Chapter 3 for rationale). This group was very different from LLL; it is run by local mothers and is held in a Healthy Living Centre in an area of socio-economic deprivation. It has a permanent home in a light and airy modern room. Unlike LLL it meets weekly so that breastfeeding women can have frequent contact with each other. Most of the women I met typified what I knew of the local population - they were almost all white, working class and from that area of the city.

The Healthy Living Centre is on the site of a 'Health Park' which includes primary care facilities (General Practitioners, a dentist, a walk-in centre), a pharmacy, a café, a crèche and other community facilities. During field-work an Association of Breastfeeding Mothers (ABM) counsellor was present (whom I will call Naomi) and a number of the women had trained as mother

supporters/peer supporters via the ABM, although it was not run as an ABM group. ABM is a UK-wide charitable support organisation founded in 1979 by a group of breastfeeding counsellors and aims:

...to promote the physical and psychological health of mothers and children through education in the techniques of breastfeeding and to advance the education of the public, especially those persons concerned with the care of children on the health benefits of breastfeeding, both immediate and long term..

(ABM, 2012). ABM trains breastfeeding counsellors and provides a telephone helpline. Training courses are run for 'mother supporters' and assistance given with setting up local breastfeeding support groups. The BIB group had a maternity support worker (MSW) in attendance and access to a crèche, run by the local children's centre, which gave it a very different feel to LLL as only babies or small children were present. At the first meeting I attended Naomi told me that most women breastfed for four to six months but at that meeting:

...the women I spoke to had fed for up to three years; most over one year with at least one of their children...

(BIB observation, field notes; 5th March 2008). In each of the three BIB meetings I attended, I met women who had breastfed for over three months.

6.3.2 What is it like in the group?

The meetings were unstructured and not facilitated, with lots of conversations going on at once. Naomi was present but not in a facilitative role. At all three meetings I attended, health or social care professionals were there either as part of their role or observing other professionals. These included a worker from the nearby Children's Centre and a MSW from the health centre next door. The MSW had portable scales with her and, if any mothers requested

it, weighed their babies. At times the meetings felt like a mix between an informal clinic and a support group.

Towards the end of one meeting, a more formal meeting took place for mothers trained as peer supporters (which was almost all of those present). At the end of another session there was a group discussion about parenting, facilitated by a local Children's Centre worker. Ostensibly, the group was run by the attending mothers, but it felt like a group that had low-key health professional oversight. Despite this I noted:

...the group has much less focus than the other groups I have been to...and it is less clearly a breastfeeding support group. There are points at which someone could intervene and use what is going on as a vehicle for breastfeeding promotion but it is not clear if that is anyone's role and it doesn't happen...

(BIB observation, field notes; July 2008).

It was much harder to introduce myself in these meetings as there was no opening round of introductions. I tried to introduce myself to individuals and to small groups of women. During my attendance the group had a fairly stable membership and so this was not a problem:

...I arrived very promptly but there were already quite a few women there. Most of them were there when I last went [despite this being three months previously] so knew who I was and why I was there...

(BIB observation, field notes; July 2008). The number of women attending varied: at the first meeting there were 10 women including Naomi and the MSW; at the second meeting there were 12 women, including two children's centre workers, the MSW and Naomi; and at the third, 14 or 15 women, including a children's centre worker, the MSW and Naomi. Sometimes a

third of those present were there in professional roles and this affected the 'feel' of the group.

It was hard to tell how many women were in the group as they came and went from the crèche at different times. Older children were usually in the crèche. There were never more than four babies in the room at any meeting so they were much quieter than LLL. I saw more small babies being breastfed and fewer older ones. In some meetings I did not see any breastfeeding at all. I was surprised at how many women were or had been breastfeeding older children as I had not been expecting to see this group of women in this area.

There was a range of food available at these meetings:

...food appeared constantly throughout the meeting. Plate after plate of white toast, pieces of fruit, lots of cake...

(BIB observation, field notes; 5th March 2008). The presence of the food seemed to be important although how much was consumed varied from meeting to meeting:

...Women chat to each other and some eat – toast and fruit. There is a lot of cake around (a lot in a box for future meetings) but no-one seems to be eating it this time. We have two rounds of tea making and drinking...

(BIB observation, field notes; 2nd July 2008). They appeared to be a group of women who were very comfortable with each other and I wondered what this would be like for women who were there for the first time:

...it's a group of women who know each other very well; there's a lot of banter and camaraderie. It's obviously been a great source of support for them but I wonder (as I did with Babes last week) how easy it would be for new women to come into it...

(BIB observation, field notes; 28th July 2008).

Breastfeeding was not discussed at every BIB meeting. This is not uncommon in LLL meetings when the discussion focuses on a parenting issue; this did not seem to be the case at BIB. However, I did observe a very supportive discussion about expressing milk:

...She came wanting to borrow a breast pump – one of her concerns was that her daughter was finding the new baby's arrival very hard and she wanted to be able to express milk for her partner to give the occasional bottle...women in the group shared experiences of expressing milk (how they'd done it, what they'd used, whether they could watch television at the same time)...[including]...useful practical tips...[like]...using breast shells inside her bra on one side while she feeds from the other....The woman seemed very interested in this advice and decided to leave the pump behind for this week...

(BIB observation, field notes; 23rd July 2008).

The group talked about a range of issues. One meeting at the beginning of the school holidays was dominated by discussion about starting school. Several women had children starting in September (including me). The conversation was often about everyday concerns – work, food, managing children's behaviour – and I found my assumptions challenged:

...I was surprised to learn that the woman with four children keeps hens and grows fruit and that the young mother supporter likes making bread and cakes...

(BIB observation, field notes; 28th July 2008). This reminded me to be open-minded and to observe what was happening without preconceived ideas (or being aware of and recognising them).

6.3.3 'Being there' in BIB meetings

From the outset, these meetings were different from the others I attended. Most women did not have their children with them in the group so I was not unusual in being without mine. I always felt less comfortable in BIB meetings

than in LLL or Babes partly because at LLL I was among women similar to me socially. My professional background has equipped me to communicate with a range of people, but in this setting where I shared similar breastfeeding experiences with the women there was some awkwardness linked to my different life experiences.

I found these meetings the least useful and the hardest to be in, although I noted after the first meeting:

...I felt very welcomed and they said that I could come back at any time...

(BIB observation, field notes; 5th March 2008). Although I was very welcomed, I was sometimes unsure how to behave:

...I think I need to go more and work harder at introducing myself. I have got used to Babes which has a very different feel. Helen makes sure that everyone knows who I am whereas at BIB it was hard to know exactly how to behave. I didn't feel uncomfortable, just unsure of the best way to play it...

(BIB observation, field notes; 2nd July 2008)

At times I found it hard to observe and to listen when I felt uncomfortable about what I was seeing or hearing. This happened on one particular occasion at BIB when the actions and talk of one of the ABM counsellors seemed at odds with the espoused values of the group:

...[she] looks tired. She has a seven week old baby....Some of the things she says this week are very hard for me to hear. I don't feel that it would be right for me to make any comment but I find it hard – I don't want the other women to hear these things either. She says, at one point that you have to learn early on that babies don't need feeding all the time. She says that babies cry and people say they need feeding but most of the time they don't (a contrast to Helen's 'when in doubt, get it out'). She also says that they have to get used to being 'independent' and that her son doesn't want to be held all the time. She says that you learn quite quickly that some babies just don't want to be held. At one point he is on her knee, lying down on his back. He is asleep with his arms flung out and looks totally relaxed. She fidgets around, says that he is too heavy and picks him up, placing him down (not very gently) on a cold plastic play mat. He wakes immediately and starts to cry. She says that he obviously didn't really want to be asleep. This feels a bit abusive to me. She frequently calls

him 'dirty' and 'disgusting' and this is not in a playful voice (he has several dirty nappies and regurgitates a bit of milk at one point). It's hard – she's a new mum and she's tired but I don't know about the kind of advice/role model that she's giving other women...

(BIB observation, field notes; 23rd July 2008).

6.4 Babes

...The group is held in (...) Children's Centre on Thursdays from 1-2.30, all year round. It is run with support from the children's centre who supply a room and a crèche worker. There is an ABM counsellor present, H. The group is held in a lovely modern light and airy room. The crèche worker is at one end of the room with toys and activities and the mothers are at the other end in a loose circle. Babies sit in the middle, playing with objects in a basket. There is the noise of the older children playing in the background...

(Babes observation, field notes; 5th June, 2008 – written after observing first meeting).

6.4.1 Background and setting

I carried out eleven observations in Babes meetings from June 2008 – February 2009. Babes is run in, and with support from, a Children's Centre in an area of the city with high levels of deprivation and social housing, and low breastfeeding rates. A stark reminder of the contrast between this area and the LLL meetings was a large 'harm minimisation service' vehicle (operated by the local specialist drugs service) setting up in the car park every time I attended.

Each meeting had an ABM counsellor present ('Helen'). She was funded to carry out breastfeeding support work locally by Barnardo's charity, and the local Primary Care Trust (PCT). A crèche worker was also present in most meetings to look after older children. During field-work, the meetings changed from Thursdays to Mondays, due to crèche worker availability. Originally, planned activities (painting or craft) took place elsewhere and children would go outside or into the centre's 'sensory room'. After this

change there were usually two people from the crèche supporting each meeting. The children were usually in the same place as the mothers, albeit at the other end of the large room, and often moved between their mothers and the crèche worker. The meetings were not as noisy as LLL meetings, due to the presence of the crèche workers and the larger space, but were usually noisier than BIB meetings. A small partitioned-off kitchen in one corner was used to make drinks; sometimes women brought cake, biscuits or fruit. Food did not generally play a large part in proceedings, apart from two occasions when a specific event was celebrated.

6.4.2 What is it like in the group?

As with BIB, the Babes meetings were unstructured and the group operated as a drop-in. On the whole most women arrived at the beginning and stayed until the end of the group. When only a few women were there a discussion usually took place with all present but, more commonly, several conversations took place simultaneously. The numbers of women present varied from four to nine. Fran was always there, as was Helen (bar one meeting), so in addition to me there were usually three non-breastfeeding women at every meeting. On one occasion a student nurse was also there observing.

The group appeared to be very supportive and was used by the women for a range of reasons. Helen was clearly there as an 'expert' and as a resource.

During fieldwork I observed her giving very practical advice and support, mostly to new mothers. This varied from:

...demonstrating positioning using a doll and a knitted breast...

and:

...the baby was asleep...but H wanted her to wake up so that she could see G feeding her in order to help her with a problem (not specified)...H took G to another room to see her feed and talk to her in private...

(both from Babes observation, field notes; 5th June 2008) to:

...Helen took her out of the room to teach her some expressing techniques...

(Babes observation, field notes; 12th June 2008). I noted that:

...Helen's manner is very reassuring, very normalising...very calm and confident and what I can hear of her advice...sounds very appropriate and (from what I can tell) accurate...

(Babes observation, field notes; 19th June 2008). Sometimes other people working elsewhere in the centre came into the room to find something; they would occasionally stay for a while and join in the conversation or offer advice.

Other women used the group to talk about a range of breastfeeding issues, appearing to gain support through discussion with each other as much as through seeking advice from Helen. Helen often took part in these discussions, drawing on her experience as a breastfeeding mother as a breastfeeding counsellor. Examples of issues I heard discussed included breastfeeding in public, breastfeeding to sleep and at night, pressure to wean, breastfeeding and pregnancy, and breastfeeding and biting. There were a core group of women who attended regularly and continued to breastfeed; this meant that babies I met at the beginning were toddlers when

I finished. Discussion topics changed as children grew older but there was always interest in the fact that I was breastfeeding an older child during this time (my youngest daughter turned four in July 2008) and so I was often asked about my opinion or experience. Generally this was a group where parenting issues were discussed less than breastfeeding (although they were discussed as they arose) and it was very non-judgemental about infant feeding decisions. As with BIB, but unlike LLL, I attended a meeting of Babes when no-one breastfed at all.

For some women the crèche worker's availability was very important – this was a big contrast to LLL where women were encouraged to take responsibility for their own children. This often meant that LLL mothers were distracted and found it hard to talk or listen without interruption. At one meeting of Babes, one woman seemed taken aback that the crèche worker was not available - it seemed particularly important to her that she could come to the meeting and focus on her breastfeeding experience without having to care for her older children.

When the session was changed from Thursday to Monday there appeared to be a drop-off in attendance but this picked up and by the time I left, the group seemed to be fairly busy again.

6.4.3 'Being there' in Babes meetings

From the outset, attending Babes meetings felt very easy and comfortable. I think this was because at the first meeting I already knew two people – Fran, who had acted as gatekeeper and who was at almost every LLL meeting I attended as well as all the Bib meetings, and Helen, the ABM counsellor who I had met once before. I was always made very welcome and the women I met were always very interested in my breastfeeding experience and my research; I was asked more questions about this than at any other location.

Out of all of the groups I observed I found it hardest to leave Babes:

...I find it hard to think about not going there again – they are so nice and I feel so comfortable. Helen said 'you're part of the group now' and when I left (...) said 'you won't be able to keep away'...

(Babes observation, field notes; 2nd February 2009). I think this was due to the regularity of the weekly meetings compared to the monthly LLL meetings.

Because I felt comfortable and there was a lot of interest in my breastfeeding experience, I talked more about myself and breastfeeding in these meetings than at either LLL or BIB. This was also the only place that I breastfed. On the last Thursday meeting a party was held, to which I was invited with my children. My youngest daughter was at home with me that day and so I took her with me. Although at that point she did not usually breastfeed in the day anymore, as she knew we were going to a breastfeeding meeting she decided that she too would breastfeed. This was probably the last time I breastfed her in public and I was surprised that I did not feel comfortable breastfeeding, even in such a supportive environment. Later when I

interviewed one of the women present she noted that my daughter was the eldest child she had ever seen breastfeed:

...I think you're the person I've seen breastfeed the oldest, 'cos she was four at the time wasn't she?...

(Sam, interview; 16th July 2009). At every meeting of Babes I attended I was the only person breastfeeding a child as old as my daughter was then; Helen had breastfed for longer but had stopped breastfeeding several years previously. Apart from this one meeting which I attended with my daughter, I was present at all other meetings as a breastfeeding mother without my child; I was not the only one in this situation:

...I am not the only one who is there without children – Helen has no children there, Fran isn't breastfeeding anymore and people like (...) come but her children are out of the room for most of the time. So I am not alone or odd sitting there with no baby or child...

(Babes meeting, field notes; 24th July 2008). A recurring theme in my notes was that I was very tired and unwell on several occasions. Although I worried that this affected my ability to be in the groups and the quality of the observations I was able to make, I think that this was mitigated by how comfortable and how accepted I felt.

When observing Babes meetings I often felt that what I saw and heard challenged my stereotypes and the assumptions that I had made about the breastfeeding women I would meet in that part of the city:

...Driving home I thought about how my stereotypes were being challenged. I didn't think I'd meet long-term breastfeeders in (...), thinking I'd be lucky to meet those still breastfeeding at six months...two weeks in a row I've met two different women breastfeeding toddlers! Plus several co-sleepers...

(Babes observation, field notes; 12th June 2008). I was expecting the meetings of both BIB and Babes to be very different from LLL but was

surprised to note that there were often similarities between the women's experiences and the issues discussed. I reflected on this after one meeting:

...It struck me that they would have been at home in an LLL meeting – in many ways they are caring for their babies in the same ways. This comes maybe less from reading and from the philosophy of attachment parenting and more from instinct/observing each other and what works for other women?...

(Babes observation, field notes; 3rd July, 2008).

As well as sharing my own breastfeeding experience, I felt comfortable with other types of input into these meetings. I shared information about some film makers recruiting long-term breastfeeders; in another I donated some books about parenting issues and breastfeeding.

When I started attending Babes meetings I introduced myself at the beginning of any meeting to anyone I had not already met. At the first meeting there was an introductions round but this did not happen again. The meetings operated as a 'drop-in' so I introduced myself again when someone attended part way through or near the end of a meeting. This was to secure proper consent (see Chapter 3). I did not record the meetings because of the unstructured format, multiple conversations going on at once and high noise levels, as the children were often in the same room. I discussed recording the meetings with Helen and she suggested arranging a structured discussion one week. I decided against this as this was not usual and I wanted to observe meetings as they usually were.

Fran's presence in Babes meetings became hard for me. I met her in LLL meetings and she introduced me to Babes and BIB and acted as a key

informant and gatekeeper. Her presence in almost every breastfeeding support meeting I attended had advantages and disadvantages for me. She made it easier for me to walk into new groups because there was someone I knew to talk to if I felt nervous. After a while I realised I had to be careful – Fran often sat near me to talk. This made it harder for me to talk to other women. After the second Babes group I noted:

...I was sat for most of the time next to Fran (again) – I think I may have to make a conscious effort not to do this sometimes as we often end up talking about LLL and other breastfeeding groups; things we have in common...

(Babes observation, field notes; 19th June 2008).

When observing LLL meetings I worried about being a participant or an observer; I was more relaxed about this when observing Babes meetings. My presence was comfortably both; the women were very interested in my experience and asked me about it regularly:

...they ask me questions every time – this time...if all older babies/children are distracted when they feed or whether they grow out of it...

(Babes observation, field notes; 19th June 2008). On other occasions I was asked about breastfeeding to sleep and at night, dummy use, breastfeeding and teething, and breastfeeding using a sling:

...[name]...asked me what I did (almost every week she asks me about my experiences – in an interested way) and I talked about my different experiences with all three...

(Babes observation, field notes; 3rd July 2008). I joined in general discussions about breastfeeding and specific parenting issues as well as in a range of other conversations.

When I observed LLL meetings I sat in the same place for the entire meeting because of the limited space and they were structured meetings. Sometimes I sat in the same place in BIB meetings but moved around a little. In Babes meetings I moved around a lot to talk to a range of women and in response to what else was going on:

...at various points in the meeting I swapped seats with people – so that Helen could talk to a mother, or so that a woman could breastfeed in a more comfortable chair...

(Babes observation, field notes; 17th November 2008).

I made the same reflection about Babes meetings that I made about LLL and BIB meeting new mothers' perceptions:

...I wondered how easy it would be to walk into as a new mother. All the women know each other and most of them meet together every week...It is obviously very supportive for the women who come regularly...I wonder what it must be like for others walking into this, maybe feeling unsure about breastfeeding, maybe with problems...

(Babes observation, field notes; 17th July 2008).

6.5 Conclusion

In this chapter I have considered in detail what it was like for me to carry out participant observation in breastfeeding support groups. I have talked about the structure and format of the three groups as well as giving examples of what took place in these groups. The following chapters look in detail at the findings from the research, using the data collected both from these support group observations and from the individual face-to-face and online interviews.

Chapter 7: Deciding to breastfeed long-term

7.1 Introduction

This chapter is the first of four identifying and illustrating my research findings, drawing on material from FTF and online interviews and participant observation. The focus is on the primary aim of my research – ‘to increase understanding of the experiences of women who have breastfed for longer than six months’ (see Chapter 1). I have done this by ‘thinking with’ my findings (Faircloth, 2010b:361, after Lévi-Strauss, 1966) and using them to describe what life is like for those who choose to breastfeed long-term. Chapter 11 discusses the findings as a whole, including an analysis of how the concepts of liminality, stigma and taboo may be applied to long-term breastfeeding.

This outline of my research findings is presented using four main themes (the process of analysis is discussed in Chapter 4). This chapter discusses how participants decided to breastfeed long-term, looking at how mothers who breastfeed long-term explain and justify their behaviour. Previous research has examined women’s decision to breastfeed (or not) and the influences on this, including family and social support, the attitudes of health care professionals and maternal self-efficacy (see, for example, Donath *et al.*, 2003; DiGirolamo *et al.*, 2005; Meedyia *et al.*, 2010). With the exception of Rempel (2004) and Britton’s unpublished doctoral work (Britton, 2000) there is little in the literature about the decision to breastfeed long-term and how

this comes about, via an initial decision to initiate breastfeeding. This chapter addresses this issue. The discussion is divided into four sections. The first three consider experiences and issues in relation to deciding to breastfeed, and to breastfeed long-term, and the personal qualities that enable women to carry on breastfeeding. It concludes by discussing what participants felt they gained from long term breastfeeding.

Chapter 8 outlines how participants talked about their lives in relation to long-term breastfeeding and their commitment to it. Chapter 9 discusses how participants talked about the difficulties and challenges they encountered in relation to long-term breastfeeding. Chapter 10 outlines the sources of support used and valued by those breastfeeding long-term as well as identifying unsupportive factors.

All four themes are discussed using extensive quotations, examples from all three elements of data collection, and from my field notes and research journal. Alongside the detail given in the previous chapter this offers 'thick description' of the findings (Geertz, 1973; Ponterotto, 2006). Interviewees are identified by pseudonym and mode of interview; further information about each is available in Appendix D. The main themes and sub-themes arose in FTF and online interviews and in participant observation. Specific differences between these groups of women, either in experiences or in the ways in which long-term breastfeeding was discussed, are highlighted. Emphases in quotations are mine unless otherwise indicated.

Some of my findings are recognised to be about what it is like to breastfeed in general, and not only about long-term breastfeeding. Some of the women observed in support groups were breastfeeding babies; some of the women interviewed talked about their experiences when their children were younger, as well as about long-term breastfeeding. An important difference between this and most other recent research about experiences of breastfeeding, perhaps with the exception of Faircloth (2009, 2010a, 2010b, 2011) and some of the breastfeeding experiences discussed on healthtalkonline (2011), is that these women had experiences of early breastfeeding and of what it is like to carry on beyond the norm (and in some instances of tandem feeding). My interviews covered all these aspects, albeit with a focus on breastfeeding long-term.

7.2 Deciding to breastfeed

Over 50% of women who breastfeed stop in the early weeks (Bolling *et al.*, 2007). The women in this study are unusual because they carry on beyond the early weeks, often long-term. I was interested in what makes this group different, whether this was in relation to their original decision or their early experiences.

There appeared to be a number of elements contributing to the decision to breastfeed and to carry on breastfeeding. Women talked about 'always knowing' they wanted to breastfeed, and about their knowledge and understanding of health and other benefits, and a perception of breastfeeding as a 'natural' activity. These are discussed in turn below.

7.2.1 'Always knowing'

The decision to breastfeed mainly came up in interviews, although it was sometimes discussed in support groups. Many participants talked about breastfeeding as something they had 'always' known or 'just knew' they wanted to do, either from the beginning of their pregnancy or, in some cases, before becoming pregnant. 'Always' or 'just' knowing was sometimes related to other factors, including family experience.

Early in each interview (both methods) I asked 'Did you always want to breastfeed?' and all women responded in similar, affirmative, terms. Some

talked about it as being part of their consciousness, even before becoming pregnant:

.. I just always had it in my mind that I would...I just assumed that I would...

(Mandy, interview; 18th November 2008).

...I was determined to breastfeed myself - it did not occur to me that I wouldn't...

(Jess, email; 10th March 2008).

Interestingly, this determination was not necessarily related to knowing others who had breastfed. Jess commented that she had very little contact with babies before becoming pregnant, and had seen very little breastfeeding. Sam also noted that, although she 'just knew' that she wanted to breastfeed, she had only known two people who had breastfed before she had her son - and yet:

...I definitely knew I was going to breastfeed...I just knew that I wanted to breastfeed...it wasn't until I became pregnant that it was something that I really gave thought to...it was the *only* thing I was worried that I wouldn't be able to do...

(Sam, interview; 16th July 2009).

For Josie the desire to breastfeed was very long-standing:

...My intention to breastfeed and be a stay at home mum were there when I was a child. I've had that intention as long as I can remember...

(Josie, interview; 28th October 2008). Later in the interview she reiterated the strength of this ambition; a sentiment I also heard from many other women:

...it's what I always wanted to do, I really felt like it was the best thing to do...I didn't want to bottle feed, I wanted to breastfeed, I *absolutely* wanted to do it...

(Josie, interview; 28th October 2008). This association of breastfeeding with determination recurred throughout the data collection. It is discussed later in

this chapter in relation to the qualities that women associated with being able to carry on breastfeeding (section 7.4).

Some women talked about the decision to breastfeed in relation to being pregnant:

...Since I got pregnant...I said from the very first moment I wanted to breastfeed my baby...

(Lucia, interview; 11th November 2008). The desire to breastfeed was clearly identified by some as preceding pregnancy:

...I had always had an interest in childbirth and breastfeeding, and had read a lot about it. I knew I wanted natural child birth...I remember saying that the one thing I would really be disappointed about if I couldn't conceive was that I would never have the experience of breastfeeding...

(Christine, email; 3rd February 2008). For others, their interest emanated from parenting philosophies, including breastfeeding on cue and child-led weaning:

...the parenting philosophy was in place before I became pregnant. Attachment Parenting was a logical consequence of TCS [Taking Children Seriously], rather than being drawn to a natural parenting approach for its own sake - being fully responsive to a baby's preferences is likely to involve co-sleeping and breastfeeding on demand and CLW [Child Led Weaning] etc...

(Jess, email; 15th March 2008).

7.2.2 Influence of others

A number of participants associated always wanting to breastfeed with family knowledge, experience and influence. Some felt that their desire to breastfeed had come from witnessing breastfeeding (as part of family life), and from influential advocates:

...Always wanted to breastfeed...my mum breastfed all of us...I saw breastfeeding, it was a very natural thing for me...I just always thought I'd breastfeed...it's been in my

family and my mum's quite a strong advocate for it, to the point of almost being judgemental against bottle feeders...

(Josie, interview; 28th October 2008), and:

...all my cousins...we were quite close to...they were all breastfed...I never really saw babies being bottle fed...I hadn't considered whether or not I would breastfeed [laughs]...it just didn't enter my radar really...

(Jane, interview; 19th March 2009).

Some women talked about how their desire to breastfeed arose from their knowledge of their mothers' negative experiences. Knowing about her mother's experience (see 7.3.1) influenced Sarah's desire to breastfeed her daughter, and to have a different type of experience herself; she particularly related this to her decision to breastfeed long-term which is discussed in the next section. For others the support of their partner/husband and family was an important element in their decision:

...it was my husband's support, he says '...you need to breastfeed the baby, you want to breastfeed the baby...it's better to breastfeed the baby'...he was really supportive of that...my mother-in-law as well, my mum, they were all saying to me, 'just breastfeed'...

(Lucia, interview; 11th November 2008). The importance of family support in long-term breastfeeding is discussed in more detail in Chapter 10.

7.2.3 Knowing about the benefits

The health benefits

Although some women prioritised the 'naturalness' of breastfeeding over the health benefits (see below), most also made some reference to health benefits and their decision to breastfeed. Often the WHO guidance (2003) was mentioned, with reference both to health benefits and overall duration of

breastfeeding (discussed further below). Most referred to the health (and other) benefits as both certain and commonly understood:

...the health benefits...immune system boost and... the cognitive, all those concrete things...

(Mandy, interview; 18th November 2008);

...obviously you have the health benefits, you know it's best for your baby, it's free...it's convenient and obviously there's health benefits for yourself...

(Sam, interview; 16th July 2009);

...I knew them [health benefits of breastfeeding]. I think I just sort of absorbed them...it was just there, you know, it's everywhere isn't it?...

(Jane, interview; 19th March 2009);

...If one reads the research and the books one can't help but realise how important species specific milk is...

(Christine, email; 13th June 2008).

Most women in this study felt there was little need to discuss the health benefits of breastfeeding in any detail as they were a given. There were a few occasions in breastfeeding support groups, particularly in LLL, when the person leading the group would emphasise the health benefits of breastfeeding, and of carrying on breastfeeding. I felt that this was primarily intended for the new mothers present; the attitude amongst the established breastfeeders being usually that health benefits were taken for granted.

Many participants referred to the support and information gained from books and the internet; several talked specifically about these as sources of information about the benefits of breastfeeding:

...what really enforced me is reading and knowing that breastfeeding is best for the baby and getting all the information, because I was reading a lot...

(Lucia, interview; 11th November 2008). Others talked about NHS leaflets and DVDs, given to them antenatally, as their sources of information.

Although the support gained from books, other publications and the internet was very important (discussed further in Chapter 10), it did not appear, for most women, that such information was particularly influential in the decision to breastfeed.

Some women talked about specific health issues for their family and/or their child and how this had influenced them in their decision to breastfeed and/or to carry on breastfeeding:

...I was very motivated to breast feed...because I had read of a possible link between cow's milk protein and type I diabetes in people with a genetic link (my father had type I diabetes since he was 2 ½ years old)...If I hadn't been so strongly motivated by the possible diabetes link, I would probably have started supplementing after 3 weeks as that was the advice the midwife gave me...

(Judith, email; 1st March 2008). Similarly, Sarah made reference to her daughter's food allergies in relation to her decisions regarding weaning and continuing to breastfeed.

Other benefits of breastfeeding

Many women referred to other benefits of breastfeeding. Some specifically mentioned emotional benefits, whereas others talked more generally about what breastfeeding gave them and their child and how this made them want to continue:

...It was really noticeable how the women present emphasised the emotional benefits of breastfeeding...

(LLL observation, field notes; 9th January 2008). Some commented on how important it was that those around them also understood this:

...[husband] is really, really important...[he] just knew that it was about so much more than just food, really understood that...

(Tina, interview; 5th July 2007). This is discussed further in relation to support (Chapter 10). One woman, reflecting on the benefits of breastfeeding for three years, said that it was:

...completely about closeness, about emotional...the bonding...the relationship between me and [son]...it's been a really strong element in meaning that we stay physically close...I got to know him through breastfeeding...I just think it is why we are so close now...

(Mandy, interview; 18th November 2008).

Many women also talked about breastfeeding as demonstrating their love for their baby (Mandy referred to breastfeeding as being 'love on tap') and as a gift to the baby and - although this was not specifically referred to as a benefit of breastfeeding - this was clearly implied when comments were made such as:

...it's a gift for life...

(Lucia, interview; 11th November), and:

...I really think it's this amazing gift I've given [son]. I just don't think I'll ever be able to come close to doing anything as good for him ever again...

(Tina, interview; 5th July 2007). The emotional benefits of breastfeeding were invariably referred to in strong terms:

...I really feel like he's the person he is because of what I did then...

(Mandy, interview; 18th November 2008).

It is difficult to separate out the perceived benefits of breastfeeding and of long-term breastfeeding. Most comments were retrospective reflections from the perspective of long-term breastfeeding and are discussed in more depth below.

7.2.4 No 'choice'/it's natural

Many women talked about breastfeeding and bonding and linked this to the 'naturalness' of breastfeeding and the influence that this had on the choice to breastfeed:

...Why deny something that is *programmed* and *natural*?...

(Tina, interview; 5th July 2008). Others related this specifically to the choice to breast- rather than formula feed:

...it's not necessarily the health benefits...I just always thought it's a natural thing...why would I want to bottle feed? I just thought the milk that a mother produces for her child is perfect for the child...

(Josie, interview; 28th October 2008). The naturalness of breastfeeding meant that for some there was no perceived choice about whether to breastfeed or not:

...I already had the feeling, ok, I've got my breasts, not only for my husband but as well for my children...it wasn't like I gave myself 'all bottle or all breast' it was... 'Breast (indicates breasts). Why different?' In this country you say 'you have a choice' [shrugs shoulders and says 'uh?']...

(LLL observation; 9th January 2008). This woman's comment also reflects her position as someone who had come to live in the UK from a European country, where breastfeeding was more usual. To her it seemed strange that one should not choose to do what was 'natural'. Others referred to the dual function of breasts:

...I guess I was always of the mind that breasts are only there for one thing, to feed a baby...Although I enjoyed the sexual feelings I got from having my breasts handled by men, I knew that that wasn't really what they were there for...

(Christine, email; 5th July 2008).

Others, particularly those who had experienced traumatic or interventionist births, felt strongly about the ability to do something they felt was natural and which facilitated bonding with their baby:

...Breastfeeding was the one natural thing I was able to do for him and I just really wanted to carry on with it, to continue with that...I...really felt that breast was best. I know it's clichéd but...it really helped me bond with him, no-one says that to you about breastfeeding. They say breastmilk is good, but the bonding...

(LLL observation; 9th January 2008). For some, the idea of breastfeeding helping with interrupted or delayed bonding was very important:

J: I'd had a traumatic birth, and I hadn't done it naturally...the way that I should have done...and therefore I wanted to give him something natural...a kind of proof, that my body could do something right in a way...we didn't do the birth the way I wanted it to...I needed the healing...and to give him something natural...it helped **so** much; it helped **so** much in bonding...

(Josie, interview; 28th October 2008).

The decision to breastfeed was also discussed in terms of the baby's need to breastfeed (and the role of this); this was primarily in LLL meetings but also in some interviews. An LLL leader, in one meeting, said that we were going to talk about:

...why babies are, how we know that babies are, so hard-wired to be breastfed...

She also commented that:

...Before our babies are born we're not aware of how much they also want to breastfeed...

(LLL observation, field notes; 9th January 2008). This suggests that the decision to breastfeed comes from the mother, but is also influenced by the

baby (and that this is part of its 'naturalness'). The influence of hormones was also noted:

...It was...scientific and not emotional...of course once you start and that oxytocin kicks in, and the emotions start, it is a different thing!...

(Christine, email; 14th February 2008).

7.3 Deciding to breastfeed long-term

A number of factors are involved in determining whether breastfeeding mothers continue beyond six months to become long-term breastfeeders.

The women in this study talked about being influenced by seeing others breastfeeding older babies and children, and about what is gained by continuing to breastfeed – both from their perspectives and from that of their children.

7.3.1 When do women decide?

For most women there was no point at which they ‘decided’ to breastfeed long-term. It seems very few women make the decision to breastfeed long-term when they are pregnant, or when breastfeeding infants. For most women it is something that evolves, for some slowly becoming part of a coherent set of beliefs about parenting (discussed further in the next chapter).

A minority of women decide when pregnant (or before) that they are going to practise child-led weaning (and therefore breastfeed long-term):

...the parenting philosophy was in place before I became pregnant...[including]...breastfeeding on demand and CLW [child led weaning]...

(Jess, email; 5th March 2008). More usually women were like Josie:

...I think a lot of long-term breastfeeders are the same...they [don't] necessarily have a goal 'I'm going to feed until they're two'...often it's just a gradual thing that happens...

(Josie, interview; 28th October 2008). This was discussed at one of the

Babes meetings I attended:

...I asked how it felt, now that it was his birthday, breastfeeding a one-year old, and had she ever planned to. She laughed...no she hadn't, but she loved it. We...[talked]...about how you never start out planning to breastfeed a one-year old [although as I write this I realise that this is not true – other people have told me that they did start out intending to breastfeed as long as their child wanted to]. The woman who had breastfed her daughter until she was two talked about how you just have a goal at the beginning of a few weeks and it just sort of happens that it goes on for a long time...

(Babes observation; 17th November 2011). Christine, looking back from the perspective of having breastfed for longer than anyone else in this research, had set herself goals each year:

...After...the talk on breastfeeding at my ante-natal class, I informed my husband that I would breastfeed for one year and then assess the situation. When my son was a year old I...decided that as we were both still enjoying it I would give it another year...on his second birthday I reassessed, and we were still enjoying it so I decided to give it a go for another year. On his third birthday, I had the brief thought of how amazing it was that we were still going. By his fourth birthday it was so much part of our lives that I didn't give it a thought!...

(Christine, from an article she had written, sent to me in an email; 3rd February 2008). Others, like Jane, wanted to 'see how it goes':

...I don't think I thought 'I am going to breastfeed for a long time', I just thought I'll just see how it goes, really, I hadn't had any firm decisions either way...

(Jane, interview; 19th March 2009). Some came to the realisation early on that breastfeeding might go on for some time:

M: ...I remember quite early on thinking I'd probably do it until he stopped and that was going to be ok. I remember saying to [husband]...'you know I might still be feeding him when he's three or four'...and his jaw hit the floor...we hadn't really discussed it, it's just something that gradually came to seem like a sensible idea...

(Mandy, interview; 18th November 2008).

A number of women talked about duration of breastfeeding in relation to health promotion messages. Many felt that they breastfed for six months because this was recommended by health professionals and policy (see Dowling and Brown, 2013, for further discussion of this point). Some women

felt that six or twelve months was understood as a cut-off point for cessation of breastfeeding:

...It didn't ever really occur to me to think about when I end...I just assumed there must be a time everyone stops...you know, that's it and...that's that, but it never really occurred to me what I would do to stop it...I never knew what that age was, I suppose either six months or twelve, I didn't really know...

(Sam, interview; 16th July 2009).

...I wanted to do, the kind of national...six months...recommendation...I wanted to do six months. I honestly thought I'd be weaned by a year. That's what my mum did and that's kind of what society...accepts in a way and I just really didn't think past that...

(Josie, interview; 28th October 2008).

Many women talked about being pressurised by other people to wean once six months had passed; this is discussed further in Chapter 10. Tina was unusual in specifically relating her decision positively to public health promotion:

...I'd always planned to do at least a year, probably two because I knew about the WHO stuff. And then I thought after that we'll just see...didn't have a fixed thing in mind...

(Tina, interview; 5th July 2007). She was also unusual in having thought about breastfeeding long-term at the outset.

Others felt that continuing to breastfeed was, for them, more logical than weaning onto another type of milk. Many women start using formula milk when weaning on to solid food - in part because cow's milk is not recommended for babies under a year old, but also because of the promotion of 'follow on' milks by formula manufacturers. However, as one woman said:

...weaning onto formula? I don't really see the point...it's my milk, and my milk's the best. If he wants milk he can have me...

(Woman breastfeeding a 9 month old boy, LLL observation; 9th January

2008). Josie also talked about this:

...I guess once breastfeeding became easy, especially before a year was up, I was like 'well I'm not going to stop before a year because that's silly because he'll have to go onto formula'. After a year I started to get a bit more...not hassle...my mum would start pushing then 'why don't you, he can drink cow's milk now'...he didn't really want bottles and he wasn't taking milk when I wasn't around...I just thought, well...I quite like it still and I don't want to force him to wean...

(Josie, interview; 28th October, 2008).

For some, the decision to breastfeed long-term was directly influenced by the experiences of others, both positive and negative:

...My own desire to breastfeed Janie until she naturally weans extends from my extensive knowledge of my mother's breastfeeding experience of me, my sister and my brother. My mother breastfed me for only 6 weeks... she really placed a lot of confidence in the advice of her doctors. She had recurrent mastitis and was encouraged by her doctors to stop breastfeeding...Furthermore her sister was a nurse and told her that all the benefits are received in the first 6 weeks...at six weeks my very discouraged and rather upset mother weaned me...Her mother had breastfed 7 children - no formula, no bottles, usually weaning when the next child was coming along...[she]...assumed doctors knew more and encouraged my mom to listen to them...

(Sarah, email; 30th January, 2008). For most women, however, the influences on the decision making process were not so clearly articulated.

7.3.2 Shocked and surprised – seeing older children breastfeed

During all interviews I asked about early experiences and feelings in relation to seeing long-term breastfeeding, many women talked about the first time they saw someone breastfeed an older baby or child. For some this was before they had a child themselves and many described it as 'shocking' or 'surprising':

'...I remember being quite shocked at the time...'

(Tina, interview; 5th July 2007);

...When we met, she was nursing her 15 month old and her 3 year old, so there was that positive model too. That was probably the oldest child I had ever seen breastfeed...the first time I saw it I was surprised for a second (not in a horrified way, just in a surprised way!)...

(Jess, email; 15th March 2008). Lucia's reaction to seeing her cousin breastfeeding a one-year old was similar:

...it was a shock, it was a surprise but then it was so normal and so physical and so matter of fact, so I say 'ok'...

(Lucia, interview; 11th November 2008). Josie's earliest exposure to long-term breastfeeding was when watching the television programme

'*Extraordinary Breastfeeding*' long before she had a child. She talked about seeing Veronika Robinson breastfeeding her seven year old:

...I don't know if I found it shocking, probably distasteful, the way she, it was happening...

(Josie, interview; 28th October 2008).

These reactions are not surprising: they are representative of our society's cultural unease with long-term breastfeeding. Some women reflected on how seeing long-term breastfeeding made them question their own plans about infant feeding:

...a couple of my closest friends did breastfeed until their children weaned themselves...I remember then when I was pregnant thinking '*I wonder if that will be me?*'...

(Tina, interview; 5th July 2007).

... it was surprising. It's...a funny visual...thing, the first time you see it...a big boy, with, you know, boots...long legs...I remember being, kind of, impressed, you know, thinking '*probably might not do that*'...

(Mandy, interview; 18th November 2008);

...mine wasn't so much when I first saw it as when I first heard about it and it was probably my conversation with Marie...she still fed her two and a half year old and I was a bit like...'**how** are you doing that? Or **why** are you doing that? And isn't that a bit weird?', you know, and, and she said 'well it just kind of happened'. And I remember thinking, '*this is not going to happen*'...

(Josie, interview; 28th October 2008). Interestingly these feelings of shock or surprise did not prevent these women going on to breastfeed older babies and children themselves. For some it was less about shock or surprise and more a feeling of unease:

...I don't think I thought 'I am going to breastfeed for a long time', I just thought I'll see how it goes really...I think I'd often...felt uncomfortable at the idea of feeding older babies and toddlers, but it didn't really bother me if I saw it happening...I might have sort of gone 'oh that looks a bit odd' but it wouldn't really have shocked me because...we've always done things differently anyway...

(Jane, interview; 19th March 2009). Some are surprised to find themselves breastfeeding long-term:

...I didn't know how long I will go, I had never realise that I would go so far...

(Lucia, interview; 11th November 2008). Knowing or meeting other women who were breastfeeding long-term influenced some women to breastfeed long-term or at least to carry on beyond the point that they were at:

...when I saw Anne breastfeeding her son at an LLL meeting it looked so natural that I knew I could nurse Janie for as long as she would need to nurse...

(Sarah, email; 29th July 2008).

7.3.3 The role of the child in the decision

A number of women talked about their child's will and involvement in the decision to carry on breastfeeding. The child's will was usually talked about in quite strong terms:

...I didn't have the will to stop him, he's a very sucky baby...a lot of it was not just about feeding, it was about love...and...about the fact that I didn't know how to stop him [laughing as she talks]...once I got this child to breastfeed he just actually never wanted to stop...it's easier for me to do that, than...deal with the emotions of him not breastfeeding...

(Tina, interview; 5th July 2007). Christine expressed this similarly:

...I don't think I could have stopped him if I wanted!...

Some women talked about breastfeeding for as long as their child wanted to
(suggesting that the child is in control):

...S: ...do you have any idea how long you'll go on for?
L: No. As long as she wants....it's up to her...
S: However old that is?
L: Five, four, she...
[laughs]
L:...I don't mind...
[both laugh]
L ...as long as she wants, it's up to her....

(Lucia, interview; 11th November 2008);

...you know, if this wasn't right for us then we wouldn't be doing it but then, you know,
I know it is because he shows me...it's him mainly...

(Sam, interview; 16th July 2009);

...I believe that if I let Janie be in control it will be much better. ...I really think what
keeps me going has as much to do with Janie's personality as mine. She is a very
determined little girl and she knows exactly what she wants or needs and is not at all
shy about making these wants and needs known...

(Sarah, email; 12th May 2008).

7.3.4 Positive enjoyment of breastfeeding

As well as benefiting their child, many women talked about what they gained
from long-term breastfeeding. This was not just in terms of the health
benefits (as Sam said, quoted previously, '*...obviously there's health benefits
for yourself...*'). Many women in support groups talked about how
pleasurable they found breastfeeding:

...the sensation of breastfeeding is something I didn't anticipate...I knew I was going
to try and breastfeed but then when I did, and you feel the let-down...when I feel it
bubbling away I think 'I love this!' [laughs] I don't want it to stop! I just really enjoy the
sensations it creates inside me...

(Woman breastfeeding 6 month old boy, LLL observation; 9th January 2008):

...I absolutely love it. I started doing it because it was...expected and I knew about
the health benefits...I love being with her, I love feeding her when she eats six times a
night [everyone laughs], I just love everything about it and that's...what I've started to
tell my friends now...they're smart enough to go and read why it's good for the baby

but so many people...look upon it as such a chore and they don't want to feed their babies...they want to do fewer feeds per day...I just love being able to feed her and I love the way she looks at me...and smiles at me...I love that I'm the only person who can do that with her...

(Woman breastfeeding six month old girl, LLL observation; 9th January 2008).

The LLL Leader at this meeting noted that it was not always easy to talk about enjoying breastfeeding:

... we're almost embarrassed, I think, to say how pleasurable, how good it is, especially amongst those mothers for whom it hasn't been such a success...

It is important to recognise that, even at LLL meetings, not everyone feels the same. One woman, in response to the previous comments about breastfeeding, said:

...I'm the opposite way – it just makes me cringe...

(Woman breastfeeding 14 month old boy, LLL observation; 9th January 2008). She was unusual in continuing to breastfeed because she felt that it was best for her child, despite finding it very difficult to endure physically.

This issue is discussed further in Chapter 9.

Other women referred to the emotional benefits of breastfeeding:

...What I most like is the intimacy and closeness that the breastfeeding relationship establishes between the mother and child...

(Sarah, email; 24th April 2008). Some women talked more generally about how good they felt about breastfeeding, seeing it as an achievement:

...I think it's fantastic and I just say 'I love breastfeeding' and everyone knows that... every time it made me happy...it just made me feel positive and like it was normal and good, a good thing...I look back on it and think it was wonderful. I'm so glad I did it...

(Mandy, interview; 18th November 2008);

...S: And if you look back over the last four-and-a-bit years, how would you describe the experience?

T: Oh, totally [pause] *amazing*...I was talking the other day to [husband] about it...about all the work and stuff I've done recently – and I said...when I look back, and I'm in my rocking chair, when I'm seventy...I think it'll be the achievement of which I

feel the proudest. I feel quite emotional saying that actually. I really think it's this amazing gift that I've given [son]. I just don't think I'll ever be able to come close to doing anything as good for him ever again...

(Tina, interview; 5th July 2007. Her emphases).

7.4 What qualities are needed to breastfeed long-term?

Many women talked about the personal qualities that they felt had enabled them to carry on breastfeeding. The qualities referred to are discussed here in two sections: in relation to confidence (self-confidence and knowledge about breastfeeding) and in relation to character traits (such as 'determination' or 'being questioning').

7.4.1 Confidence in self and in knowledge

Breastfeeding was talked about in relation to confidence on a number of levels: self-confidence, confidence in knowledge about breastfeeding, and confidence that it was the right thing for the child. For some, this confidence had the effect of limiting potentially difficult interactions with others:

...I've never had any pressure to wean from health professionals. I think it is partly down to not having had much illness, and partly down to confidence on my part - by not really quite grasping that anyone could have a problem with it, they find themselves unable to have (or at least to articulate) any discomfort...

...Honestly, I can't imagine having needed to persuade anyone of the advantages of breastfeeding. Perhaps my blithe assumption that no-one would object meant that all were intimidated into not doing so!...

(Jess, email; 4th April and 15th March 2008).

Many talked about confidence being a character trait present before they began breastfeeding or one that developed over time:

...I was confident in my knowledge...

...I am...much more confident about nursing as time goes on - confident to nurse in front of others in most situations and confident that I am doing the right thing for Janie...

(Sarah, emails; 6th February and 24th April 2008);

...I think I'm...very confident, I've always been quite a confident person and...I'm pretty brave as well and I've got good self-esteem so I think that...adds up to me going 'well, I don't really...care what other people think'... I think because I am confident I probably don't even draw that much attention to myself...I'm not...looking around...looking worried or anything, I've just...carried on and fed and carried on chatting as normal...

(Jane, interview; 19th March 2009);

...I have been told that I am very self-confident. So I guess that helps. I don't look for approval in what I do, I look for results. I follow my instincts...

(Christine, email; 12th March 2008).

Some women referred to being confident that breastfeeding was best for their babies:

...I guess I found it nearly impossible not to do what I knew was best for my baby's development physically and emotionally...

(Sarah, email; 14th February 2008).

...I'm...very clear in my mind that I'm doing the best for my baby so I don't mind what other people...think, I know that I'm doing the best for my baby and that's it... [it] is very clear to me that it's most important thing for my child and me...

(Lucia, interview; 11th November 2008).

7.4.2 Character/personal qualities

As well as confidence, determination was identified by many women as important in enabling long-term breastfeeding:

... Being determined to do what is right for my family rather than what society deems normal...

(Jess, email; 1st May 2008);

S: ...what is it you think that makes, why do some women like you do it? What is about you...

T: That's a good question. I think probably *sheer bloody mindedness*...

(Tina, interview; 5th July 2007). Tina's phrase resonated with me as I had often said this about myself in relation to my breastfeeding experience.

Christine identified intelligence and an ability to be questioning as key traits facilitating breastfeeding:

...I think that intelligence may have something to do with it too. If one reads the research and the books one can't help but realise how important species specific milk is...Maybe also a questioning mind. I never hesitate to question authority, and in that I include parents, politicians and people generally!...

(Christine, email; 13th June 2008). Christine's point about questioning authority is interesting: generally speaking the women in this research were not afraid to stand up for their beliefs and to question authority (health professionals were often perceived as 'authority' but their judgement and knowledge questioned – see Chapter 10).

In the previous sub-section Jane referred to herself as 'pretty brave'; Lucia talked about long-term breastfeeding in similar terms, referring to the need for courage:

...it's just that you finally get the courage and you go on and you go on and you go on...

(Lucia, interview; 11th November 2008). Many women acknowledged the need for strength of character in order to breastfeed when most mothers bottle feed, and most people disapprove of breastfeeding.

Sarah talked about having a strong sense of responsibility towards her child, and how this quality contributed towards her continuing to breastfeed:

...What keeps me going is this very strong sense of responsibility that I have towards my child...when I am overwhelmed or feel resentment I...have an exaggerated sense of this...this is also related to my having made the decision to resign when Janie was so young. I devoted myself to parenting with as much energy as I did with my academic work. It became what defined me and gave a very clear purpose to what I was doing...There are probably other factors, but in terms of my personal qualities it probably would be my perhaps extreme sense of responsibility...

(Sarah, email; 2nd July 2008).

7.5 Conclusion

This chapter has focused on women's decision to breastfeed and to carry on breastfeeding. Salient factors include what women feel is gained from continuing to breastfeed and what qualities they feel they need in order to carry on. The following chapter looks more specifically at what it is like to live with the commitment to breastfeed long-term.

Chapter 8: Living with long-term breastfeeding (commitment)

8.1 Introduction

This chapter considers what it is like to live as a long-term breastfeeder and how this changes women's lives. Participants talked about living with breastfeeding in relation to 'physical and emotional commitment', 'commitment to a way of life' and 'commitment to a style of motherhood'. There is some overlap between this chapter and the next with challenges identified in both.

Long-term breastfeeding impacts on lives in many ways. Continuing to breastfeed is a commitment to a way of life which is made at the outset or evolves over time, through meeting other long-term breastfeeders or through an interest in other parenting decisions/philosophies. The effect of this commitment varies, but was clearly demonstrated in all the data.

This discussion relates to both early and long-term experiences in the breastfeeding relationship. 'Baby' refers to points made specifically about babies, and 'child' when the reference is to babies and/or children.

Emphases in quotations are mine unless otherwise stated.

8.2 Physical and emotional commitment

8.2.1 Physical commitment

Most participants talked about the way that breastfeeding affected their lives physically: particularly tiredness and lack of sleep. Parenting a breastfed baby is likely to mean less predictable sleep patterns than if formula milk is used, and for long-term breastfeeders this unpredictability can last for months or years:

...Janie continued to breastfeed every two hours until she was very nearly 3! *It was exhausting...*

(Sarah, email, 2nd February 2008). Women who breastfeed on demand during the night could become very tired, although this was sometimes underplayed:

...daughter usually feeds three hourly in the night...a few different days and nights and the cumulative effect of the lack of sleep have made her '*a bit exhausted*'...

(LLL observation; 14th May, 2008). Most women talked at some point about sleep and tiredness:

...I just remember being so *exhausted*...

(Tina, interview, 5th July 2007). All three women quoted above talk about breastfeeding being more than just tiring.

The commitment to breastfeed on demand affects all areas of life. Some women, such as Jess, are able to return to work and keep their baby close.

Sarah tried this:

...We were very lucky to be academics. Mark worked out his teaching schedule so that he could hold Janie in my office while I attended...meetings. But the older she was the more confidence I had to simply breastfeed her in front of my colleagues...[however]...She seemed to need to be on my breast constantly. As long as she was there she was fine. She never stopped nursing during the night and quite

frequently was sucking at my breast the entire day. She was still doing this when 9 months old! It was...clear to me that I was not going to be able to continue my research and teaching...if this continued to be the case...

(Sarah, email; 30th January 2008).

Some women made a choice to 'attachment parent': see later in this chapter for further discussion. These women often breastfed on demand at night as well as during the day and co-slept. Most slept with their partner and their child (or sometimes, children) in the same bed; in other families arrangements were worked out according to need and/or convenience with the mother sleeping with the baby whilst the father was in another bed, even in different room. Often these arrangements evolved; some were conscious decisions. This was not always without difficulty:

...I think the co-sleeping became an issue when we had a by the bed cot...probably around the age of eight months [son] stopped wanting to sleep in the cot, he wanted to be in the bed with me...[husband] started moving next door half way through the night...then after a while, we realised it wasn't a temporary measure, and **then** it became an issue...

(Josie, interview, 28th October 2008). Some mothers did not overtly connect co-sleeping with attachment parenting: it evolved because it felt right. For Sam this realisation came on the night her son was born:

...an hour later I gets back up and sits there holding him again for the next whole night and then I was like, maybe I should try lying down and go to sleep and he just stuck there. I said to [husband] 'you don't mind him sleeping in bed with us, do you, 'cos...you have those things about cot death...' and he was like 'oh, no I'm quite happy'. Actually I think I said something like '...he'll probably be out of here when he's six months'...[laughs]...Now he's going 'remember that time when you said...'

(Sam, interview, 16th July 2009). Her son was nineteen months old at the time of the interview and still co-sleeping.

Some women were able to night feed without much disturbance to their sleep; not surprisingly they were more positive about the benefits of co-sleeping for the whole family:

...I like it that she can feed at night *without waking anyone*...

...(I'm)...not bothered about feeding at night - *I'm asleep!* So no, I don't mind that my child hasn't weaned...

(Jess, emails; 4th April 2008, referring to her four-year old daughter).

For some a combination of approaches worked best, with the child starting the night in their own bed and then coming into the parental bed during the night to breastfeed and remaining there. This might mean very little sleep disturbance:

...he'll wake up in the night and I tend to grab him, put him in bed and he'd latch on and we'd both go back to sleep and I don't really know anything until the morning ...I don't really know how many times he's fed in the night...because...*I'm asleep!*...

(Sam, interview; 16th July 2009). Tina had a similar experience:

...he's always slept with us and he still does...he breastfeeds to sleep...I'll go into his bedroom, he'll breastfeed to sleep and then...at 3 or 4 in the morning he'll come and hop into bed with us so we'll still all wake up together...

(Tina, interview; 5th July 2007).

Some women felt that although co-sleeping and night feeding were the 'right' choices, they suffered, both physically and emotionally, as a consequence:

... We were reluctant co-sleepers...Janie just would not sleep unless she was latched on. We had a crib...next to my side of the bed. She never slept in it. Neither of us could sleep as we were both afraid of rolling over on her...

(Sarah, email; 6th March 2008). Sarah commented (Janie was now three years old) that:

...Janie is accustomed to sleeping with me next to her and she needs to be latched on to fall back to sleep...I never imagined that this would continue for so long. Without any significant breaks I get a bit worn out...at times I get

short with her. Sometimes I've been physically worn out from nursing and from the continued nursing at night. I'm amazed how much better I feel since night weaning...

(Sarah, email; 6th March 2008). The exhaustion engendered by breastfeeding at night and co-sleeping can affect all the family:

...Mark is chronically sick due to the lack of sleep...always physically run-down and extremely tired. He falls asleep whenever he sits down. This is...a problem for him [at work]...I do get very worried about him and his chronic state of poor health...

(Sarah, email; 28th March 2008).

Some mothers continue breastfeeding at night until their child self-weans.

Others, like Sarah, decide to wean at night (whilst still breastfeeding during the day). A range of techniques achieve this:

...I think she had...squash in the middle of the night if she woke...we started trying other things...I remember counting to a hundred...and then getting to ninety-nine and going 'ninety-nine...fifty. Fifty-one...fifty-two'...and I was going 'go to sleep and if you're not asleep by the time I get to a hundred I'll feed you'...once she started going to sleep without feeding, she very, very quickly weaned...with [second child] it wasn't very difficult...she stopped feeding to sleep very, very young, so that wasn't an issue...

(Jane, interview; 19th March 2009). Some tried to do differently but it was too distressing for the child. At one point, Sarah recalled:

...(we) tried to night wean Janie but it was so awful that I just couldn't. She cried so hard and I felt that she still needed to nurse at night...

(Sarah, email; 30th January 2008). For some, night feeding was acceptable but continuing indefinitely was daunting:

...I intend to keep going for as long as he needs although sometimes wonder when the night feeds will stop – he started feeding every 1-2 hours at about 4 months and hasn't stopped!...

(Josie, pre-interview email; 15th August 2008). Josie elaborated on this further in the interview, concerned that feeding her son at night might affect plans for another pregnancy and birth:

...the thing that worries me...is that I want a home birth for the next one...but...who would look after [son] if I had to night feed him, if that's the only way he slept?...

(Josie, interview; 28th October 2008).

Issues with breastfeeding and sleep also relate to how the child falls asleep. Most of the participants were clear that they did not agree with the technique of 'crying it out' (where the baby is left to cry itself to sleep, eventually learning to get to sleep alone):

...obviously if that's how somebody else wants to do it, that's their choice, but I could never do it...I knew that I was never going to let my baby cry...

(Sam, interview; 16th July 2008). Most of the mothers whose experiences are discussed here breastfed their children to sleep. This can entail breastfeeding until the child falls asleep at the nipple (noted by Sarah, above) and may be very time consuming as the child can sometimes wake up repeatedly, particularly if the mother tries to move away. Many did this when their babies were very young, some continuing into toddlerhood or beyond. Although mostly disapproving of alternative methods and believing that they were doing what was right for their child's emotional and psychological development, this was often an aspect of mothering that left women feeling most tied to their children. Additionally, this practice was often disapproved of by others - particularly grandparents but also sometimes fathers - acting to isolate these women, often setting them apart from their peers.

The difficulties in committing yourself to a way of life that is counter-cultural were discussed by many women; discussed further in Chapter 9. Some mothers felt it difficult when visiting other people:

...the co-sleeping thing is a problem when you go and stay with people...the arrangement that we've come to, which works perfectly well in our house is that [daughter] goes to bed about eight o'clock and I go to bed with her...if she's sleeping **really** soundly and I want to talk to [partner] then I'll get up again and put the baby monitor on...if I'm tired, and he's going to go to bed as well then we just go to bed at eight o'clock...you go to stay with friends and they're like 'It's about six o'clock, are you going to put [her] to bed?' and we'll have supper afterwards' and I have to say 'Actually, can we have supper now, because I'm going to go to bed'. And they **just** do not understand. It's very awkward and I try and avoid going to stay with people like that now...

(woman at LLL meeting; 11th June 2008).

This was talked about specifically in relation to close family but also more generally; many women had received comments about their children's sleep and/or breastfeeding from a range of people:

Josie says:

'...I think the thing that I get... I still do a lot of night feeding...we started co-sleeping quite early on...it's mainly from my family, I don't get...direct things said but I get...'so, is he sleeping through the night?' and I get that from a lot of friends as well...'

E says:

'...maybe because they want to feel normal?...'

and Josie replies:

'...well it's our society though isn't it? Once they get to a certain age, maybe four months, they're supposed to be sleeping through the night, so if he's over a year and he's not sleeping through...'

(LLL observation; 11th June 2008). E's comment above is interesting, suggesting that many parents make decisions in common with the majority – which is a comfortable position - rather than choosing the different path.

In LLL meetings practical advice was shared about how to manage co-sleeping. Advice varied from thinking about the practicalities (size of the bed, the positioning of the child within the bed, using bed-guards or special

pillows), to how to manage other people's comments and views. Co-sleeping was discussed less at other groups, although it was occasionally raised and some mothers attending were co-sleeping. Breastfeeding to sleep and during the night were common topics of conversation at all support groups.

There were exceptions to the majority views outlined above. For example, Lucia was breastfeeding long-term but co-sleeping was not part of how she or her husband wanted to be with their children. Difficulties in night-time sleeping had been managed differently with each of her three children:

L: ...my little one...she wants me next to her all the time and I passed through a very hard period when she was about six months, I had to sleep with her all the time...I ...sleep with her until she really fall asleep...otherwise if I was trying to wake up, she was waking as well....

S: Did you find that hard?

L: Yeah, it was really hard because she want me to breastfeed her all the time, she wanted to be on my breast...all the night...it was really hard...

(Lucia, interview; 11th November 2008). Although there were occasions on which she had slept with each of her children she was clear this was not intended to be a regular part of family life:

S: Did you and your husband make a decision that you didn't want to sleep with the children?...

L: No...when, when there is need, for any of the children...to come to my bed and stay with me for a while, they're coming. Or...yesterday night we had [daughter] since four o'clock in our bed because she was very unsettled, she was crying...she want me. But...if there is no reason of staying...in my bed...they must be in their beds, that's what we decide. Because when do you have a private life, you don't have time anyway?

[both laugh]

L:...We had a period...about one and a half year ago, when...my oldest was about four...my little one was about one and a half... I had a period where three of them were in my bed, I said 'no!, please'...

(Lucia, interview; 11th November 2008). Lucia was one of the few women who related co-sleeping to intimacy with her partner. Sarah raised the topic in terms of her relationship:

...When we moved to England we tried the family bed again...none of us were sleeping well. So Mark again went into a separate room. This has had a big impact on our relationship...If I try to work in the night after Janie sleeps we hardly see each other...we feel a lack of connection and he doesn't feel connected to Janie. Quite simply Mark's a bit lonely...

(Sarah, email; 6th March 2008).

8.2.2 Emotional commitment

Feeling tied

Another recurrent sub-theme was how breastfeeding on demand tied mothers to their children in other ways. The mothers' emotional commitment meant that many talked about wanting time away from their child, but of finding this difficult, even impossible. Some women were with their child almost all the time (for some, **all** the time), day and night. Although they were committed to parenting in this way there were consequences in terms of personal sacrifice (for Sarah, in relation specifically to her career and her identity as an academic):

...Breastfeeding...on demand without pumping or using bottles, necessitates the continual presence of the mother. When I began this I did not expect that I would end up staying at home taking care of a small child...some of my frustrations with the lack of separation extend from a sense of never having made a decision to quit and stay at home...a set of circumstances led to a provisional decision to resign...As this...continues without a clear end in sight I get increasingly frustrated with the breastfeeding relationship...the distinction between breastfeeding and attachment parenting is difficult to make...the attachment parenting literature more so than the breastfeeding literature played a greater role in the parenting choices we were making early on...

(Sarah, email; 24th April, 2008). These issues are discussed further in

Chapter 9. Sarah also noted that the tie felt by some breastfeeding mothers may be particularly difficult as a different sort of relationship can be seen in those around them:

...[it]...might be very hard to cope with...the level of commitment extended breastfeeding brings - the child really does need mommy and...this may or may not be potentially overwhelming for a breastfeeding mother. It becomes increasingly difficult as the mothers of similarly aged children are returning to some state of normalcy and yet the particular mode of life that accompanies breastfeeding on demand continues...

(Sarah, email; 2nd July 2008).

The decision to parent in this way, whilst creating a strong bond, can also lead to feelings of being tied:

...Given the strength of the bond between me and Janie I am at times a bit exhausted by her need for me. I sometimes very much long for a break. Just a day to myself or a night without a toddler twiddling...

...perhaps because I have had so little time away from Janie that I am psychologically and emotionally ready for the breastfeeding relationship to end...

(Sarah, emails; 24th April and 29th July 2008). Others noted this too:

...it was...the emotional clinginess and just thinking 'I need, I just want some space' and because there's just no space at work, or studying or running the home...I felt quite claustrophobic...breastfeeding could feel like that sometimes...

(Tina, interview; 5th July 2007).

Some felt that this tie could affect the child's relationship with others, particularly fathers :

...[Sam] also talked about how she feels that [son] is very, very attached to her...and so she doesn't feel like her partner is really able to build a relationship with him because [son] doesn't want to do things with [partner], he's always wanting to know where she is. If [partner] takes him out...he's asking if she's coming too. She recognises that that will change in time but she sometimes finds that hard...

(Sam, interview field notes; 16th July 2009). In the interview she noted that:

...I do feel tied because I don't really feel like I can go out and I'm always conscious of it...

(Sam, interview; 16th July 2009). Many women talked about this; the extent to which they viewed it as problematic varied. It was hard for some partners to parent their child, for others it was more extreme:

...Another point is the relationship that Janie has with her father. She screams if he comes in when she wakes up...Mark is a very gentle caring father and he finally admitted that it hurts. We never imagined that we would have a marriage in which we followed traditional gender roles but this sort of parenting...does perhaps inadvertently reinforce some of the traditional parenting roles. Mark is left on the outside far too often as much as he tries to be close to Janie...

(Sarah, email; 6th March 2008). Jess and her partner were unusual. They had worked out a way of being with their child enabling continued breastfeeding, a close relationship with the father and for Jess to retain her professional identity (and to feel less tied, both physically and emotionally):

...I would always come home from work, or have her brought to me...when she was needing milk. So judging that was a delicate three-way process...because she and her father have always been probing that area...when is milk the answer, and when will other things satisfy - since she was very tiny, with me being the one working full time, I have been able to build up a sense of separate identity, both physical and emotional, through my working life, while being absolutely assured that my child is in the best possible care (her beloved daddy!). So it's easy for me to be a bit smug here - my daughter and I both have someone for whom a major part of their role is providing a parental alternative to the comfort of the breast as far as that is acceptable to the child, while guarding my professional life for me...

(Jess, email; 3rd June 2008).

Feeling 'touched out'/needing space

One consequence of the commitment discussed above is that many participants describe sometimes feeling the need for physical and emotional space:

C says that she finds it hard as:
'...I feel like I've constantly got one or other of them climbing on me...'
and B says:
'...it sounds like you need 'me time'...'
C elaborates:
'...one or other of them has to be leaning up against me, climbing on me...'
J says that it sounds as though she'd love to have some space.
C: '...I would...'

(LLL observation; 13th February 2008). Jess saw this differently (possibly because she was able to return to a job she loved, whilst still having very close and regular contact with her child):

...I have occasionally spoken to people who say what a tie breastfeeding is - that the mother has to be close by. And the answer I wish I had thought of before to say is "yes. That's right. The mother of a small child OUGHT to be less than 24 hours away, honestly, and if you don't want to be at someone's disposal on a daily basis you should get a dog instead"...

(Jess, email; 4th April 2008).

Not getting much time to oneself is perhaps expected when a baby is small

but when this carries on it can be hard:

...Marie talks about how hard it is with a new baby to find time to do anything – cook a meal, have a shower.

[one woman says she's given up showers and everyone laughs]

Woman E (breastfeeding daughter, aged around eight months; also has an older child) says:

'...my aim in life is to have five minutes in the bath *on my own*...'

[someone says "oh, yeah"]

and that as soon as she is in the bath her children want to get in too and this is not what she wants. F (breastfeeding a one year old) says:

'...when I am there in the shower she stands there making the sign for milk because she can see my breasts...'

[laughter].

Woman G (breastfeeding her two year old son) says that whenever her son sees her naked he wants to breastfeed...

(LLL observation; 13th February 2008).

For some women the constant sharing of their body with another can at times feel too much.

'...they're mine, I've got to say "they're **my** boobies" and he says "no, **my** boobies. And I say "they're **my** boobies and I've got to have them to myself for a minute...*you just need some time don't you*...I'm not just a pair of boobs...'

(woman breastfeeding a two year old, LLL observation; 14th May 2008). This lack of personal space comes for some during the night as well as during the day:

...I so much longed for a night without her climbing on me...

(Sarah, email: 2nd July 2008).

8.2.3 Maintaining the commitment

Committing to this way of life without extended family support was challenging for many women. Participants recognised that cultural norms did not support their choice. In our society, nuclear families often live apart from relatives and extended family, with few expectations of family support:

... this approach to parenting is extremely difficult without an extended family. Everything works so well whenever we are at my parent's house or when they are here. It really takes at least two people home to make this possible without causing everyone to be exhausted...

(Sarah – whose parents lived abroad - email; 28th March 2008). This was specifically discussed at one LLL meeting where the topic was 'Preparing for a new baby' and much of the conversation focused on how to manage more than one child. Jenny echoed Sarah's point, above, when she used the phrase:

..."it takes a village to raise a child" ...

(LLL observation; 13th February 2008). Issues of family support are discussed in more depth in the following chapter.

I asked all email interviewees what they would advise other mothers who were potentially embarking on long-term breastfeeding. Responses focused on the commitment needed by the mother:

...a mother planning to do this for an extended period of time, wanting a child-led weaning, may...perhaps need to start thinking about what it will be like breastfeeding a four-year-old and if this is something she can imagine doing...once a commitment is made to do this it is very hard to break it as a certain relationship is established between the child and mother...

(Sarah, email; 2nd July 2008).

...[a mother should be]...absolutely sure in her own mind why she wants to continue breastfeeding while her child still wants and needs it...

(Jess, email; 3rd June 2008). These comments highlight how - in the absence of a supportive culture - women may embark on breastfeeding long-term without fully appreciating the extent of this commitment. Sarah also noted that a style of parenting which prioritised the child's needs was difficult to change later:

...How we practiced attachment parenting also grew out of our attempts to respond to Janie's needs. It would be very difficult to change this approach...when I have tried to make changes without following Janie's lead it has usually been a bad idea...

(Sarah, email; 2nd July 2008). As has already been noted, this commitment to a way of life can create difficulties for those who choose to breastfeed long-term, whilst at the same time being considered appropriate and beneficial to the child.

8.3 Commitment to a way of life

8.3.1 Other parenting decisions and their relationship to breastfeeding

Attachment parenting

For many women, the decision to breastfeed long-term is related to other parenting decisions and is part of a commitment to a specific way of being as parents and as a family. Not all women who breastfeed long-term make the same decisions; common themes (in this data set, other research and a range of online forums) include co-sleeping, extended carrying (in slings or other baby carriers) and other methods designed to enable close proximity to the mother, and home educating. The majority of these behaviours loosely align with 'attachment parenting' philosophy (Sears and Sears, 2001, as discussed in Chapter 2). I asked all interviewees about this - what they were doing and what they thought about it - and it was also discussed in breastfeeding support groups.

Some women did what felt right and found out about attachment parenting later:

...I don't look for approval...I look for results...follow my instincts...only much later that I found that there was a name for it! Attachment parenting!...

(Christine, email; 12th March 2008).

...I found this thing called 'attachment parenting'...I found it when [son] was six months old and I read all about it and said 'but I've been doing that' but didn't know it existed...

(LLL observation; 14th May 2008). Others described attachment parenting without naming it as such:

...we've always made choices based on what we've read, we usually read a lot around things before we make decisions with parenting and...based on what our children's needs are...

(Jane, interview; 19th March 2009). For some, there was a gradual evolution of a way of parenting:

S: So do you think they were a conscious collection of parenting decisions?

T: I think it was...what feels natural we then talked about as a family...because...so much had happened during my pregnancy...We were buying a house and [husband] was ill...we had talked a little about things...friends had slings so I kind of knew we would do that, but...one thing did lead to another, and...in a very organic way...and it all sort of fits together somehow...I guess it is conscious...yes, I do think it probably is all part of a pattern...

(Tina, interview; 5th July 2007). Others made a deliberate decision to be 'attachment parents', or to follow similar parenting philosophies:

...Attachment parenting seemed to be the best way of raising a baby and I couldn't think of doing things any other way. Luckily Mark agreed with me...we were both so moved at the sight of Janie and both felt so much intense love for her. How could I not continue breastfeeding on demand for as long as she needed to, even if she needs to until she is 5 years old? As we got to know Janie this desire to give her what she needed grew deeper. She is a very very sensitive child...I knew that breastfeeding and having the security of mommy always there would be essential for her...

(Sarah, email; 14th February 2008).

Sam's experience and views were interesting. She was one of the youngest interviewees and came from a different social and educational background to most of the others (see Appendix D). We talked about the relationship between breastfeeding and other parenting decisions:

...SD: And...I think for some people it seems to go together, breastfeeding and keeping going, and co-sleeping and sling wearing and quite a lot of people home educate...were they sort of conscious decisions for you or did they just...[fall]...into place...

Sam: I think it did just fall into place...I know that since I've had him a lot of my opinions of parenting's changed...I can never let babies cry anyway, it was just never my thing...if that's how somebody else wants to do it, that's their choice, but I could never do it...I knew that I was never going to let my baby cry. But with the sling...I just missed him so much when he wasn't on me...I just couldn't put him down...When he was a tiny baby I'd just sit here and feed him...and never moved...we used to have the pushchair over there with the carry cot in...I couldn't just let him sleep there while I slept on the settee, I couldn't do that so I had to have him right next to me, so I think that's why I wore the sling a lot...

(Sam, interview; 16th July 2009).

Aspects of attachment parenting that were most discussed were co-sleeping and using slings (sometimes referred to as 'baby wearing'). Slings were used to carry babies and children, to keep them close to the mother, to breastfeed discreetly whilst in public and to help get children to sleep. They were mentioned most frequently in LLL meetings but also by some interviewees. Mostly the discussion was positive:

...some nights when you just know that they're not really tired or...they're teething...they're not going to settle...we'll wear the sling in the evening and they'll go off to sleep but you can still get on with your stuff and when we're...staying with friends as well we'll do that so that we're not missing out on any of the evening...

(woman talking in LLL meeting; 11th June 2008). Examples were also given of breastfeeding whilst wearing a sling:

...I slinged him for ages, because he was so tiny...it was easier. But even as a toddler I used the sling a lot...I was terribly good...I'd breastfeed him in a sling...walking along and my mum would go 'Are you feeding him?' [laughs]...

(Tina, interview; 5th July 2007). Interestingly, this parenting choice is still seen as different and often viewed negatively:

...Someone else says:
'...I've had more negative comments about slings...than breastfeeding...
'oh, is he suffocating in there?, can he breathe?...'"
Other women echo similar comments. One says that someone shouted at her 'you're not in Africa, love'; another that someone had said to her that carrying babies in slings is cruel as 'all they want is to be free and run around'...

(LLL observation; 9th July 2008).

When I started observing at Babes I was surprised at some of the similarities between Babes and LLL, in terms both of topics discussed and of the way that women chose to be with their babies:

...When I arrived Sam was wearing a 'kari me' sling...and her son was asleep in it. Again a breaking down of my stereotypes (she would look at home at a LLL meeting!).

We talked about slings – B has ordered one from the US on the internet for her 8 month old...we talked about how possible we had found it to breastfeed wearing a sling (none of us had although...knew people who had)...

(Babes observation; 19th June 2008).

...B's son was in the new sling that she had bought for him and we talked about that. When C arrived...she had bought a new sling too...she wanted A and B's help with working out how to wear it...they helped her try it on and work out how to position her baby in it. She wants to be able to feed him in it...there was discussion both about how to manage this with the sling and the sort of clothes she would need to wear. Practical suggestions included trying out the sling using one of her daughter's dolls until she is confident.

[It struck me that they would have been at home in a LLL meeting...they are caring for their babies in the same ways. Maybe coming less from reading and from the philosophy of attachment parenting and more from instinct/observing each other and what works for other women?]....

(Babes observation; 3rd July 2008):

Home educating

Many interviewees (both sets) articulated the links between parenting decisions and long-term breastfeeding.

...I think the extended breastfeeding community and the HE [home educating] community overlap significantly...both are expressions of family life which takes the needs and wants of the children as seriously as the needs and wants of the parents...

(Jess, email; 27th March 2008);

...I didn't home educate because there are a lot of people that share my style of parenting, I home educated first, and then found that a lot of them share my parenting style...in the end I found that they were home educating for similar reasons to me...they want to meet the needs of their children...school wasn't doing that...that is how it all starts. You breastfeed because it meets the needs of your baby...you find when you meet the needs of the baby, both the baby and mum are happier...you just carry on doing it...

(Christine, email; 12th March 2008). At LLL meetings the relationship between different ways of being with babies and children and breastfeeding was often implicit, as well as more overtly discussed.

Although the number of women I met who were home educating were small it was a topic that was often discussed, both in LLL meetings and in interviews. It was not raised in other support group meetings, perhaps reflecting the different socio-economic situation and educational background of the two groups of women. Home educators made a clear link with breastfeeding:

...there is an active home ed group that we go to twice a month...it is like an LLL meeting because there are so many people breastfeeding both babies and toddlers! There is a lot of breastfeeding in the home ed community!...

(Christine, email; 14th July 2008).

...but I now have a much wider circle of home ed friends, and they are very much more accepting. In fact breastfeeding is given as a reason for home educating! ...

...because to send a child to school while they are still breastfeeding a lot just feels wrong...

(Christine, emails; 14th July and 12th March 2008).

Sarah felt her five year old daughter was not ready for mainstream schooling:

...So, again a bit reluctantly, I will be home schooling her next year. In the US school starts at age 6 so I don't really think of this as home schooling, just following a different schedule that suits Janie...

(Sarah, email; 12th May 2008). Others recognised home educating as an option:

S: And do you have any plans to home educate...or is that not part of it?

M: No...not as yet...my plan is to try the local school...and then if it doesn't work that will be an option, definitely...

(Mandy, interview; 18th November 2008). Others felt comfortable with people who had made similar parenting decisions to themselves:

...And I do remember thinking, very strongly when I went to...the first home ed meeting...and [eldest daughter] was two and [second child] was just four months...I remember feeding [eldest daughter] there...I wouldn't have done this if it had been any other sort of meet...because it was of home educators who had already made...a really alternative choice...it didn't occur to me that it wouldn't be ok...

(Jane, interview; 19th March 2009). As has been noted, making decisions about parenting that are different from the prevailing cultural norms can be difficult (this is also discussed in the next chapter). Many women talked about this as doing something important and 'right':

...we've just made choices according to what our needs are and what suit us and...once you start doing that it's much easier to keep doing that. It's much easier to go 'I'm not going to do that just because everybody else does, I'm going to do it because it's right for our family'...it really does free you up, you start...not worrying about what people think and...more about...what's important and what's right...

(Jane, interview; 19th March 2009).

8.3.2 A parenting tool

Many women talked about breastfeeding being a parenting tool – breastfeeding was not only about nutrition but was also a parenting strategy with their child:

J: It's quite convenient that he still feeds because I know kids wake even though they don't...so when all these people say well it's the breastfeeding, I know that's not true...he goes to sleep almost instantly...I don't actually have a lot of disturbance, especially like when he's ill and things...it's a really good way of...settling him...
S:...useful parenting tool, isn't it?...
J....it's very useful!...

(Josie, interview; 28th October 2008).

Others talked about it in terms of fostering intimacy and helping their child manage difficult behaviour:

...What I most like is the intimacy and closeness that the breastfeeding relationship establishes between the mother and child. I feel that Janie really trusts me...this gives her confidence and security. It has enabled me to know Janie very well...to be sensitive to her needs and her moods. She is a very intense child...some days I don't know what I would have done to calm her down if I were not breastfeeding...

(Sarah, email; 24th April 2008).

...S: What, what about...non-physical effects on the children, do you think it's helped them be calmer...or closer to you...

L: Oh yes, it's a very, very strong toddler tool, it is!

[both laugh]

L: It is, especially with my boy...he's the naughty boy...of the family, he's a very active boy...The only way to calm him down is just giving him cuddle, cuddle, cuddle him, put him to my breast, put his head here, 'calm down, calm down' and that was it...

(Lucia, interview; 11th November 2008). Interestingly, Lucia doesn't talk just about breastfeeding but about putting him close to her breast (*'put his head here'*).

...I found it also really helped me cope with tantrums...they just stopped immediately I fed and [eldest daughter] didn't have very many tantrums...which I...put down to breastfeeding...[second child] didn't have any tantrums at all until she weaned and [third child] weaned very young...at eighteen months and she's been very tantrum-ey. [laughs]

(Jane, interview; 19th March 2009). Others made less specific reference to this:

...I liked the way that it solved so many problems...

(Christine, email: 7th April 2008).

8.4 Commitment to a style of motherhood

8.4.1 Transition to a new phase

Many women talked about the relationship between motherhood and breastfeeding, both positively and as a tension with other roles in their lives. Breastfeeding was usually tied in with their identity as mothers. Two interviewees (Tina and Sarah) talked specifically about this, it was also discussed in support group meetings, most often at LLL. Some talked about breastfeeding being a particular part of motherhood and about the time spent breastfeeding (however long) as a specific period within this:

...when you look back over your life, this is going to be such an incredibly short intense period of it... a 'phase' which will have passed...

(Tina, interview; 5th July 2008). Tina described mothering as:

...the most important thing that I do...

discussing a tension between mothering and other things she had to do (study, work, pay the mortgage). Breastfeeding played a key role in this for her.

Mandy commented on how breastfeeding helped her:

...motherhood is a pretty big thing isn't it? It's a big transition...it took me a long time...with difficult times in the beginning when he...cried for three months and the only time I could hold him when he wasn't crying was when I was feeding him was the beginning and that was the way it worked for us and I was, like, ok, this works, I'm going to hold onto this. And from then on, I just enjoyed it...

(Mandy, talking in LLL meeting; 14th May, 2008).

8.4.2 Being a mother to more than one child

A number of women talked about how commitment to this style of motherhood had affected how they thought about their potential ability to

mother more than one child. This was because they were breastfeeding at night and because of the bond they had with their existing child:

...In relation to having another child; mothering two in this way...With Janie still needing me as much as she does...still needing to nurse quite intensely at times we don't see how we could have another child as much as we had wanted to...I'm very worried that my milk will go at some stage in the pregnancy and that this would be traumatic for Janie and very sad for both of us. I...don't see how I could manage to parent two children this way and still maintain some sort of relationship with Mark...

(Sarah, email; 6th March 2008). Josie was concerned about this too, and also wondered how she could practically mother two children:

...J: If I wasn't going to have any more children I think I'd just leave it until [son] was ready. Because we want more children...I keep thinking...around now is when a lot of people start trying, or even have had children...the thing that worries me most is the nights, I don't mind tandem feeding during the day but it's the nights, I just don't know how I'd do that,
S: But not altogether? You, you don't mean stop breastfeeding...
J: No, just the night feeds. It's just the night feeds that I want to get rid of really...if I was going to have another one...

(Josie, interview; 28th October 2008). In the period since these interviews Josie has had another child; Sarah has not.

Some women, having made the decision to breastfeed long-term, including breastfeeding at night, became concerned about how this might affect their ability to have another child. This was talked about in groups:

...There were some specific questions from women in the group around having another child (how to conceive if you are still breastfeeding and your periods haven't returned? Can you conceive if you are having periods but still breastfeeding lots? How can you think about having another baby if you are breastfeeding lots, particularly at night and co-sleeping?). Jenny gave knowledgeable advice and women in the group talked about their experiences...

(LLL observation, 12th March 2008). During data collection I met some women with more than one child who talked positively about their ability to mother them in the way that they wanted (Jane, for example, was doing this with her four young daughters); others found the experience very difficult. During one LLL meeting one woman talked about this. The difficulties she

refers to are specifically in relation to tandem nursing but her desire to do this stemmed from wanting to do what she believed was best for her children:

‘...there’s not many places where I can...say this, but...my experience with tandem feeding is...I was really positive, it was something I wanted to do...looking back at it...what I wish I’d done is to have a much bigger gap between the two of them...because I do feel I haven’t met [daughter’s] needs...anywhere near as well as I should have done...because I was committed to the whole breastfeeding thing, and I’m still committed...but...I really don’t think that I’ve given them both the best deal...’ [She starts crying. There is silence in the room and then someone says ‘it’s ok’]

She continues:

‘...I didn’t want to come in here and be really negative...but I think...for anyone who is really committed to the whole breastfeeding thing that it’s something to consider, if you’re thinking about a second child...I wish that I’d just weaned [daughter] completely and not put her through it afterwards, or...left a much bigger gap so that I could have met [daughter’s] needs for as long as they needed to be met before the second one came along with all their needs...’

A number of women talk at once and someone says ‘but you are meeting so many of her needs’ and she says:

‘...but I’m not meeting *mine* a lot of the time and I’m just finding it really difficult to get past that...’

[she is crying again]...

(LLL observation; 11th June 2008). This woman also identifies a dilemma felt by others – how to meet both her own and her children’s needs when committed to this particular style of parenting.

8.4.3 Working outside the home

Deciding whether to work or not

The decision to breastfeed long-term and to adopt a particular parenting style often means that the mother does not return to paid work for some time beyond what is considered a ‘normal’ maternity leave period. In order to practice attachment parenting and breastfeed long-term most women need to be living in financially secure circumstances (although some do breastfeed long-term and return to work). There are often inherent assumptions about women’s social and economic status in discussions about AP and I may not

have been sufficiently critical about this in the analysis of my data. At LLL meetings I was more likely to meet stay-at-home mums of older babies/children than at other groups, although breastfeeding and returning to work were discussed at both. Only one interviewee (online and face-to-face) was working outside the home when we met (see Appendix D). As noted above, for Sarah not working was a reluctant choice but for others it was deliberate:

...my intentions to breastfeed and to be a stay-at-home mum were there when I was a child. I've had that intention as long as I can remember, I always wanted to get married, have children, be a stay-at-home mum...I think if you have a child...if you can afford to stay at home you can. And so we made sure that we could do that....

(Josie, interview; 28th October 2008). Sam also said she had always planned to be a stay-at-home mum, just '*holding out*' at work until she could go on maternity leave (and not planning to return). Many mothers plan to return to work but change their minds once they have a child:

...I had planned to go back one or two days a week, but then we decided it would be better for me to be at home full time and I enjoyed it...

(Jane, pre-interview email; 10th July 2008). Sometimes the decision not to work outside the home is hard to explain to other people:

...M: I was working long hours.
S: Right. And then you stopped work completely?
M: Yeah.
S: And had that always been your...intention?
M: I'd always...said I'd take a year off and then we'd see but by a year I didn't want to go back...I was really lucky I could be at home and that was weird, people found that very weird...
S: That you didn't go back to work?
M: ...I was so happy not to go back to work and they were just like 'you must be so bored' and I was 'no! that's the one thing I'm **not**, the one thing I **was**, bored...
[laughs]
M: ..and now I'm not! So....it was a hurdle!..

(Mandy, interview; 18th November 2008). Mandy also specifically discussed this in relation to the perception of men's and women's roles and to what is seen as 'work':

...But I just feel really strongly that it's something we can do as women that men can't do that should be celebrated and respected...we should be allowed to enjoy it...I just think if I don't do it now, I'll regret it, I'll really, really regret it...I want this to be my work for now and then I will go back to work later. Everyone says you can't have a brain if you don't go to work...it's crazy...

(Mandy, interview; 18th November 2008).

I have chosen not to explore further here the economic and class assumptions which could be seen to be inherent in this discussion of women's decisions to work, or not, outside the home. Further development of this would be interesting and could usefully draw on Giddens' notion of 'life-planning' (1991) to further contextualise these women's experience within their broader social context.

Some women find that once they have a child there are other ways to work e.g. doing voluntary work. This can combine interests with the decision/commitment to be close to, and available for, the child – and also, for some, enables them to home educate. Examples include those who undertook training as breastfeeding supporters (Clare, Mandy, Lucia) or those who volunteered in other areas (Christine).

Jess was in many ways unusual – she returned to work when her daughter was very young but continued to breastfeed for many years. She was perhaps lucky in being able to make these choices, having both a flexible

occupation as an academic and a supportive partner who cared for their child. This meant that they were able to be very responsive to their daughter's needs:

...She came to work with me until she was about 8 months old...we'd time it so she was with me for feeds and naps...her father would then take her away and entertain her in the near vicinity until she needed milk again!...

(Jess, email; 10th March 2008).

The commitment involved in working outside the home

For those who decided to work outside the home and continue breastfeeding long-term there were particular difficulties. Managing the milk in their bodies is more of an issue for women with younger babies although all breastfeeding mothers are aware of it:

...I didn't ever express milk at work. I just remember coming home from work and rushing to the nursery and just being so relieved, probably being more relieved to see him than he was...to see me...

(Tina, interview; 5th July 2007);

...F was waiting for her son (8 months) to wake up as she had been at work, forgotten to take her breast pump and her breasts were feeling very uncomfortable and full...

(Babes observation; 5th June 2008). One LLL meeting had the theme 'working and breastfeeding':

...Jenny talked about each woman working out for herself what she needed to do and emphasised that returning to work did not have to mean an end to breastfeeding (but qualified this by saying that it depends on the age of the baby and the hours worked)....

(LLL observation, 12th March 2008). At several LLL meetings women asked about returning to work, seeking advice about topics such as using expressed breastmilk in bottles or cups and negotiating weaning styles with other carers. Although I had expected the majority of women in Babes and

BIB meetings to need to return to work, working and breastfeeding were seldom discussed in these groups.

8.5 Conclusion

This chapter has considered the commitment involved in long-term breastfeeding. This includes physical and emotional commitment as well as commitment to a way of life that, for some, involves other choices about parenting, including education. A commitment to a style of motherhood is also shown, including decisions about working outside the home and about having further children. A number of these issues have been shown to be particularly challenging for women who breastfeed long-term. The following chapter focuses on the findings in relation to further challenges - breastfeeding in public and responding to/knowing about cultural unease with breastfeeding long-term.

Chapter 9: Challenges in breastfeeding long-term

9.1 Introduction

As demonstrated in the previous two chapters, breastfeeding long-term is associated with many challenges for women. The previous chapter identified challenges in breastfeeding on demand, at night and co-sleeping, the need for emotional and physical space, and working outside the home. This chapter looks at other challenges facing women who breastfeed long-term. Two main sub-themes in relation to challenges are addressed in this chapter: breastfeeding in public, and responding to/knowing about cultural unease with the practice.

9.2 Breastfeeding in public

I initially hypothesised that many women who breastfed long-term would – as I had done – find breastfeeding in front of others and in public places increasingly difficult as their child grew older, that they would be more likely to breastfeed in secret (or, at least, in places less likely to be construed as public), or that they would hide the fact that they were ‘still’ breastfeeding from most of the people around them. One of the biggest surprises for me was that, for most women I met, this was not true. This section discusses how women experienced and talked about breastfeeding in public, specifically about the perceived need to be ‘discreet’ and about the strategies employed in order to feel comfortable breastfeeding in public.

I open with a discussion about how women interpret different spaces as being ‘private’ or ‘public’, and then focus on the ways in which women both understood and anticipated the reactions of those around them when they breastfed, both outside and inside their homes.

9.2.1 What does ‘breastfeeding in public’ mean to women?

Many participants talked about how they felt the need to manage other people’s reactions in their own homes as well as in public places. What might be seen as private places can be experienced as public when breastfeeding. Sam talked about managing breastfeeding in front of her father-in-law:

...Sam: ...A lot of the time it's a bit awkward...he comes and visits us here and obviously when you're at home, they tend to have access to you [she is talking about her son here] and he just wants...most of the time he's sat there and I'm sat here and he's leaning across and just feeding and obviously you're out for all to see so it's a bit like, I have to say, 'lie down like this' and he tends to get a bit shirty because he doesn't like lying down to feed...so...
[laughs]

SD: So you feel like you have to change your behaviour a bit?

Sam: Yeah. Well, yeah, because...you can't just leave it all out!..

(Sam, interview; 16th July 2009). Some women did not make a clear distinction between outside and inside the home as both apparently felt like breastfeeding in public:

...since he turned eighteen months I'm finding it a bit more difficult breastfeeding in public, but he doesn't usually ask...I feel like kind of ok around my mum and my sisters...if there's a big room of my family, if they're all there...I do feel a little bit self-conscious...

(Josie, interview; 16th October 2008). This might even be with people who are perceived as supportive:

...Woman A talks about not feeling comfortable 'doing it' in public from when her older daughter was about a year, perhaps even from about eight months:
'...I just feel it's such a personal and private thing, I just couldn't bear it...and even in fact, my mum, my parents, who are very open to breastfeeding, when they came when she was older I felt I had to go into a room with her and feed her there. I didn't find it comfortable in public...'

(LLL observation; 8th January 2008). Ideas about what is personal and private could be because cultural messages about the appropriateness of behaviour around breastfeeding have been internalised. It is important to also recognise that individual women will have different experiences of these issues. Although these women talk about the effect that their behaviour had on their feelings, saying '*it's a bit awkward*', *I feel...self-conscious*' or *I just couldn't bear it...I didn't find it comfortable*' it seems that often what they are implicitly talking about is managing their behaviour to avoid other people feeling uncomfortable.

In this relatively long excerpt from our interview, Josie demonstrates how breastfeeding at home can be far from straightforward:

...J: I try...not to let my insecurities get the better of me so I'm still breastfeeding around my friends and around my family...I have gone into another room on a couple of occasions and [husband] always says to me 'what are you doing?' ...but I do tend to take myself...if we were all sitting round the table...I'll go and sit on the sofa. In the same room but just so that I'm not...at the table breastfeeding... And I may do the same if we were sitting on the sofas, I may go...just so that I'm not right in front of them but I'm still in the same room saying it's ok to breastfeed my child...

S: And your mum's partner, are you ok about breastfeeding in front of him, and your father-in-law? Is it any different, with them?

J: Not really. But again, it's more how many people are in the room...I guess maybe feeling on display...last time I did it...there was, my whole family were there and all their partners, there were ten of us in the room, I felt like everyone was looking at me even though no-one was...I felt like I was on display. It was very discreet but that's how I felt...no I don't really feel a big difference with the male...in fact it's kind of more so with the females 'cos I know they're the ones judging me.

S: That's interesting.

J: So..., I know that the blokes will be, you know they don't really have much of an opinion...whereas the women, I know they do...

(Josie, interview; 16^h October 2008).

Josie also recognised that there is a cultural expectation that breastfeeding would take place out of public view:

...I heard a breastfeeding discussion on the radio about breastfeeding in public and there were all these...quite old people phoning up and saying 'you shouldn't do it, you shouldn't do it in public, it's something to do at home you know' but bottle feeding's fine. And that annoys me [laughs]...

(Josie, interview; 16^h October 2008). Although not an issue for those who were breastfeeding long-term, she also recognised that feeling comfortable with breastfeeding in public was important for those who were establishing breastfeeding:

...because in the beginning you're learning something and you're not confident with it...that's the time you really need support, you need people around you to say 'it's ok to breastfeed here dear', you know...

(Josie, interview; 28th October 2008).

9.2.2 Actual versus anticipated reactions

Many women talked about how others reacted to their breastfeeding and, in turn, how this affected their behaviour and their ability to breastfeed comfortably. For the majority of women reactions were anticipated (or perceived), therefore implicit rather than explicit; most said that they had not had any comments or adverse reactions to breastfeeding in public. However, anticipated reactions (their sense or feeling that something was going to be said or done) often affected their breastfeeding experience. Some women had experience of actual comments or reactions when breastfeeding. The discussion below is therefore sub-divided to reflect these two main issues.

Actual reactions

The majority of women when asked said that they had breastfed in public, for most it was part of everyday life:

...I had lots of friends who were doing the same thing...it was normal...

(Mandy, interview; 18th November 2008). Although most women had not received any negative comments when breastfeeding, as Tina said:

...absolutely *none*...

(Tina, interview; 5th July 2007), some did refer to negative comments that they had received and suggested that they had perhaps adjusted their

behaviour accordingly:

...I'm quite lucky we haven't had *too many* negative comments recently, whether that's because I don't feed quite so much in public anymore...I've stopped meeting up with friends I know will say anything about it...I've given up trying to explain it...

(woman in LLL meeting; 7th July 2008). Lucia talked about having received negative comments but not being influenced by them:

...L: I never had a problem with breastfeed my baby anywhere. Never. I've never felt I...had to go somewhere...or discreet, or something like...never...

S: So you've breastfed wherever...

L: I have breastfed my baby wherever I was and however I want, I never have this problem. And if somebody was disturbing because I was breastfeeding my baby I say 'it's none of your business, it's my business' so...

S: And have people said things to you?

L: Yeah, yeah.

S: Lots of times?

L: I had some incidents and I have told them, 'please, if you don't mind to see me, please, I'm doing the more natural thing for my baby...it's not your business'..

(Lucia, interview; 11th November 2008).

Some gave examples of both positive and negative reactions:

...there was one day when he must have been about 6 when he had a meltdown in town, and I sat on a bench and nursed him until he calmed down, and someone came up to me and said how lovely it was that I was still nursing him! I had to nurse him during a meltdown in a public swimming pool and the duty manager asked me to leave. John was really screaming and I wanted to leave anyway...the next morning I got onto the council and gave them one! They didn't have a breastfeeding policy so I said they had better get one quickly! Within days they had a policy in place saying that you could breastfeed anywhere, and the duty manager was told off for not allowing breastfeeding!...

(Christine, email; 13th June 2008). Sarah also gave positive examples:

...Once I nursed her on a walk and she was having what I call melt down right by the Catholic Cathedral...So I nursed her there on the steps until she fell asleep. A very friendly priest came up and had a chat with me, not at all fazed that a 2+-year-old was sleeping and nursing. That was the only time someone actually approached me when I was nursing in public (I was prepared for a rather different response). Janie and I went back on our own to the US last August, when she was over 3, and I nursed her on the flight with no trouble. I must say that I've been quite surprised...

(Sarah, email; 14th February 2008). Mandy talked about feeling that

breastfeeding in public was positive:

...S: So did you breastfeed in public...altogether?

M: Yeah, yeah.

S: Up until what sort of age?

M: Well...we moved here...and I would still feed him in the park...people would come up and talk to me...often children would come and stand there...you know how they're fascinated, like an inch away, and their parents would come sidling up and sometimes people... would then say, oh they're a friend of a friend, 'oh you know about breastfeeding, what, what should I do about this, or...'

S: Right, they saw you as a source of, as a resource?

M: It was kind of a positive thing...yeah. I didn't get any negative comments...
(Mandy, interview; 18th November 2008). Sam, who breastfed in an area with very low overall rates of breastfeeding also noted that she had never had negative comments:

SD: And going back to the thing about not many people breastfeeding round here, have you always breastfed him in public?

Sam: Yep.

SD: Even now?

Sam: Yep.

SD: And how's that been?

Sam: I think that...nobody's said anything...he doesn't need to be fed in public that much anymore, so it's only on the odd occasions, but...nobody's said anything, so...I do it...

[laughs]

(Sam, interview; 16th July 2009).

For others there were specific reasons to be concerned about reactions to breastfeeding:

...Just before Janie was a born a sex abuse case was brought against a mother in our city who was breastfeeding a 5-year-old boy. She was...held in custody with no access to her son during the trial...the whole case, particularly since it was in our city, made me very worried about breastfeeding in public...

(Sarah, email; 6th February 2008). Although this case is unusual and took place outside the UK it is an example of extreme cultural unease with breastfeeding an older child and demonstrates how these attitudes can affect the behaviour of individual women with their children. One of the mothers I interviewed had also been reported to the authorities in relation to her parenting, including her decision to carry on breastfeeding her son:

...people in the village turned against me, and twice reported me to social services. The first time the social worker just appeared on the doorstep and told me not to worry about it. She knew it was neighbours disapproving of our lifestyle. The second time...we had to endure a full initial assessment. One of the items...reported was that I was still breastfeeding and that it was a cause for concern (there was a huge long list of them, most of them amazingly silly)...the social worker said that it wasn't a problem at all...they weren't concerned at all, and were really apologetic about it...

(Christine, email; 14th February 2008). Although the authorities were sympathetic towards her, the reaction of her neighbours is indicative of the prevailing social and cultural attitudes towards long-term breastfeeding.

Anticipated reactions

The anticipated reactions of others were expressed in a number of ways.

Feeling self-conscious was often talked about in relation to breastfeeding in public, this perhaps coming from an awareness of other people's discomfort:

...I was more *self-conscious* about doing it in public as she got older (closer to a year old) but that didn't stop me...

(Judith, email: 14th June 2008). Almost all women, however comfortable they said they were about breastfeeding in public, were aware of an increased awkwardness as their child grew older:

...when they're little...before he was six months especially I didn't care about feeding him out in public but now you do...you feel a bit *awkward*...

(Sam, interview; 16th July 2009).

...and he was quite young and everything but I did feel **very** uncomfortable because I knew...that the café owner could come and ask me to stop...and it's just that embarrassment factor...at the time I wasn't confident enough, I'm much more confident now he's older...but, even though it's a bit more taboo...

(Josie, speaking at LLL meeting; 9th July 2008).

It was also interesting that many women talked about being surprised when negative reactions were **not** forthcoming. They clearly had an expectation that others would find breastfeeding older babies and children difficult and anticipated unpleasant or difficult comments. Sam told me that no-one had ever commented when she breastfed her son in public, even as he got older and she was doing this in an area where there was very little breastfeeding,

even of babies. The final line of this quote indicates that she expected that someone would say something:

...SD: It does interest me that nobody's ever said to you 'this is really weird' or...
Sam: Yeah, I know...
[laughs]
Sam: I'm still waiting for the day someone's going to say it...

(Sam, interview; 16th July 2009). Sarah clearly expected negative responses to breastfeeding a toddler in public (in the situation discussed above) and was surprised when these were not forthcoming:

...I was prepared for a rather different response...Janie and I went back on our own to the US last August, when she was over 3, and I nursed her on the flight with no trouble. I must say that I've been quite surprised....

(Sarah, email; 14th February 2008). Many were aware of the potential for a reaction if they breastfed in public and even those who had been very confident about breastfeeding older children began to think more about this over time:

...this is something which has been shifting for me in the last few months. I feel less comfortable about it, and it is because of potential reactions...

(Jess, interview; 1st May 2008).

Interestingly, even if women did not actually receive negative or adverse comments, sometimes other people's behaviour was interpreted as indicative of a negative reaction:

...Woman H asks how those women who have older children cope socially, feeling that there might be 'bad looks'; she has friends who have had remarks when they've fed their children on trains... She talks about how we can shut out their comments as we know we are doing the right thing but that saying 'mind your own business' doesn't really change anyone's perception...

(LLL observation; 8th January 2008). I talked about this with Sam:

...SD: And have you ever had a sense that people might be thinking something, even if they haven't said it?... like a look, or... know other people have said to me they just...try not to make eye contact and that sort of thing...
Sam: Yeah, yeah, definitely.

SD: But is that because you think if you do...you think they might say something...
Sam: Yeah, they might say something...yeah, if you catch each other's eyes, yeah.
SD: So you have a sense that they might not, might not like it, or approve of it?
Sam: Yeah. Might not approve it, yeah...

(Sam, interview, 16th July 2009).

9.2.3 Being discreet/feeling comfortable in public

Many women talked about feeling that there was some need to be 'discreet' when breastfeeding and what that meant to them. This was not only an issue for women breastfeeding older babies and children, but also those feeding younger babies. I focus here specifically on those whose experience was with on-going breastfeeding. Many women talked about being discreet as something that was expected: using the term 'being discreet' suggests a need to protect others from the sight, rather than the focus being on the woman feeling comfortable in being able to breastfeed her child wherever she was. Tina here talks about being able to breastfeed without other people noticing:

...I think people either haven't noticed or its been ok.....I was terribly good...I'd breastfeed him in a sling, I'd be walking along and my mum would go 'Are you feeding him?' [laughs]...

...I think probably from about two and a half on, it got less and less, unless I could really, you know, often it would...[husband] used to say 'it just looks like you're having a nice cuddle'...

(Tina, interview; 5th July 2008). Although Tina refers here to breastfeeding her son in public less as he grew older, Christine breastfed her son in public until he was over six years old. She talks here about being discreet, and perhaps others not noticing because they did not know what they were seeing:

...There was the time when I was down at the...Horse Trials and John was about four and a half. It was the...cross country day, and John and I set up our blanket between two jumps...There wasn't many people sitting there, but lots of people would walk between the jumps. I had a really baggy long sleeved T-shirt on, because John preferred to nurse under my shirt. He dived under, and it was so big that most of him disappeared. And then a foot or hand would appear out of the neck! He would wave and kick, and occasionally unlatch himself, and stick his head out! People were laughing their heads off because it was so funny watching us, and I just smiled away at them! If only they knew what was really going on underneath!...

(Christine, email; 13th June 2008).

Sam talked about not wanting to expose her breasts in public and the difficulty in not doing this with her son, and feeling a need to be discreet (here she is speculating about what might happen in the future, with an older child):

...SD: And can you imagine if you were out and he didn't want to be distracted, can you imagine breastfeeding him aged three in [area of city] and...what might happen and how you might react? ...

Sam: It hasn't happened yet...hopefully...sometimes, like now, he tries pulling up my top...when he's feeding...he doesn't like having material touching him...so he's obviously got my boob out...so when he's that age he should be able to understand that...I'm hoping I'll be able to talk to him about it and he'll understand so hopefully I can do it quite discreetly, I've got a feeling I'll be doing it very very discreetly...

(Sam, interview; 16th July 2009).

9.2.4 Strategies for breastfeeding in public

Most women described strategies they used in order to manage public situations. This perhaps indicates that long-term breastfeeding in public is a socially difficult situation that needs to be managed, even by those professing to be comfortable with it. These strategies included only breastfeeding in public with other women who were also breastfeeding, careful positioning of both self and child in public places, and not making eye contact. Sarah wrote:

...I have nursed Janie on demand until very recently so this means that I did indeed nurse her in public. I never was worried when Mark was with me. I just looked at him and Janie and didn't look around. So when on my own I felt uncomfortable and worried but I did the same thing - I just never looked up, hoping that if I didn't make eye contact no one would talk to me or say anything...

(Sarah, email; 14th February 2008). Not making eye contact was also a strategy used by other, otherwise confident, women for dealing with potential reactions from strangers:

...I just don't meet people's eyes on such occasions...

(Jess, interview; 1st May 2008). Others focused on their child and not on those around them:

...I just kind of ignore people around me, when I'm doing it...sometimes I do try and go in a bit of a quieter place...you don't really want to be the centre of attention when you're doing it anyway, but...on occasions, you might not be able to so you're kind of sat there...you do feel a bit like a spectacle just sat in the middle of a room, but...you know, I just ignore people, so I don't really pay any attention to that...

(Sam, interview; 16th July 2009). For Sam and others there is an obvious tension between professed confidence about breastfeeding in public and the feeling that *'you don't really want to be the centre of attention when you're doing it'*.

Distraction was used by some women to try and avoid breastfeeding in situations where they did not feel comfortable:

...[Eldest daughter] and [second child] were both...two and three quarters when they weaned. I probably fed them, I'm sure I fed them in public. If they'd had a tantrum or something I definitely would have done, if they really needed it. I probably...would have been trying to distract them...

(Jane, interview; 19th March 2009). Jess also talked about this, suggesting that breastfeeding in public became a last resort as the child became older (her daughter was four at this point):

...Luckily we are now at a stage when I only have to breastfeed out and about for the length of time it takes to get a snack or a drink out of the rucksack. And that's fine, and gradually I get better at anticipating the snack moment before it is a red light emergency...

(Jess, email; 1st May 2008).

Other women talked about confidence itself being a good strategy, a belief in doing the right thing:

...Breastfeeding itself has become easier in that I am much more comfortable with nursing and it feels more natural. I am also much more confident about nursing as time goes on - confident to nurse in front of others in most situations and...that I am doing the right thing for Janie...

(Sarah, email; 24th April 2008). For some this was about doing what was right for their child as well as a recognition that breastfeeding older children in public helped to normalise it for other people:

...on the odd occasion I've felt a bit uncomfortable I've thought 'well, I'm just going to do this, because my child's more important' **and** also 'it's good for making breastfeeding acceptable'... it just becomes normal, the more you see it the more normal it is...

(Jane, interview; 19th March 2009). Others made reference to their strength of character as an element of their ability to manage breastfeeding in public, for example saying:

..I have to say, I don't care what anybody out there thinks, you know... if they've got something to say they can say it to me...

(Sam, interview; 16th July 2009):

...I have this feeling I kind of give off this aura of 'just you try saying something!'...

(Jane, interview; 19th March 2009).

Some women were able to discuss issues to do with breastfeeding in public with their children when they became old enough. Christine, for example, negotiated specific behaviour with her son:

...The more often I fed in unusual circumstances, the easier it got for me...now I don't bat an eyelid...we do have rules about how high John can lift my top in public....

(Christine, from an article she had written, sent in an email; 14th February 2008).

9.3 Impact of cultural issues (taboo etc.)

9.3.1 Secrecy

Keeping long-term breastfeeding secret

Long-term breastfeeding is a behaviour which is, on the whole, not accepted in our culture. This brings particular challenges to women who practice long-term breastfeeding, and these are dealt with in different ways. For many, the longer breastfeeding continues, the more likely it is to become secret or hidden. In part this is because longer-term breastfeeding often takes place at times which are more private, such as first thing in the morning or last thing before sleep, but it is also in reaction to actual or perceived responses from others. The secrecy related to long-term breastfeeding for many women is partial – they may tell close friends or family but not be open generally about it in public, or they may tell close friends but not their wider family. The example given here is more extreme, but not unique:

...I've had friends who've...said 'you know, he's at work all day, actually he doesn't know'.. [about the child's continued breastfeeding]...

(Tina, interview; 5th July 2008).

Some women feel more uncomfortable about others knowing that they are still breastfeeding the older their child gets, and find different ways to manage this. Sarah wrote about this:

...now I have told her that nursing is private. She understands that things related to the body are private and I explained it to her in that context. I also told her that we don't talk about it with people outside the family for the same reason. She proudly announced to visitors who commented on her growth that she still wasn't too big for nursing. I also worried that this makes it something to be kept secret, something potentially shameful even. But she is very sensitive and would be hurt by comments people might make...

(Sarah, email; 14th February 2008).

Expectations around the ending of breastfeeding

In a culture where few women breastfeed beyond six months there are expectations about weaning:

...Woman E introduces herself and her thirteen month old daughter. She says: '...we've just started to find that people are...of making comments that she's still feeding even though she's just over a year...how do people deal with that, how do you respond to people?...'

(woman at LLL meeting; 11 June 2008). The expectation that babies will be weaned early from the breast is strong:

...Marie talks about how people express surprise if you are breastfeeding longer than a year 'like you are a funny person'...

(LLL observation; 11th June 2008). Many reported versions of this comment:

'...why are you **still** breastfeeding?...'

(LLL observation; 11th June 2008). Most women recognised that they were choosing to behave in a way that set them apart from others:

'...you're sort of out of synch with the common view aren't you? 'Cos I'm really proud that I'm still feeding her, I think it's brilliant and it feels like totally the right thing to be doing. But it is sad, it's sad to be in a situation where you don't feel you can be proud of it because people don't understand...'

Someone asks how long before it feels like that. F says that she thinks that when it got to about a year, when everyone else was doing something else and it was:

'...Are you still feeding him? Are you still feeding him? Now he's eighteen months they just assume that I've stopped, nobody's mentioned it for a while...'

(LLL observation; 11th June 2008). To a certain extent, by 'allowing' others to think that they have stopped breastfeeding (maintaining the secrecy discussed above) these women can also be seen to be contributing to the invisibility of long-term breastfeeding, even though they are also challenging the cultural expectations through their behaviour. There was also some acknowledgement of expectations around the sexual nature of breasts:

...I know people who've given up because their husbands want their tits back, you know...

(Tina, interview; 5th July 2008).

9.3.2 Taboos

There was general acknowledgement amongst this group of women that breastfeeding long-term was in many ways taboo. Specific examples were given and some issues discussed in more depth. Tina talked about breastfeeding her son in church and recognising that this might not be culturally acceptable:

...I remember thinking in the pew just thinking 'oh my god I can't believe I'm doing this' [both laugh], 'oh my god there's going to be a thunderbolt' [both laugh again], yeah and feeling really uncomfortable...

(Tina, interview; 5th July 2008). As discussed earlier there was also a recognition that breastfeeding a baby in public beyond a certain (quite young) age was also taboo:

...and he was quite young and everything but I did feel **very** uncomfortable...I'm much more confident now he's older...even though it's a bit more taboo...

(Josie, speaking at LLL meeting; 9th July 2008).

Breastfeeding older boys

Many women talked about breastfeeding older boys and the associated social and cultural discomfort:

...I don't know if this view exists here, but in the US it is a common belief that the extended breastfeeding of boys will result in their being homosexual...

(Sarah, email; 6th February 2008). I also raised this issue in interviews, if the interviewee did not raise it themselves. Interestingly some women had not come across this, whereas others were very familiar with the idea:

...S: ...have you ever found...sometimes people say to me...that people see older boys breastfeeding differently than older girls...
M: Oh yeah!
S: You've had that?
M: It's definitely there isn't it? That whole sex thing...or gender thing, I don't know what it is, what is it? We expect boys, we're just so...we are gender based, aren't we? Boys should be independent earlier and...you know...outside things.
S: Big boy.
M: Not be mummy's...
S: ...did people say anything about that? Or is that more that you have that kind of awareness that that's there in our culture and...
M: No, I don't think somebody's ever said that to me but, yeah, I have had that feeling...

(Mandy, interview; 18th November 2008). Josie (breastfeeding a boy) had not heard of this:

...she was surprised to hear that some people find the idea of older boys (toddlers, young children) breastfeeding [strange]...It wasn't something she had really thought of and no-one had commented to her about it...

(Josie, interview field notes; 28th October 2008).

Tina talked about managing her mother-in-law's feelings:

...I did find it difficult managing that...all her stuff as well. 'Ooh breastfeeding...ooh I didn't breastfeed [Tina's husband] very...ooh ooh, breastfeeding a boy, ooh it's a bit odd, isn't it?'...I think that's quite odd actually [both laugh]...

(Tina, interview; 5th July 2008). Jane related feelings about breastfeeding boys both to cultural norms and to the sexualisation of breasts:

...S: ...people find it hard, in our culture, the idea of a boy...being breastfed older
J: I can see that that's a widespread feeling, I think, but there is obviously the theory that the reason that men in our culture are so obsessed with breasts is because they weren't breastfed enough!
[laughs]
J: And in cultures where babies are breastfed for ever, breasts aren't the...most sexual part of a woman's body, so...it does kind of bear, bear out. So I think, you know, I mean I would be, it wouldn't worry me, feeding a boy or a girl...

(Jane, interview; 19th March 2009).

Negative attitudes towards long-term breastfeeding

Many women talked about negative attitudes towards long-term breastfeeding, particularly relating this to cultural and social misunderstandings about the practice:

...I just think it's this just amazing thing that's...not...given enough importance in our society and it's political...it's about the environment...it's about so much more than women in their homes with their babies, it relates to everything and it's...you know, we could change the world...you can get all kind of worked up about it but it's so important...so exciting...so easy and yet there's such misunderstanding around it and...it's cloaked in all these bad connotations and words and negativity...it would just be nice to get more positive views out there...

(Mandy, interview; 18th November 2008). A woman at an LLL meeting talked about being under pressure to stop breastfeeding from peers (in France):

...if you were a feminist, or a liberated woman, you were probably **not** going to breastfeed, because that's the way you can keep your life, so everyone was very keen not to breastfeed. And I came back and I was breastfeeding...'you're not still breastfeeding are you?'... and there's this big pressure...it's weird, it's pressure from people my own generation, to stop breastfeeding...
She goes on to speculate as to what the reasons for this might be:
...I think they're disturbed by, by seeing a breast with a small child...disturbed by the fact that the child might remember the breast...I don't know what it is. It creates big arguments around family tables...
(laughter).

(woman at LLL meeting; 8th January 2008).

9.4 Conclusion

This chapter has examined the findings in relation to particular challenges faced by women who breastfeed long-term: challenges experienced when breastfeeding older babies and children in public (both actual and perceived reactions from others), and leading to the development of a range of strategies with which to manage these situations. The impact of a range of cultural issues was outlined, including knowing that breastfeeding long-term is considered taboo, the secrecy involved, pressure to wean and breastfeeding boys. The following chapter considers the range of ways in which women are supported to breastfeed, as well as the ways in which support is not always forthcoming.

Chapter 10: Being supported in long-term breastfeeding

10.1 Introduction

For women breastfeeding long-term, support may be crucial as their choice is not approved of in society generally. Analysis of the data identified a number of sub-themes linked to the overall category of 'support'. Participants talked about four main categories: families (including partners), friendships, support groups and health professionals. Support was sometimes expected but not forthcoming. Support through books and from the internet are also identified by women as significant.

10.2 Support from families and partners

Families could be important sources of support or experienced as unsupportive.

10.2.1 Families supporting long-term breastfeeding

Jane was breastfed until she was eighteen months old and talked about the support given by her mother. After the birth of her second baby, Jane had a radioactive scan for a suspected pulmonary embolism and was not able to hold or feed her two day old daughter for twelve hours. Her mother fed the baby expressed breast milk from a cup but:

...she was just getting frantic and it was horrible and in the end I said to mum, 'oh could you see if she'll latch on to you, because she obviously needs to suck on something'...and she did and she went straight to sleep after about ten seconds...

(Jane, interview; 19th March 2009). Jane's mother was present throughout much of our interview, helping to care for Jane's four daughters while we talked. Reference was made by Jane to family support of a range of parenting decisions, including co-sleeping and home educating, in addition to long-term breastfeeding.

Some women experienced their mothers as generally supportive, although this was not without difficulties. Many of the grandmothers had their children when breastfeeding was less common than today, and breastfeeding support and knowledge were lacking:

...she had struggled to feed me as a baby...it was 1966 and they...gave her tablets to dry her milk up after a couple of days...later on (she) was able to be supportive, and even now to quite a passive extent...

(Tina, interview; 5th July 2007). For some family support was a welcome surprise:

...even Mark's elderly father was supportive of my extended breastfeeding. I was concerned about breastfeeding a two-year-old in front on him. But he was so incredibly happy to know that I was doing this...

(Sarah, email; 30th January 2008).

10.2.2 Lack of support from families and others

Negative comments and attitudes

Some of the most unsupportive attitudes towards long-term breastfeeding came from the families of breastfeeding women. Lack of support from families was expressed through negative comments and attitudes addressed to the breastfeeding women, usually from mothers or mothers-in-law. One woman told me at the end of a LLL meeting that she no longer visited her parents with her two year old son because her mother had told her that continued breastfeeding was '*disgusting*', and not something that she wanted in her home. Another woman recounted her experiences:

...J: It's mainly my mum and my mother-in-law *because they're more vocal about it*. I'm sure there's other people that find it difficult that...in my friendship groups...but...it's...my family that...I have...the most difficulty with...they see parenting differently to...the way I see parenting...

(Josie, interview; 18th November 2008).

Women participants experienced a range of reactions from their families to their breastfeeding:

...I think people like my dad found it really difficult to start with, you know, and...there would be quite a lot of leaving the room...

(Tina, interview; 5th July 2007). The discomfort of family members was often acknowledged even if it was not verbalised.

...S: Has she talked to you about it? [long-term breastfeeding]
J: No, she doesn't. She just sort of...you can just sort of tell.
S: But doesn't say that to your face?
J: No, not to me...

(Jane, interview; 19th March 2009). Jane knew her mother-in-law had expressed negative views to other family members, although not directly to her:

...it's very difficult to tell because I do think people sort of go 'well there's no point saying anything to J'...

(Jane, interview; 19th March 2009). Others acknowledged that their family might have difficulties with their parenting decisions, but did not allow this to affect their behaviour:

...I am quite firm with extended family about the fact that my daughter still breastfeeds and will do so until she's had enough. I have no idea if any of them have issues with it. I suspect they are too busy worrying about our plans to Home Educate and how that will turn her into a social misfit...

(Jess, email; 1st May 2008).

Some negative reactions were verbalised in quite strong terms:

...That was the hardest thing though, going to stay with the in-laws and them...thinking extended breastfeeding's very strange and so, yeah, from my father-in-law and from [husband's] grandmother, they would say, you know, *it's bizarre, it's completely unnatural, it's for you not him*...

(Mandy, interview; 18th November 2008). Here she talks about going to stay with her in-laws:

...S: And...did knowing that they felt like that...stop you? I mean, did you say you had to go into another room, or did you just...
M: Yeah, it would make the whole thing very tense, I'd try and entice him upstairs or something, which he wasn't used to... [laughs]
S: Yes.
M: ...and then he would get cross and then I'd get cross and we'd be so now, locked up in the room...oh it was awful...

(Mandy, interview; 18th November 2008).

Jane experienced similar lack of support from in-laws in relation to breastfeeding and other parenting decisions:

...J: [husband] said later that his mum had gone upstairs and told him and said 'Oh, [sigh] I think she should have just given her a dummy' and thankfully [husband] said 'well that's not the way we're parenting'... it just showed, she...kind of wants to be supportive but really just kind of thinks 'Wha...that's a bit odd!'
S: But doesn't say that to your face?
J: No, not to me. And she's also mentioned...we bed share...probably about a year ago now...[eldest daughter's] still in our bed most nights, we've got a very big bed so it's not a problem...she wants to sleep in her room but she wants to wait for [second child] to join her and [second child] isn't ready...his mum's also...said to him 'oh, you know, shouldn't she be sleeping in her own room now?' and [husband's] like 'well, no? why?'...

(Jane, interview; 19th March 2009).

Pressure to wean ('still' breastfeeding?)

Disapproval and lack of support for continued breastfeeding is experienced by many women as pressure to wean to solid food, or from the breast, or both. Josie's mother supported breastfeeding, but was concerned about long-term breastfeeding because her grandson did not 'need' breastmilk anymore, and his close maternal attachment restricted the grandparent relationship:

...for her it stops at a year or, before. And I said 'what's that about, why?' and she said 'well because it changes from a need to a want'...she said 'he doesn't need your milk any more'. ...I think one of the main frustrations, for both sets of parents is the fact that he is still so attached to me, so they can't do the grandma thing...I can't just leave him and he does pretty much need me to go to sleep at night...

(Josie, interview; 18th November 2008).

Sam experienced the lack of comment on her continued breastfeeding from parents as lack of interest, rather than positive acceptance:

...S: They don't say anything, no...we've just got back from holiday with [partner's] mum...we'd had a few drinks and I was like 'You never say anything about it...' she goes, 'I don't think there's a problem with it', she's quite happy...it doesn't matter to

her. The only thing she said, was the fact that it makes it harder for other people to look after him, which is does...I just think they know I know what I'm doing, so...they might ask me more than...you know 'do you think...when do you think you might stop?'. They **haven't** asked me that but they might.... I do sometimes think 'do you not care enough?'

(Sam, interview; 16th July 2009).

Some mothers used different strategies to prepare for negative comments from their families. Lucia felt that she had to 'train' her family in order for them to be supportive by providing them with knowledge and information:

...I have to pass them a lot of informations...but I had the informations from my group and also from my League training...from La Leche League leaflets and everything and books and...so I pass it to them and...my mother-in-law was more keen on learning and doing than the whole family but...all the other family...I had to tell them and *I had to train them* and I had to...explain them...

(Lucia, interview; 11th November 2008). Others prepared in a different way, for example by:

...having some pithy one-liners for extended family and friends so they don't pile on the pressure...

(Jess, email; 3rd June 2008).

Pressure to wean was discussed in breastfeeding support groups. Usually the pressure came from relatives but could be more general, especially for those living in areas with low breastfeeding rates:

...One talked to me about the pressure from relations to bottle feed; others talked about the bottle feeding culture around them – it's unusual in their area to breastfeed...

(BIB observation; 5th March 2008).

...I asked her if she had been under pressure to wean from anyone else and she said only really from her mother-in-law...[who]...had found it very hard that she breastfed eldest son until he was seven months and has found the longer breastfeeding of the next two even harder. No pressure from husband who has been very supportive...

(notes after BIB observation; 2nd July 2008).

...C talked about how she had family pressure to wean and some disapproval that she was breastfeeding a two year old...

(Babes observation; 12th June 2008). Many women experienced pressure to wean in the latter part of the first year, or an assumption that they had stopped, suggesting that breastfeeding beyond this time becomes increasingly socially unacceptable and that support wanes:

...about a year, when everyone else was doing something else and it was 'Are you *still* feeding him? Are you *still* feeding him?' Now he's eighteen months they just assume that I've stopped, nobody's mentioned it for a while...

(woman at LLL meeting; 11th June 2008).

...C says that she doesn't think that her daughter is ready to give up and she doesn't want to make her, but:
'...it would be nice to know that's what other people still do, that's kind of normal...'
Marie suggests that people are probably asking why she is still feeding and C says:
'...dealing with parents-in-law, saying '*what are you still doing that for?*'...'

(LLL observation; 11th June 2008).

Comments about weaning range from the inappropriateness of breastfeeding long-term to concerns about introducing solid food:

...E says that the only experience she has of this is from her parents-in-law, who keep suggesting that her daughter should eat more solid food and that she says:
'...yes, yes, we'll keep trying' and, you know, just carry on feeding her...it's frustrating because obviously their generation is very different and they put their children on the [indistinct] at the age of four months or whatever it was in those days...I'm sure it's not the right attitude but I cannot be bothered to explain, I just say to them 'she wants this, it'll make us both feel better' and leave it at that...'

Woman F says that one thing she could say to them, if they are concerned about how much solid food she is having, is that breastmilk has far more calories in it than most food.

Woman E says that people say to her ('one of the things that you come up against') that her daughter is not getting enough iron and so on and that's why she's not growing (but E says she's small for her age and she always has been) but people are now saying that she should be eating more solid food....

(LLL observation; 11th June 2008).

Tandem feeding is unusual in our culture and is also hard for those generally unsupportive of long-term breastfeeding to understand. One woman talked about this at a LLL meeting:

Woman C says:

'...I can't actually remember the newborn days, but, this was a bit later on, my mother-in-law...her advice was – I was having issues with my older daughter wanting to feed all the time as well – and her advice was that I needed to wean [son] 'cos if I weaned [son] then [daughter] wouldn't see me feeding him and then she wouldn't want to feed either...'

[there is incredulous laughter]

Marie asks how she responded:

'...well I was shocked so I didn't actually respond that much...she wanted to justify why she hadn't fed my husband...it all very much came up that it's her stuff...'

(LLL observation, 9th July 2008).

10.2.3 Support from partners

Most of the participants had supportive partners:

...L: I couldn't have done it without, without him. And he's...it's funny because once I started doing the training and...started learning more about breastfeeding he was...
[laughs]

L: ...starting say to his job tell other fathers as well...

[both laugh]

L: ...I say 'leave it to me to support...and not you' and he really help a lot of other fathers, he likes to talk about breastfeeding as well... He was always very positive about it, I was really lucky with that...

(Lucia, interview; 11th November 2008). An important element of partner support was a broader understanding:

...[husband] is really, really important and got it and just knew that it was about so much more than just food, really understood that...

(Tina, interview; 5th July 2007). Many women referred to their partners' practical and emotional support in the early days:

...M: His support was amazing because...we were all in the bed together and [husband] would wake up with me, **every time**...

[both laugh]

M: ...and just kind of be there, not necessarily doing anything but because I knew that he was aware that I knew he was awake.

[laughs]

M: It was just psychologically nice...

(Mandy, interview; 18th November 2008).

Some women talked about how breastfeeding meant that their partners had to find other ways of bonding with their children:

...He has been unfailingly supportive - I think the fact that he was on duty while I worked from a very early age meant that he has always been doing his own bonding with our child, and hasn't felt the need to shove a bottle in her mouth to achieve it...

(Jess, email; 27th March 2008). The challenge of finding ways for fathers to bond with their children could persist for several years:

... Mark is left on the outside far too often as much as he tries to be close to Janie...once I do finally get out the door to go down the road to a cafe to read for an hour (happened for the first time last week!) she eventually settles down and enjoys Daddy time...

(Sarah, email; 6th March 2008).

Some women wrongly predicted that not being able to feed the baby would be an issue for their partner:

...S: I think he kind of did wanna be able to feed the baby...before we had him he felt like he was going to be left out...I remember we had that conversation, but I think once he got here...well he just let me get on with it. Once or twice I did try to express, just to kind of see if he would take it from a bottle. He just never really seemed bothered...so I thought, I don't want to give him a bottle, so, 'if you're not going to bother then...' ...but [partner], I don't think he thinks anything about it either way, he's quite happy to not have to worry about it himself!...

(Sam, interview; 16th July 2009). Other men, for different reasons, were also less involved, although this was not necessarily an issue for the mother:

...He (partner) offered very little support in the early days. He moved to [City] when John was six months old and didn't return until he was two! ...But that was actually a good thing. He was very much the old school of 'baby rearing is for women so let them get on with it.' So there was no pressure to bottle feed, because he didn't want to. He didn't want to have John for 'every other weekend and two weeks in the summer' which is the usual divorce thing...he left it all up to me, which in some ways was brilliant! I got to do it my way!..

(Christine, email; 14th February 2008).

Some women made parenting decisions jointly with their partners. Other women reported taking the lead, although their partners were still considered

to be very supportive, but left many of the day-to-day (and some more major) decisions about parenting to them:

... my husband has been brilliant...in that he's pretty much, has...well I guess 'cos I **think** more about parenting, 'cos it's my role every day he's, he's always trusted my judgements so I don't like to say he's just followed my lead but I guess kind of in a way that's what he's done...he's been **absolutely** supportive of long-term breastfeeding, I think the only thing that he gets frustrated at is that again, the thing that he, he can't settle [son], it has to be just me, which means that sometimes I get frustrated...

(Josie, interview; 28th October).

10.3 Support through friendships

10.3.1 'Like-minded people'

...You know most of my friends have come through [breastfeeding support group] and through NCT and, and also through home educating. So I probably know a few people now who, who did formula feed but I've only met them since their children were older and so it's not an issue, it's not part of it anymore. Because most of my friends made choices along the same lines, it's not even, it's not something that is a particular choice, it's just what we, what one does with a baby...

(Jane, interview; 19th March 2008). The decision to breastfeed or formula feed is an issue that can divide new mothers: the strong association of feeding method with differing parenting styles can make it hard to give and receive appropriate support:

...I mean in the beginning, all I had was my NCT friends and we were trying to meet up once a week and I found it really uncomfortable *because they were so different to me*...a lot of them had stopped breastfeeding within four to eight weeks...and it was always hard work...after two or three weeks of doing this I said to [husband] 'I'm not doing it any more' and he felt I should really be getting out there and I said 'well actually I think I need to be getting out there with people who make me feel more comfortable' . So after that I gravitated towards *people that were more like minded* because it made me feel better and therefore I was a more calm person to be around [son]...

(Josie, interview; 18th November 2008).

As breastfeeding continues and the child grows older, support from those who are also making this choice becomes more important:

...I guess my closest friends are long-term breastfeeders or, have done that similar closeness...growing up closer...I ring them for support all the time...

(Mandy, interview; 18th November 2008). For some, difficult experiences lead to a more deliberate choice:

...I do try to limit myself to be around those who are tolerant of my parenting style, more than just the breastfeeding. The cost has been our isolation...During half-term I tried to re-establish contact with a German woman I had met...but unfortunately even though Janie no longer nurses in public I will not be able to continue meeting with her and her son. Janie is confused and upset when she sees a very different dynamic between a mother and child than she is used to. She was quite disturbed and crying

that she wanted to go home to which the woman responded, well what's wrong with her...

(Sarah, email; 27th February 2008).

Josie also talked about feeling isolated, living in a small town where few people shared her attachment parenting principles. More than once during the interview she talked about needing to be with '*like-minded people*'. She and her husband had decided to move into the city for this reason. Sam talked about how knowing others who were also breastfeeding long-term made her not feel so alone:

...'cos you do feel you've got to justify it to people a lot of the time anyway so knowing that you've got friends...knowing that you've got people out there that, that do it as well, then it's kind of...don't know, you just don't feel so much alone...

(Sam, interview; 16th July 2008).

Knowing that other mothers are breastfeeding long-term through publications and the internet is important, Sarah said she initially thought this was enough. Later she clarified this: during the time that we corresponded with each other she met and became friends with another mother who was also breastfeeding a four year old (this was Jess, whom I also interviewed by email). Sarah had been concerned that even at LLL meetings she only heard people *talk* about their parenting and did not see different ways of being with children. However she noted:

...I realised today after meeting them again how important it is to have friends or a social network of women who are parenting in this way. I have been feeling a bit insecure about various things but just seeing how Isobel and Jess are together and knowing they are doing what we are doing reassures me that this is right...

(Sarah, email; 27th February 2008). Sam also talked about the reassurance of knowing that other women were facing similar parenting issues:

...Yeah, it's nice to have somebody to compare things with...the fact that [friend's son] now can lie down at night time without having to feed and...I know that he is a boob monster, so, you know, if he can do it – we'll get there! It's quite nice to see improvements in someone else's relationship and know that...it will happen eventually...

(Sam, interview; 16th July 2008).

Children who are breastfed long-term often do not know other children who are breastfed long-term, particularly if their mothers are not connected with support groups, or if breastfeeding occurs first thing in the morning or at bedtime. These children may think their peers still breastfeed or, equally, that they are unique. Sarah told her daughter that my 4 year old daughter was still breastfeeding, and said that she found this comforting. During the project she met two other women who were breastfeeding four year olds:

...I have recently met another four-year-old girl and mother who are breastfeeding. The girl is in Janie's ballet class... Janie was very happy to know this and now she very much likes [girl] and asks all sorts of questions about her...

(Sarah, email; 29th July 2008).

10.3.2 Friendships with formula feeders

Many women, in interviews and support groups, talked about friendships with women who had chosen to use formula milk. Breastfeeding women can sometimes find it hard to gain support from women whose choices are so different from their own. We discussed this in one Babes meeting:

...Sam (breastfeeding her six month old son) said that these other women wanted to talk about how many extra ounces of formula they were giving their babies and that this was very different to their own experience. They met each other through the group and had valued this support, going out together and breastfeeding in public places together... (such as the local Morrison's supermarket)...

(Babes observation; 5th June 2008).

Most long-term breastfeeders found that other mothers stopped breastfeeding early on, leaving them feeling different and isolated:

...it is mainly friends (who have breastfed for shorter periods) who say things like: 'oh well, you've done it for so long now *you don't have to put yourself through it any more*', and '*you've punished yourself enough by breastfeeding her*' and 'if you don't give up now she's still going to be breastfeeding when she goes to school' and at the moment I've just been sort of smiling and nodding and not getting into it but then it's a problem, isn't it?...

(LLL observation; 11th June 2008). There was recognition that over time other sources of support were sought:

...I did find I limited the amount of time I spent with those people ...it's not like you're putting them down or putting them away but it depends what space you are whether that's ok for you, if it's ok that they do different stuff then that's ok but if you're feeling a bit isolated then it's better to create a life where you don't feel like that...

(woman at LLL meeting; 11th June 2008). These comments highlight the importance of support groups for long-term breastfeeders and that existing networks may be perceived as unsupportive if other mothers are formula feeding.

10.4 Support groups

10.4.1 When support groups are helpful

Not all women find support groups in their area, or find attending them helpful. For others, these groups become part of their lives. Sam, who had been attending Babes since her nineteen month old son was very young, talked about this:

...Sam: [I] made friends and it became part of our routine.

SD: So what in particular about it was it that you loved?

Sam: I think it was just the fact that everybody else is in the same boat as you...you throw around ideas, if you have problems then...somebody somewhere will have an idea of how to overcome it and...you can help other people...

I think, *the older they get I think the more support you need* because people just forget about you...after six months sort of thing...but you still have like problems and that...I had the problem with him biting a lot and that was getting really quite bad but nobody...

SD: Nobody to talk to about it...

Sam: Exactly. Exactly...

(Sam, interview; 16th July 2009).

Most of the women I spoke to identified the importance of gaining support from other breastfeeders as their child grew older. Support came from individual friendships and from support groups. Sam joined a group of other mothers, the majority of whom were not breastfeeding, but found support from them and from her friend's presence (she was also breastfeeding a toddler):

...Sam: I think if I didn't have [friend] there it probably would have put me as an outsider...because she's there and...she's still breastfeeding as well...there's a group of us that meet up on a Tuesday every week, there's five of us. So out of the five of us, me and [friend] still breastfeed...

(Sam, interview; 16th July 2009).

Some of the women I met developed their interest in breastfeeding and trained either as peer supporters (Sam, Lucia), breastfeeding counsellors (Jane) or LLL Leaders (Christine and Mandy). Mandy was passionate about support groups and what they could offer women, based on her own very positive experiences:

...what I say about La Leche, you know, 'it's women talking' and they say 'well I don't need that, I've got loads of advice' and I say 'no, it's not like that, it's...' It's so hard to explain what's so good about it...

(Mandy, interview; 18th November 2008).

From my observations in support groups, conversations and interviews with individual women, I noted that support for long-term breastfeeding covered a wide range of issues including sleep, biting, weaning and other food issues, tandem feeding, getting pregnant and having more than one child, working, discipline and breastfeeding in public.

10.4.2 When support groups are not helpful

Some women do not experience groups as supportive. Tina carried on meeting with a group where she was the only long-term breastfeeder, which she found undermining:

...I remember the NCT meetings when A was about three...sometimes he would come on with breastfeeding, especially if there were new babies there he would see breastfeeding and think 'ho ho, yes, well that would be quite nice' and I think that got quite difficult really...I did feel when other kids would say 'ooh, why's A having mummy milk' and they would go 'mummy milk's really for babies, you don't have that now' and that kind of low level... stuff I just thought, I can't be doing with it really...

(Tina, interview; 5th July 2007). Groups can feel unsupportive if the majority appear to have a different view or experience from the woman seeking support. This had happened to Judith (talking about LLL meetings):

...Sometimes I left the meetings feeling more anxious than when I arrived. For example, when I was trying to cut down milk feeds and give more solids, I would hear that I should be giving as much milk as the baby wants (but [daughter] never gave obvious signals to me so I didn't know what to do!). My experience sometimes seemed to be different from everyone else...

(Judith, email; 6th April 2008).

Sarah also identified that older breastfeeding children can understand and think about what is being said at support group meetings, which may worry or upset them. This caused her to seek other sources of support; even when she had found a friend who was also breastfeeding long-term she felt she had to adjust her behaviour:

...I potentially would have been able to find support at LLL but Janie always sat and listened at the meetings. Sometimes she even added to what I was saying - before she was three! It was distressing to her. I did find support by emailing with Anne while she was still an active LLL leader (and even a few times since). I also avoid discussing breastfeeding with Jess because Janie is always listening...

(Sarah, email; 12th May 2008).

10.5 Health professionals

Most respondents did not experience health professionals as supportive although data collection took place before our city achieved UNICEF BFI community accreditation (which involves all health professionals working with breastfeeding women in the community receiving up-to-date training). Health professionals are members of a society which is not supportive of breastfeeding in general, or long-term breastfeeding in particular. This is reflected in their attitudes and behaviour, as described by women participants. This suggests that attitudes towards long-term breastfeeding will take time to change.

The extent to which women ask for help from health professionals varies, as does their belief that they will get unbiased and evidence-based advice. A number of the women in this research were not from the UK, and therefore not familiar with the service provided by health professionals:

...I didn't ask for help from health visitors because I didn't really know what health visitors did or were responsible for (no such thing in Canada). I also didn't think they would be able to give me the on-going advice I needed. I needed to ask for help more than once...I didn't think that a health visitor or midwife would have the time to spend with me. I preferred to ask a breast feeding counsellor, thinking that they would have more time...even if it was just on the phone. *I also thought they would be better informed...*

(Judith, email; 6th April, 2008). Some women felt very strongly about the advice offered by health visitors and other professionals:

...dangerous is a really strong word but I...think that this particular health visitor's quite dangerous...I would challenge a lot of her knowledge...I don't think she was very up-to-date on the evidence...I would say...you know people really aren't sure about the weight charts...I was quite well informed. She was completely ignorant of...where the current weight charts come from and how much people really don't think they're the right thing to be using and...just trying to get me to wean him at four months and even though he was six weeks early... I just felt she was incredibly judgemental...

(Tina, interview; 5th July 2007). Some women found that, even though in other areas of their lives they were confident and assertive, life with a young baby was difficult, and they placed their trust in the (assumed) better knowledge held by health professionals:

...Writing this out makes me realise that very early on I lacked confidence in my breastfeeding. I was confident in my knowledge. But then I looked at my very small little girl and worried so much. I was afraid to refuse the advice of health care professionals when Janie was only a few days old. Likewise when she was 5 months old. I was not a confident mother and needed reassurance that breastfeeding exclusively was not only alright, it was the best thing I could be doing, even if my daughter was thin...

(Sarah, email; 6th February 2008). She also talked about how she felt unsupported by health professionals in her decision to carry on breastfeeding:

...Shortly after our arrival in the UK Janie had a seizure. We ended up in the Children's Hospital. They wanted to run tests on her without me present so that I wouldn't interfere. I refused. They told me to give her a bottle and her cuddly and she would be fine. I explained I was breastfeeding and she would want her mommy. In a room with a poster advocating breastfeeding on the door the nurse proceeded to complain about this and in frustration with me snapped at the doctor that I was not cooperating because I was breastfeeding. Mark and I looked at each other absolutely shocked...

(Sarah, email; 6th February 2008). Jane also felt a lack of support and respect for how she had decided to parent her children:

...I think that's something that makes me most cross about health visitors...not just health visitors but some health professionals...is this kind of attitude that everybody wants to do things the way I would want to do it...you know they are kind of 'oh you'll make a rod for your own back', well you know, I feed them out of a tantrum and it means that they always need feeding out of a tantrum...big deal, it doesn't bother me, so don't assume that it will...

(Jane, interview; 19th March 2009)

Other women reported that they either chose to ignore health professional advice and opinions – or stopped consulting them altogether. This was often discussed in LLL meetings, with more experienced breastfeeders advising

women to ignore or avoid their health visitors. Usually this was done with humour, indicating a shared understanding in the group:

...Woman G talks about her own mother's parenting style, how she avoided health visitors:
'...because she thought they were really annoying...'
[laughter], and that she spent a lot of time in the company of other like-minded women with their babies and:
'...just did what she felt was right...and I thought "why don't I do that"...[laughter]... but then I realised that I was doing that...'
[more laughter].

(LLL observation; 14th May 2008). This was not something that I heard at other support group meetings.

Sarah and Mandy expressed concerns about the lack of support and encouragement for breastfeeding:

...The longer I have breastfed Janie the more determined I am to resist what health care practitioners say and just do what I know is best for my daughter...I find it disturbing that NO health care professionals have been explicitly supportive of my breastfeeding Janie beyond one year. There are no encouraging comments or pats on the back for a job well done. If I weren't so dedicated to doing what I feel is best for Janie I probably would have given up long ago...

(Sarah, email; 6th February 2008) and:

...S: Any, any comments, or problems with health professionals as he got older? Or have you tended to avoid them?
M: Well it was just annoying...you know they were only interested in giving him a jab...I'd take him in and say, 'he's breastfed' and they were like 'oh, well, we don't care'... [laughs]
M: I'd say 'no, this is really important!'...

(Mandy, interview; 18th November 2008). Sam's doctor suggested that by breastfeeding her seventeen month old son she had done more than was expected or necessary:

...S: One told me I've 'gone beyond the call of duty' haven't I?

(Sam, interview; 16th July 2009). Sarah had a negative experience with a health professional. Her daughter suffered severe trauma having teeth extracted and she saw a psychologist for advice :

...It has been very good – her nightmares have gone away and she no longer has these severe attacks of terror. But of course the psychologist had issues with our parenting. She explained that Janie needs to break the bond with me, that she should have her own room, that I needed to send her to school, and of course that I should wean. Last week I went in again because Janie has been showing signs of stress and anxiety again (I am not able to leave her except to go to these appointments - she screams and never stops if ...I leave her at home with Daddy and go out for a walk. So I don't.) The psychologist actually told me that if I continue breastfeeding Janie to help her calm down that I am contributing to her developing an addiction later in life, to anything that she can take into her mouth - food, alcohol, cigarettes, or drugs!!!! I was shocked and really upset...But still, she's a psychologist and it planted the seed of yet another worry and fear that what if she's right even though I know she isn't. Needless to say I'm not going to consult her ever again. I guess it's that nagging fear or worry that grows from comments other people make that leads me to restrict our surroundings...

(Sarah, email; 27th February 2008). Health professionals' comments can have a big impact on breastfeeding mothers, even if inaccurate or not evidence-based. Sarah talked about modifying her behaviour in response and restricting interactions with others.

Comments about health professionals are not entirely negative and some women receive support in the early days and as they continue breastfeeding.

Sam had mixed experiences:

...SD: What about health visitors...

Sam: I haven't seen them for ages, but my health visitor was always quite happy, yeah.

SD: They were probably really pleased to see you!

Sam: ...she did...when he was biting and that she did, not anything bad against her, because she was just trying to cover all options...she did mention...'what if it got to the stage when you're going to have to stop...if he keeps biting you, you know'. She wasn't saying 'stop' but...

SD: Helping you think about it?

Sam: Yeah...we got past that and that's been fine, I haven't really seen her since then...I think I had one nurse and she just said 'oh yeah, I breastfed all mine until they were two, so well done you!', but nothing, no-one else's really said anything...

(Sam, interview; 16th July 2009). Jane also had positive experiences about her decision to breastfeed during pregnancy and to tandem feed:

...the midwife I had with [third and fourth children] was an NHS midwife, but she's very...natural-minded...she's been brilliant about it...it's just not an issue really.

(Jane, interview; 19th March 2009). Although Tina describes positive experiences, her comments suggest scepticism even when receiving support:

...I had to do a chart thing and bring it in to a dietician and he 'phoned me...I don't know whether he was doing it to just try and build a relationship but he said, 'well my wife breastfed until two and a half and my daughter's eighteen months and she's still going'...he would give me advice about not filling up before meals to try and get more solid food in, but, in a low key kind of way really...

(Tina, interview; 5th July 2007).

10.6 Support from books and the internet

10.6.1 Support gained from books

Books were frequently talked about as a source of support; this surprised me because I did not use books for support during my breastfeeding journey. In all three support groups there was a 'library' from which books could be borrowed - less evident at Babes, at BIBS the bookcase was on wheels pulled out from a cupboard and, at LLL meetings books cover a table to one side of the meeting room. Books were referred to and recommended in meetings, mentioned in all interviews.

All the women were clear that books played an important role for them - women who were socially isolated as well as women with multiple sources of support:

...I guess I would say that most of the support I have received for breastfeeding has been through publications. Knowing the WHO guidelines are backed by the APA was important. More significant was the Sears's publication *The Baby Book*, supporting attachment parenting, and *Mothering Magazine*, a US publication. One of the midwives told me about *Mothering Magazine* (he happened to be British and was our favourite midwife, very supportive of attachment parenting). It made me feel connected to a community of breastfeeding mothers. Since arriving in the UK *New Beginnings* has served that purpose as well as LLL...

(Sarah, email; 6th February 2008). Some women used books as part of planning to breastfeed longer term; Lucia was 38 when she had her first child, knew that she wanted to become pregnant again quickly and so was interested in tandem feeding:

...the first thing when I was getting pregnant I bought the NCT book, *Breastfeeding Beginners*, and that was because there was an article inside on...pregnancy and breastfeeding...right from the beginning I was trying to find information if I can breastfeed a baby when I be pregnant...I was trying to find out as much information as I can...

(Lucia, interview; 11th November 2008).

Other women found that books were unhelpful during early periods:

...M: I was surrounded by books that told me I was doing it wrong and I didn't want to listen to them but I just felt guilty for what I was doing...

S:...in hindsight, was that because they were the wrong books?...

M: For me, yes...but I just didn't have anything to counter them...

although later she talked about how helpful books had been to her:

...S: If you if you look back on those three years, what would you say were your biggest sources of support?

M: [husband], La Leche, and I read **all** the books!..

(both quotes, Mandy, interview; 18th November 2008). For some, the

information they read was confusing or unhelpful and therefore unsupportive:

...I found various different opinions about how often I should breastfeed her once she was on solids. I never found anything that recommended how often to breast feed after 1 year of age. Everything I read suggested that after 1 year breast feeding is not necessary...

(Judith, email; 1st March 2008).

Some women also talked about the leaflets that they received when they were pregnant or new mothers. Some aspects of these were more helpful than others:

...I think leaflets as well, we got leaflets when we were going to the antenatal classes and it shows you, obviously, the position you should be in and I suppose it just like gives you ideas, so I don't know...it's not obviously as straightforward as they make out in the book so I expect if you were having problems it would be better to have somebody else there rather than trying to look at a picture...like when they, they've got the picture of the baby and they're like 'the baby's mouth opens and then you put them on' and it happens so quickly in real life that you miss it half the time, so...so they...but for the pictures obviously to show you what it should be like, it did help...

(Sam, interview; 16th July 2009).

10.6.2 The internet as a source of support

The internet was also mentioned as important although less so than books. Even though only a few years have passed since data collection this might be different today. Personal observation suggests that there has been a proliferation in websites and internet groups offering support for long-term breastfeeding and other related parenting practices. Many of these are US based although UK sites are increasing e.g. Attachment Parenting UK (<http://www.attachmentparenting.co.uk/>).

Christine talked about internet support for a number of parenting issues, including long-term breastfeeding:

...I got some support from the internet, particularly Kathy Dettwyler (<http://www.kathydettwyler.org/>). I used to go around quoting her, and I was so excited to meet her at an LLL conference in 2000!...Home educators are very well networked so I have lots of friends all over the country, all happy with my lifestyle!...

(Christine, email; 14th July 2008). For others the support was more useful in the early days:

...one website was extremely helpful to me (the bf counsellor on the phone told me about it) in fact, I think this website saved me from supplementing. www.drjacknewman.com...

(Judith, email; 6th April 2008). Sarah talked to me about how supportive she found it knowing that there were other mothers who were parenting as she was, even if she did not know who they were. Sam said something similar:

...SD: And have you been on...there's loads of breastfeeding support internet groups...
Sam: I look at them, I don't join them, I don't kind of write in...I don't know how people seem to have so much time to do it all the time!...I just nose in and if there's a problem they normally have someone else ask the same kind of problem, so...
SD: Have you found that useful?
Sam: I do. Yeah, definitely...

(Sam, interview; 16th July 2009).

Women breastfeeding long-term can sometimes feel isolated. This woman at an LLL meeting talked about the potential isolation of tandem feeding and the range of support available, including the internet:

...compared to people like [name], who had no-one when she was doing it, I mean I'm in a really lucky position, I've got email forums and lots of people who I've met through La Leche League who are doing it so...

(woman at LLL observation, 11th June 2008). While not finding attendance at LLL meetings very easy, Sarah found continued contact with an LLL leader helpful:

...I did find support by emailing with Anne while she was still an active LLL leader (and even a few times since)...

(Sarah, email; 2nd July 2008).

10.7 Conclusion

In this chapter I considered issues of support for breastfeeding long-term. I have shown that there are many sources of support for those who continue to breastfeed, with women finding partners, friendships with other breastfeeders and support groups helpful. There are also a number of ways women are not supported in continuing to breastfeed. For some, families are a source of strength and support; for many women, there is a more difficult and less supportive experience. The women in this research identified difficulties in maintaining supportive friendships with others who have made different feeding and parenting choices.

Chapter 11: Discussion

11.1 Introduction

In this chapter the main focus is on discussing how the experiences of women who breastfeed long-term might be understood, by drawing on literature relating to liminality, stigma and taboo. In addition, the chapter also summarises the main findings from this study, considers the contributions it has made to new knowledge and reflects on the strengths and weaknesses of the work.

The ways in which each concept has been used to think about breastfeeding in the three identified texts (Mahon-Daly and Andrews, 2002, Smale, 2001 and Battersby, 2007) will be discussed alongside the findings outlined in the previous chapters. I consider how useful the three concepts are when used in conjunction as a theoretical basis for thinking about long-term breastfeeding.

11.2 Long-term breastfeeding and liminality

11.2.1 Mahon-Daly and Andrews: breastfeeding long-term

Mahon-Daly and Andrews (2002) is the only published work to specifically use the concept of liminality to think in detail about women's experiences of breastfeeding. They give examples of women's experiences in each of the three levels of liminality they define. Their work does not consider issues of long-term breastfeeding, but is useful in providing a theoretical framework which can be further developed.

I will focus in this discussion on space and time and the idea of being 'betwixt and between'. Although liminality has been related to both 'betwixt and between' and 'matter out of place' (Jackson, 2005), the latter will be considered in more depth below, in relation to taboo and the work of Battersby (2007) and Douglas (1966). In addition to defining three levels of liminality as the theoretical basis on which they approached their data collection, Mahon-Daly and Andrews considered their findings specifically in relation to space and time. They also wrote about the medicalisation of breastfeeding, the body and breastfeeding and breastfeeding as pollution, which I discuss in relation to taboo.

In Mahon-Daly and Andrews' schema the first liminal phase is the post-natal one. Those who choose to breastfeed are not immediately reintegrated into society (and therefore do not fully experience transition):

...total reintegration may not occur so long as lactation is active and positive. Breastfeeding bodies are indeed physically different, are relatively uncommon, and are experienced by a minority...

(Mahon-Daly and Andrews, 2002:65). Although most women experience reintegration fairly rapidly, those who choose to carry on breastfeeding (as do the women in my study) remain in the liminal state, some for a considerable period of time. These women can clearly be seen to be in a 'betwixt and between' place as their experience continues to be different, both to those who have stopped breastfeeding and those who have never breastfed. In this study I have shown how women talked about being different on many levels, in particular recognising that they are not in a 'normal' position when other mothers are 'returning to normal'. They talk about having entered a phase that it is hard to see a way out of, including having another child, returning to paid work or to the selves that they were before (however these were identified). Being in a particular place – such as mothering one child in this way – makes any other place (having another child for example) seem hard to move into. This was referred to by a number of women, in different areas of the data. Many participants gave examples of how they saw themselves in a different place than they were before they became mothers; for some this was related specifically to breastfeeding, for others more generally to parenting. Women in this liminal phase did not know what or how they would be in the future.

Many participants also talked about their experience as isolating, setting them apart from other mothers (as those in a liminal phase are set apart from the rest of society). This isolation was experienced both emotionally and

physically and was referred to as a 'cos' (Sarah, email; 27th February 2008).

They also talk about being committed to a way of life that they cannot see their way out of - a phase with no end:

...as this time continues without a clear end in sight...as the mothers of similarly aged children are returning to some state of normalcy...

(Sarah, emails 24th April and 2nd July 2008). This is a commitment to a way of life that places women in a liminal space. These women can be seen both to place themselves in this space by virtue of the decisions they make, but also to have been placed there by a society that views their behaviour as transgressive and not worthy of support. This is of course not true for all women who breastfeed long-term: the experiences of 'Jess', for example (discussed in the previous chapters) were very different, but unusual. Smale, although primarily discussing stigma, noted that:

...breastfeeding can be constructed as a refusal of the woman to make the expected rite of passage back to the pre-pregnant state, extending a dangerous or liminal state...

(Smale, 2001:240).

The second level of liminality is seen by Mahon-Daly and Andrews in relation to the way in which experiences of breastfeeding change women - as a transition to a new understanding of both themselves and their bodies. They also talk about how these women:

...communicate their 'new world' to others...

(2002:65). Participants in this study talked about communicating their changed perceptions to others in relation to the decision to carry on breastfeeding and to the qualities that enabled this. This was shown when they talked about their determination and how they did not allow others to

criticise their behaviour, and also in their expressions of pleasure and delight in what they were doing:

...I love this! I don't want it to stop!...

(woman at LLL observation; 9th January 2008). These women also referred to confidence in relation to communicating with others and confidence in their decision to breastfeed long-term, as well as having a self-confident personality.

In the third level of their explanation Mahon-Daly and Andrews considered how breastfeeding women use places in order to ensure both that they and others are comfortable about breastfeeding and thus how breastfeeding is liminal in relation both to time and space. In their research women talked about moving in and out of spaces where breastfeeding felt comfortable. My participants also gave examples of this, talking about where they breastfed and who they breastfed in front of. In this research I found, as have others (Pain *et al.*, 2001; Scott and Mostyn, 2003), that at times women interpreted spaces in their homes as public. Conversely, women were able to make public spaces feel private, through the use of a range of strategies to make long-term breastfeeding in public more acceptable. They talked about this both in terms of their own comfort but also that of those around them. Most women were very aware of the discomfort of others about long-term breastfeeding. They claimed that they felt comfortable breastfeeding in public (which could mean breastfeeding in front of relatives at home and breastfeeding outside the home), and simultaneously adjusted their behaviour in order to minimise the discomfort of others.

For many women breastfeeding support groups became places where both breastfeeding long-term and talking about it were comfortable, in a way that most other places were not. This was particularly in relation to behaviours associated with long-term breastfeeding, such as tandem nursing, or other parenting decisions such as co-sleeping. Similarly the gradual association, for many women, with a range of other groups (which could be seen as sub-cultures) enabled them to remain in a liminal space for some time and, perhaps, with some security. For some participants the liminal phase did not lead to reincorporation into society as they had known it, but incorporation into a new society as a changed being. This was particularly true of those who, as long-term breastfeeders, came to identify themselves as attachment parents or home educators, and whose decisions about how they lived and behaved separated them from most other parents. Whilst breastfeeding, whether for months or years, these women are 'betwixt and between'. For some women the liminal phase is clearer as they intend to return to their former life. For most women however there was recognition that life would never be the same again. Some used this experience to build a new identity, not only as a long-term breasteeder but as a breastfeeding counsellor, a birth educator or in another related field.

11.2.2 Liminality: understanding long-term breastfeeding

The findings from this study are clearly supportive of those of Mahon-Daly and Andrews, whose findings about women breastfeeding babies have also been shown to be applicable to those breastfeeding long-term. Jackson

(2005) points out that Turner recognised two sorts of liminality, that relating to ritualised transitions between states (as in the Van Gennep 'rites of passage' meaning), and that relating to ambiguous or less clearly defined states.

Some experiences, such as long-term breastfeeding (or in Jackson's example, chronic pain) can be seen as both/either:

..."not-quite-either" or "some of both"...

(Jackson, 2005:345). The idea of *communitas*, of those in the liminal phase inhabiting a common space, can be seen to be particularly relevant (although not universally so) to long-term breastfeeders. For some long-term breastfeeding women, their breastfeeding and associated decisions become part of how they identify themselves and how they identify with others, leading to a clear sense of belonging to a community and the:

...shared sense of alterity...

identified by Czarniawksa and Mazza (2003: 273). This is particularly true of LLL attendees and of those who identify with the philosophy of attachment parenting, the '*like-minded people*' referred to by Josie (interview; 18th November 2008). Deflem's discussion about *communitas* and the liminal phase is particularly relevant to LLL:

...around these happenings a union of followers was normatively organised, with their own places and times where communities could be experienced on the margins of the society at large...

(Deflem, 1991).

The concept of anti-structure (noted in Chapter 3, p.107) is also of relevance here. Women who identify with attachment parenting philosophy and with that of LLL could be argued to be counter-cultural through their rejection of

some of the commonly adopted 'structures' of early parenting in mainstream Western culture – including attempts to induce independence in babies (through separation from the mother, and including 'sleep training') and culturally accepted norms around infant behaviour, including both the timing of feeding in the early days and the duration of breastfeeding as time goes on.

This shared sense of community can be experienced, even without a shared physical presence - 'Sarah' talked eloquently about how a sense of community can be acquired through reading and the internet – although she later appreciated having '*actual contact*' (email; 27th February 2008). Madge and O'Connor talk about how *communitas* is characterised by:

...an equality of relations, comradeship that transcends age, rank, kinship etc. and displays an intense community spirit. Thus people from all social groups may form strong bonds, free from structures that normally separate them...

(2005:93). They also note how useful the liminal space of cyberspace is to new mothers. The recent proliferation of internet-based support groups for long-term breastfeeding suggests that cyberspace is becoming more important as a source of support and contact.

Women who are breastfeeding long-term see themselves to be 'in a phase' and in a different place to other mothers. Decisions that are made, about feeding their babies/children, how they are helped to sleep (and where they sleep), how they behave with them (for example, in extended periods of carrying) and in longer-term decisions they make (for example, about

education) set this group of women apart from their peers and mark them out as different from early on.

Turner's point, about liminal people being:

...at once no longer classified and not yet classified...

(Mahdi *et al.*, 1987) is also relevant. I asked all of the women that I interviewed what they called their continued breastfeeding. Whilst most women commented on the range of terms available, some noted that they had no word for what they did, due in part to it not being something that was discussed with other people. Women who breastfeed long-term are between social identities, with a temporary identity for which our culture has no name, perhaps even as in Navon and Morag's example:

...permanently unclassifiable...

(2004:2344). Coming to an understanding of their social identity is particularly hard for women who see their behaviour discussed negatively in the media or who are unable to talk to those around them about it. The liminal state can be lonely. 'Sarah' talked about the loneliness of experiencing motherhood differently to most other women around her, but also in terms of her altered identity (from full-time academic to full-time mother), relating this to her decision to breastfeed long-term and to adopt the attachment parenting philosophy.

The social anxiety associated with liminal people, as noted by Warner and Gabe (2004), can also be clearly seen in relation to long-term breastfeeding. The media attention that followed the recent *Time* magazine cover (May 21st

2012) showing a woman breastfeeding a four-year old is one example. That many people felt the need to comment on this in negative or disturbed terms on discussion boards, newspaper websites and in television programmes is a clear demonstration of social unease around long-term breastfeeding. The behaviour of women who choose to breastfeed long-term and who are open about it is interpreted culturally as transgressive and as a threat to order (Smale, 2001). This is discussed further below in relation to stigma and the way in which liminal people provoke stigmatising reactions in others. Liminal states can be perceived as disturbing, potentially even threatening or dangerous, and liminal people seen as ambiguous and separate.

The liminal state is not culturally acceptable when its duration cannot be controlled (Hogan, 2008). This is an issue for women who continue to breastfeed despite significant societal pressures to wean. Taylor (2008) notes that there are societal expectations in relation to rites of passage. Women in this study talked about how clearly others demonstrated their expectations about the end of the breastfeeding period ('*still* breastfeeding?') but also how, before they started, they usually had clear ideas themselves about when breastfeeding would end. The way that breastfeeding is talked about suggests that it is acceptable for babies, unusual but generally tolerated up to about a year of age and considered unnecessary, inappropriate and even bizarre beyond this point. Comments about the appropriateness of breastfeeding once teeth have erupted, or once a child can walk and talk, are common. My research participants talked about

having these opinions themselves, prior to breastfeeding – as well as feeling shocked and/or surprised when they first saw long-term breastfeeding - indicating how commonly held are these societal expectations. Expectations in relation to set patterns/rules of behaviour are internalised; long-term breastfeeders break these rules but, in common with others in liminal states, are relatively powerless in relation to how their behaviour is seen. They may also not be happy in their new liminal state, but cannot easily return to their old state. The ways in which many of the women in this study talked about the difficulties they experienced, despite making a positive decision to breastfeed long-term, illustrates this point.

Being in a liminal state can be unsettling, both for those who experience it and for those (friends and family) around the liminal person (Hogan, 2008). In this study participants talked about how close relatives found their long-term breastfeeding difficult due to its perceived inappropriateness and also because it was seen as preventing other people (particularly fathers and grandparents) from relating to children. For the breastfeeding women there was the knowledge that they could perhaps not have the personal space or bodily freedom experienced by their non-breastfeeding peers. In this 'betwixt and between' time and space women often expressed mixed emotions about both the benefits of the emotional and physical closeness they experienced through breastfeeding, and the feeling of being 'tied' both to their children and to a way of life.

11.3 Long-term breastfeeding and stigma

11.3.1 Smale: breastfeeding long-term

As discussed in Chapter 2, Smale (2001) uses the concepts of 'origin' and 'peril', building on the ideas of Jones *et al.* (1984) to discuss the stigmatisation of breastfeeding, focusing specifically on breastfeeding in public and on the 'mark' of stigma in relation to leaking breastmilk and the noises of breastfeeding. Whilst more relevant to a discussion of early breastfeeding than breastfeeding long-term, these concepts are nonetheless felt to be useful. A stigmatised person can be seen as one who has:

...an undesirable difference...

(Goffman, 1963); the way in which this difference is culturally and socially constructed is important in relation to long-term breastfeeding.

Smale recognises that the:

...stigmatisation of breastfeeding...[is]...an entrenched reaction...

(2001:234). She notes, as I have above, that breastfeeding is often socially tolerated up to a certain point:

...feelings about offering the breast to babies with teeth or speech, signs of autonomy, are not based on biological but cultural objections. Social support for the breastfeeding mother changes to toleration, then, via indifference, to active encouragement for and 'social coercion' towards weaning...

(2001:238, quoting Morse and Harrison, 1987:205). The ways in which my participants talked about the pressure to wean, or the assumption beyond a certain point that they have already weaned, echoes this. Many participants were told that what they were doing was harmful to their child, or that they were doing it for themselves and not the child:

...it's bizarre, it's completely unnatural, it's for you not him...

(Mandy, interview; 18th November 2008).

Smale's discussion of the 'mark' of breastfeeding, the dimension of 'origin' and the way in which she relates this to the work of Jones *et al.* is relevant to a consideration of long-term breastfeeding. Although the visible signs, smells or noises of breastfeeding may reduce as the child grows older, those who breastfeed older children in public are clearly marked by the visible nature of the action. Jones *et al.* wrote about one aspect of 'origin' being:

...the individual's own role in engendering his or her own mark...

(1984:56); this contributes to the level of stigmatisation experienced (Smale, 2001). Smale notes that this may limit how much women talk about breastfeeding difficulties: my participants talked about having few places to discuss their experiences, particularly if they found them difficult (for example, in relation to tandem feeding or with co-sleeping). Women who choose to engage in a stigmatised activity may find little sympathy from those around them when this activity causes them difficulties:

...when a marked individual is known to be responsible for the degrading affliction possessed, he or she is more likely to be treated negatively and to be viewed unfavourably...

(Jones *et al.*, 1984:58). Smale also relates Jones *et al.*'s suggestion that stigmatised conditions might be seen as the result of '*some earlier sin*' (2001:236) to breastfeeding difficulties – particularly to the choice of '*breastfeeding style*'. The women in this study talked about being criticised for their breastfeeding and parenting decisions, for having 'selfish' motivations for continuing to breastfeed, and about making life more difficult

for those around them by choosing to continue to breastfeed on cue, to breastfeed to sleep or to practise child-led weaning. The sentiment behind:

...you've punished yourself enough...

(LLL observation; 11th June 2008) resonates with Smale's interpretation of Jones *et al.*'s concept.

Smale also discusses the dimension of 'peril', suggesting that

...breastfeeding is constructed culturally as a threat to order...

(Smale, 2001: 236). She only considers this very briefly and does not relate the idea to the concept of liminality, although there can be seen to be clear links between this idea and that of liminal people as threatening and disruptive, as discussed above. Whilst women who breastfeed long-term are not seen as dangerous, they may be perceived as threatening, in that they do not behave in culturally prescribed ways. Jones *et al.* note that '*the essence of stigma is fear*' (1984:65) and that people who are different (but accepting of their difference) may challenge our view of the world (and therefore be perceived as threatening). They talk about different ways in which stigmatised people may be seen as dangerous: of interest here is their discussion of people who are stigmatised because they lead:

...Sybaritic, self-indulgent lives...

(1984:75), for example, prostitutes, drug addicts or gamblers. Long-term breastfeeders report that others suggest that they are doing it for themselves and not their child. Comments about how enjoyable it is:

...we're almost embarrassed...to say how pleasurable it is...

(LLL observation; 9th January 2008) may also contribute to it being seen as 'self-indulgent'.

Smale also considers the times and places when breastfeeding is particularly threatening. My participants demonstrated their awareness of how their behaviour is seen when they talk about the strategies they employ when breastfeeding in public and about how they minimise the opportunities for other people to feel uncomfortable with their behaviour, discussed above.

11.3.2 Stigma: understanding long-term breastfeeding

There are a number of ways in which Jones *et al.*'s (1984) concept of stigma can be applied to long-term breastfeeding. My participants talked about their experiences in ways which demonstrated their understanding of cultural norms and expectations. Many expressed shock or surprise when long-term breastfeeding was first seen, clearly showing that it is a behaviour which is not expected or usual. Some women reported that it was not something they envisioned themselves doing. Comments such as '*this is not going to happen*' (Josie, interview; 28th October 2008) and '*probably might not do that*' (Mandy, interview; 18th November 2008) clearly demonstrate this, with the sub-text being '*why would I want to behave like this?*'

Smale (2001) considers 'origin' and 'peril'; Jones *et al.* (1984) also wrote about 'concealability', 'course of the mark', 'disruptiveness' and 'aesthetics' in their discussion of stigma. Although Smale may not have considered these

applicable to breastfeeding *per se* they are seen to have some relevance to long-term breastfeeding, as is Link and Phelan's dimension of 'discrimination' (2001). Long-term breastfeeding is concealable and it could be argued that those who choose to continue breastfeeding in private are less likely to be stigmatised than those who make their decision public. Conversely, the less long-term breastfeeding is seen, the more likely it is to be stigmatised. Jones *et al.*, building on Goffman's ideas about discredited and discreditable people, considered the importance of concealability, suggesting that those who were able would choose to conceal their stigmatising condition. It is interesting that most of my participants said that they would not conceal the fact that they were breastfeeding long-term (although some chose who they shared this information with). The clearest example of this was the way that nearly all women said that they were happy to breastfeed in public. By doing so they clearly challenged the stigma, associated with long-term breastfeeding, whilst simultaneously managing the stigma through adopting various strategies.

Jones *et al.* (1984) also note that, even when a stigmatising condition or mark is concealed there may still be consequences for people and their relationships. Many participants in this study talked about the effect on social relationships of their breastfeeding and parenting decisions, exemplified by the move towards '*like-minded people*' and away from other mothers. Many talked about how difficult it was to retain close friendships with formula feeders:

...I limited the time I spent with those people...I would make a conscious effort to
...create more of a life [with other] people...

(woman at LLL observation, 11th June 2008).

In 'the course of the mark' Jones *et al.* (1984) recognised that some conditions become less stigmatising as time progresses. Whether this is true or not for a particular condition will affect relationships with other people. In the case of long-term breastfeeding, by contrast, the stigmatising effects are likely to become greater the longer the breastfeeding period lasts. Some participants who were still breastfeeding relatively young babies/toddlers were able to gain support from a range of friends but for many, as time went on, this became more difficult:

...I've stopped meeting up with friends...I know will say anything about it...I've given up trying to explain it...

(woman at LLL meeting; 9th July 2008). This results, for some, in extreme loneliness and wariness about friendships - for others it leads to clear identification with alternative sub-cultures and groups of people with shared interests.

Jones *et al.* (1984) also note that there are situations where others, including family as well as certain professionals, may try to change the 'course of the mark'. Women who continue to breastfeed beyond certain culturally sanctioned points find themselves under increasing pressure to wean. This pressure comes from family, health professionals, the media and formula companies (see Dowling and Brown, 2013, for further discussion on this point).

'Disruptiveness' was noted by Jones *et al.* to be a less clear - and perhaps less useful - concept than the other dimensions. There are, however, ways in which it can be seen as particularly useful in thinking about long-term breastfeeding. Disruptiveness is considered to be the way in which the 'mark':

...hinders, strains, and adds to the difficulty of interpersonal relationships...

(Jones *et al.*, 1984:46). In this study, participants noted difficulties in maintaining friendships with other women who had made different infant feeding and parenting choices, as well as with family members who found long-term breastfeeding difficult to accept. Particular difficulties were experienced with friends who chose to formula feed, and with mothers and mothers-in-law.

The dimension of 'aesthetics' relates to the way in which attractiveness is an important element in interpersonal relationships. Some stigmatising conditions cause disfigurements and may engender feelings of revulsion or disgust. Jones *et al.* (1984) note that this dimension is different from the others, as the response is affective rather than cognitive. Some people find long-term breastfeeding disgusting: evidence can be found in online reactions to television programmes such as *Extraordinary Breastfeeding* (Channel 4, February 1st 2006), comedy sketches such as the 'bitty' sketch in *Little Britain* (BBC, 2007) or to the recent *Time* magazine cover (May 21st 2012). Examples of these reactions can be easily found (Lau, 2012 for example). Reference was made by many participants in this study to these programmes; these women were aware of the cultural and societal views

represented by these reactions. Some women were told that what they were doing was '*disgusting*', others were acutely aware that those around them did not want to see them breastfeeding. Ideas about the sexual nature of breasts, about female attractiveness in our society and about the natural function of breasts come together when women talk about breastfeeding their children, saying '*you can't just leave it all out!*' (Sam, interview; 16th July 2009) or '*I felt like I was on display*' (Josie, interview; 16th October 2008).

As has been noted, Link and Phelan (2001) considered that an additional dimension of stigma – *discrimination* – should be added to those of Jones *et al.*:

...Most definitions of stigma do not include this component...the term stigma cannot hold the meaning we commonly assign to it when this aspect is left out. In our reasoning, when people are labelled, set apart, and linked to undesirable characteristics, a rationale is constructed for devaluing, rejecting, and excluding them...[this] leads them to experience status loss and discrimination...

(Link and Phelan, 2001:371). Interestingly, none of my participants described feeling overtly discriminated against and so I have not considered the concept of discrimination in my analysis. However, the ways in which long-term breastfeeding is portrayed in the media can be seen as '*devaluing, rejecting and excluding*'; as this is part of the social context in which women decide to breastfeed and to carry on breastfeeding it is considered important. There is a need for further work on the nature and extent of discrimination against breastfeeding women, especially those who breastfeed long-term.

11.4 Long-term breastfeeding and taboo

11.4.2 Battersby: breastfeeding long-term

As discussed in Chapter 3, Battersby's work (2007) clearly addresses issues of taboo and has obvious links – although not explicitly stated – with the work of Douglas (1966) and the idea of 'matter out of place':

...breastfeeding...is the cause of embarrassment, and the butt of smutty jokes and innuendoes. It arouses feelings of disgust and disdain. Bottle feeding is seen as sterile and clean while breastmilk is considered a pollutant, a bodily fluid that should be contained...perceived by some as dirty, unclean or even obscene...

(Battersby, 2007:101-102). Battersby also links her discussion – which is primarily about breastfeeding in public – with the concept of stigma.

Although Battersby only briefly mentions long-term breastfeeding, her work provides a useful structure with which to think about the experiences of women who breastfeed long-term.

In my study women did not talk about their breastmilk as dirty or impure, or about feeling the need to hide evidence of their breastfeeding (leaks, stains), possibly because they focused on their experiences when their children were older. I also met and talked to women who were breastfeeding young babies, but issues to do with the early containment and management of breastmilk were rarely discussed. Other studies have noted women's feelings about the impurity of their breastmilk (Mahon-Daly and Andrews, 2002; Schmied and Lupton, 2001); often contrasted with the purity of formula milk.

Participants in this study talked about longer-term breastfeeding in ways that demonstrated an understanding of 'matter out of place'. Participants talked

about the times when they had expected negative reactions, for example when breastfeeding a toddler on the steps of the Catholic cathedral, in church or in other public places – clearly showing their understanding of taboos in relation to breastfeeding and where it might be considered socially inappropriate. As Stewart-Knox *et al.* noted, many women think of:

...feeding publicly as breaching a cultural taboo...

(2003:267). Participants talked about feeling more uncomfortable breastfeeding in public as their child grew older, and about being more aware of the potential for reactions from others. They also gave other examples of times when their lactating breasts and/or their breastmilk were considered 'matter out of place' by talking about where breastfeeding felt comfortable, including who it was comfortable to breastfeed in front of:

...you can't just leave it all out...[referring to her breasts]...

(Sam, interview; 16th July 2009). As noted above, others talked about feeling '*on display*' or about not feeling comfortable breastfeeding with certain people present as their child grew older, even in their home.

Battersby (2007) also considers the way in which lack of containment of breastmilk can be interpreted as lack of control by a woman over her body. Women who breastfeed long-term may also be seen as lacking in control, by not bringing their behaviour in line with others. In this study Sam talked about being told that she had:

...gone beyond the call of duty...

(interview; 16th July 2009). A participant at a LLL meeting commented that she had been told:

...you've done it for so long now you don't have to put yourself through it any more', and 'you've punished yourself enough by breastfeeding her'...

(LLL observation; 11th June 2008). Implicit in these comments is the suggestion that the woman was doing something transgressive, and possibly damaging, but also that it was within her control to change this.

Battersby's discussion of breastfeeding in public (2007) includes observations on the ways in which women are often expected to go into public toilets to breastfeed or express milk. Although Battersby does not make links with liminality, Wolch and Philo's ideas about liminal people being 'banished' to:

...marginal spaces and unloved places...

(2000:144, quoted in Warner and Gabe, 2004:389) are clearly relevant here. Again, as the focus was not on early breastfeeding, this issue was not often discussed with participants in this study. Participants, even those who reported being comfortable breastfeeding older babies and children in public, referred to what could be seen as self-banishment to less attractive places – for example, moving to breastfeed in another room or area, in order to separate themselves from others (who may be experiencing discomfort). The restriction of movement by breastfeeding women in relation to place, in order to breastfeed comfortably, was noted by Scott and Mostyn (2003). The strategies employed by participants in this study in order to breastfeed older children in public, whilst not necessarily demonstrating restriction of movement, show a specific use of space and an interesting use of self and space in relation to managing potential disapproval by others.

Battersby (2007) also considers the sexual connotations of breastfeeding and the cultural confusion that arises about the function of breasts – and consequently the appropriateness of breastfeeding in public. She makes one mention of this in relation to long-term breastfeeding. Most participants in this study talked in a matter-of-fact way about how breasts are perceived culturally: as an unfortunate but accepted part of life. Interestingly, although many talked about wanting their bodies to themselves at times (*‘they’re my boobies’*), there was very little discussion about breasts and sexual function or about partners’ views on this. The discussions that I had with my participants about breastfeeding boys also showed that, although most had no direct experience of adverse reactions in relation to this, they were aware that this was considered taboo. The examples given in the findings chapters (both in relation to breastfeeding boys) of knowing of a child-abuse charge levelled at a woman breastfeeding long-term and of being reported to the local Social Services are both indicative of this.

11.4.2 Taboo: understanding long-term breastfeeding

As noted in Chapter 3 there is a range of work about taboo which is relevant to thinking about long-term breastfeeding, particularly in relation to bodily fluids and to ideas about ‘matter out of place’. Particular symbolic importance has been shown to attach to breastmilk and to the observance of ‘proper’ boundaries in relation to its containment, as discussed above. The blurring of boundaries is also shown by not behaving as expected in relation

to weaning and the duration of breastfeeding; this leads to the cultural unease associated with:

...that which is marginal and different...

(Schmied and Lupton, 2001:245). Steiner (1956) noted that taboos are connected to rites of passage and how people make sense of the behaviour of others; Radcliffe-Brown (1952) that taboos serve as expressions of social values. In these ways long-term breastfeeding can be seen as taboo – it is generally misunderstood and culturally interpreted negatively. This is part of the context within which women experience their behaviour and understand the reactions of others. Although the majority of participants in this study had not received negative comments, there were many examples of how others perceived their behaviour – ranging from leaving the room, to '*little comments*', to more overt expressions of disgust or unease. Even if comments were not made, participants were aware of the potential for this, sometimes expressing surprise if they were not forthcoming.

I propose that long-term breastfeeding can be considered as 'matter out of place' in present-day UK culture simply through its existence. Cultural and societal expectations about weaning and about appropriate behaviour in relation to a range of parenting issues all build on a series of taboos. These include sexual connotations in relation to breasts, the prioritisation of a child's access to a woman's body (and the duration of this) and incest taboos in relation to breastfeeding boys. Wherever a woman breastfeeds an older baby or toddler she is, through her behaviour, 'out of place'.

11.5 Understanding long-term breastfeeding: liminality, stigma and taboo

Using the three concepts together can offer a new lens through which to view long-term breastfeeding. Although the concepts are distinct they are also inter-related, historically and conceptually. Individually they each offer useful insights into women's experiences; used jointly they are even more insightful. In reviewing the literature on liminality, stigma and taboo I found that the concepts were often linked, most usually stigma and liminality but also taboo and liminality. They were rarely discussed together, although occasionally reference was made to the three concepts in a single piece of work (for example, Jackson, 2005).

Breastfeeding women have been shown to be in a liminal space and place; women breastfeeding long-term remain liminal for extended periods of time, with some never fully reintegrating into society as they were before. These women are clearly 'betwixt and between' in both senses discussed above and their actions make both their breastmilk and their bodies 'matter out of place' – at the same time both liminal and taboo. Leach talked about human body products that are considered dirty when separated from the body (for example, menstrual blood, semen, urine), and how these 'me' and 'not me' products (Leach, 1964, quoted in Jackson, 2005:343) are 'betwixt and between' and considered taboo. Women who breastfeed long-term use their breastmilk (both 'me' and 'not me') in both liminal and taboo ways. The presence of a taboo material (breastmilk) in many social situations (in most

public spaces, in specific spaces such as churches and also in relation to the presence of an older child with teeth, speech etc.) is culturally 'matter out of place' and as such both disturbing and threatening.

Turner's concept of *communitas* as a central characteristic of the liminal phase has been shown here to be particularly useful in understanding the role of support groups in long-term breastfeeding. *Communitas* can also apply to virtual communities and other methods of gaining support. It also aids understanding of the importance for breastfeeding women generally of 'like-minded people' and of those who share not only similar experiences but viewpoints and philosophies: a shared space and time.

Through an exploration of Jones *et al.*'s understanding of stigma, long-term breastfeeding has been shown to be a stigmatised activity; a thorough reading of the literature suggests that liminal people are also often stigmatised by virtue of their difference:

...transgress[ing] several crucial boundaries that people find essential for understanding, ordering and evaluating experience...

(Jackson, 2005:348). Women who breastfeed long-term – and who make other related parenting decisions - are in a marginal place, both due to being not '*one thing or another*' and because of the way in which they are seen to contribute to their stigmatised behaviour ('*the course of the mark*'). Women who breastfeed long-term can be seen as threatening, both in relation to the 'peril' of the stigma (Jones *et al.*, 1984) and to the danger felt in relation to liminal people (Turner, 1969). That which is seen as potentially polluting is

also seen as dangerous (Douglas, 1966). The ambiguity attached to people who are not clearly classifiable, such as those in the liminal state, can also be attached to stigmatising behaviours. The woman who breastfeeds long-term can choose to conceal or not conceal the 'mark' of her stigma; this in turn may be culturally confusing. Jackson notes that liminal phenomena:

...elicit high affect of a negative or ambivalent nature...

(Jackson, 2005:343). The disgust that is often expressed in relation to long-term breastfeeding is an example both of this and of its taboo nature.

Participants in this study clearly recognised that what they were doing was both stigmatised and taboo in our culture. Most also demonstrated that they were very aware of being in a different place to where they were before; for some there was also recognition that they would never return to their old selves. Participants used space in liminal ways, moving in and out of places to create comfortable spaces in which to breastfeed – recognising, through their adoption of a range of strategies, that their behaviour was stigmatised by many of those around them.

Liminality, stigma and taboo are all relevant concepts with which to understand long-term breastfeeding and are related and useful together. Women who breastfeed long-term may talk about being comfortable with their decision and with breastfeeding in public but most are very aware of the views of others, the stigmatisation of long-term breastfeeding and of the potential for difficulties in relation to this. The decision to remain in a state which is culturally expected to be of a short duration creates difficulties for

these women in relationships with others, in maintaining their sense of self and, for some, in relation to their former identity. Many, although through choice, find themselves in a phase for which they can both see no end and no return to 'normal', including the potential to have another child. The many and strong forms of support that long-term breastfeeding women access, including for some the gradual integration into alternative cultures, enable women to manage the cultural taboos around their behaviour.

11.6 Summary of main findings

The main purpose of this work was to address a range of questions in relation to women's experiences of breastfeeding long-term. Specifically these aimed to look at difficulties encountered and support received, as well as considering what could be learned from the experience of these women and whether this knowledge could be used to help other women breastfeed beyond six months. I was interested in what enabled women to sustain this behaviour, unusual in our culture and society. As the work developed a further aim became to consider theoretical approaches that might help to increase understanding of the experience of this group of women.

The findings – outlined in relation to themes of 'Deciding', 'Living with the commitment', 'Challenges' and 'Being supported' - are rich and complex. The overall picture is of a group of strong-willed and determined women who have a clear sense of purpose and of 'doing the right thing' in continuing to breastfeed. Most talked about 'always knowing' that they would breastfeed, about feeling that there was no choice about whether it was the right thing to do, considering it 'natural'. A small number of participants set out with the intention to breastfeed long-term, but for most it happened gradually. Some associated this with the developing relationship with their child and with the child's will. Many participants talked about finding long-term breastfeeding 'shocking' or 'surprising' before they themselves became long-term breastfeeders.

Some participants breastfed long-term with support from friends and family, but for others it was a very isolating experience which set them apart from their peers and from usual sources of support. Many sought out alternative sources of support and became involved with networks in a sub-culture of like-minded people; often this was specifically related to breastfeeding but was also connected to other choices such as home-educating or attachment parenting. This work shows strong links between long-term breastfeeding and other decisions about parenting and child-care. It also clearly shows that, although continuing to breastfeed may be a deliberate choice, it is not one made without difficult consequences – in relation to personal well-being, relationships and working outside the home. It has also been demonstrated that women who breastfeed long-term do so in the knowledge of how it is perceived by wider society – shown both by what is said to them and by how they behave with others. Although most participants said that they were happy to breastfeed older babies and children in public, almost all developed strategies in order to do this comfortably, including avoiding eye contact and thinking carefully about how they positioned themselves.

These findings are congruent with those in the existing literature, reviewed in Chapter 2. Although most other work about long-term breastfeeding is dated and not from the UK, similar themes occurred in this research. As noted in Chapter 2, previous work identified a lack of support for long-term breastfeeding, challenges in finding support and coercion/pressure to wean, particularly in the second part of the first year of life. Participants in other

studies referred to the 'naturalness' of long-term breastfeeding and the importance of the relational and behavioural benefits, including calming children and helping them to sleep. This research shows that these are current issues for women breastfeeding long-term and that they are pertinent to women living in the UK. These similarities in experience suggest that long-term breastfeeding is both considered an important aspect of parenting for a minority of women, and that it continues to be considered negatively, culturally and socially.

Although there is little recent work into the experiences of long-term breastfeeders, this study concurs with some of the findings from Gribble (2008) and Stearns (2011). Stearns' work presented 'cautionary tales' in relation to breastfeeding children who 'walk, talk and take' (Stearns, 2011:547). Some comments by participants in my study (about when they first saw long-term breastfeeding) echo these ideas. She also notes, as does Gribble, pressure to wean, the stigma associated with long-term breastfeeding and the importance, for long-term breastfeeders, of the space of LLL meetings. Gribble also found that continuing to breastfeed was associated with both nutrition and nurture. As in my work, participants in Gribble's study faced challenges in continuing to breastfeed and restricted contact with mothers who had made different infant feeding choices. Although there is recent work exploring long-term breastfeeding in the UK (Faircloth, 2009, 2010a, 2010b, 2011), my study has had a different focus. Some of the ways in which women talk about breastfeeding in Faircloth's

work are similar to those in this study but the emphasis given to them in the writing from the research is different.

Through developing an increased understanding of the theoretical concepts of liminality, stigma and taboo I have also shown how these ideas can be used to think about the experiences of this group of women. It has been shown that their experience can be considered to be liminal, in relation both to time and place and using ideas of '*matter out of place*' and '*betwixt and between*'. Being in this liminal phase – threatening to some in society as it may seem to have no end – stigmatises the women and reinforces their status as those engaging in taboo behaviour.

11.7 Contribution to new knowledge

This work has made a clear contribution to new knowledge in a number of areas. Knowledge has been furthered by presenting in-depth, rich findings about the experience of an under-researched group in a sensitive area. Presenting these within the context of a cross-disciplinary perspective and by using insider research methods has strengthened their authenticity and credibility. By using online asynchronous interviews via email correspondence as one method of data collection I have added to the body of work that shows this as a suitable method for researching sensitive issues, and demonstrated that it has been a particularly good method for understanding more about breastfeeding experiences in this context. In particular I have highlighted the important methodological finding that using a disembodied medium such as email does not necessarily disadvantage research into embodied experiences such as breastfeeding.

The use of the Social-Ecological model (SEM) with which to structure an understanding of the context in which women breastfeed has also demonstrated theoretical development. Used in other contexts to understand breastfeeding *per se* and to focus public health action in improving breastfeeding initiation and duration, the SEM can also be used to understand the complex social and personal structures within which women decide to carry on breastfeeding beyond culturally accepted norms. It has been used here to structure a review of the relevant literature but also to underpin the thesis as a whole, including the discussion of the findings.

A contribution to theory and to the theoretical understanding of breastfeeding experiences has been made through the use of the concepts of liminality, stigma and taboo. Building on the small body of work previously in this area and on the theoretical concepts underlying this I have developed new ways of understanding women's experiences. I have shown that using a number of distinct but inter-related concepts in conjunction with each other can be helpful and illuminating; these are used for the first time here to think specifically about experiences of long-term breastfeeding. This work has also demonstrated the challenges, as well as advantages, of building on work from a number of disciplines and of moving outside disciplinary boundaries.

11.8 Strengths and limitations of the work

This work shows a number of strengths. It has clear breadth and depth, drawing on a wide range of material from a number of disciplines and using this to support the methodological approach, discussion of the findings and development of theory. By using a number of methods I have both demonstrated rigour and increased the trustworthiness of my findings. By using classic methods and approaches from ethnography I have demonstrated understanding of the appropriateness of these; in addition the use of more innovative methods has complemented and enhanced data collection. Through dissemination of work about this, throughout the period of the PhD as well as in future planned publications, this knowledge is also available to other qualitative researchers. The personal nature of the topic and my role as an insider could potentially have led to difficulties and compromised the integrity of the work. I have addressed these issues throughout and believe that the final thesis is strengthened both by my intimate involvement with my subject and by the demonstration of my ability to reflect on the role of this in research design, data collection, analysis and discussion of findings.

The development of theory through building on the work of others is also a clear strength of this work. I have demonstrated a sound understanding of the concepts and how they have previously been used to understand breastfeeding experiences, and built on and developed this to show how they

can be used together to further understanding of the experiences of women who breastfeed long-term.

I have reflected on some of the limitations of this work throughout the thesis.

One particular methodological weakness is considered to be in only collecting data from face-to-face interviewees on one occasion each.

Reviewing the quality of data collection from this method compared to others later led me to feel that it was a mistake to only conduct one-off interviews.

Having further opportunities to meet these participants, and to clarify and explore points made, would have been beneficial, perhaps leading to fuller representations of their experiences. This is however believed to be

mediated by the richness of the total data set, and by the opportunities for triangulation through the use of three methods. A further limitation which I

acknowledge is that, although the majority of interviewees were not LLL

attendees, they were broadly similar in terms of education and socio-

economic status. It would have been beneficial and added to the richness of

the data obtained if I had recruited more interviewees from other

backgrounds and areas.

On reflection I also feel that only conducting observations at BIB meetings on

three occasions limited this aspect of data collection. I justified this at the

time as I was also attending Babes, in a similar area of the city. Revisiting

my notes and recordings during the process of analysis caused me to re-

consider. I might have met an even wider range of women (and experiences)

if I had continued with these observations. Leaving that group was probably

more to do with my discomfort there than any other factor. The nature of my data collection may also have limited some of the ideas I was able to consider in my analysis, for example the concept of discrimination.

This work might also be considered limited in geographical scope – although the intention was to undertake a small scale qualitative study, accessing women from a wider area would be quite straightforward, given the proliferation of online support groups for breastfeeding long-term as well as related parenting issues.

The disciplinary breadth of this thesis, whilst considered a strength, may also be seen as a weakness. Reviewing literature from a range of disciplines, some of which were unfamiliar, potentially risks demonstrating a lack of understanding and depth. By attempting to be consistently thorough in my approach to new material and by discussing uncertainties in supervisory meetings I hope to have minimised these risks.

11.9 Conclusion

This chapter has used the theoretical concepts of liminality, stigma and taboo as an interpretative lens with which to discuss the findings from this research. The main findings from the work have been summarised and the contribution made by it to new knowledge outlined, along with an assessment of the strengths and limitations of the work. The following chapter draws the thesis to a conclusion, providing an overall summary and identifying potential areas for further research.

Chapter 12: Conclusions and implications for future research

12.1 Implications for future research

This thesis has raised a number of questions which indicate a need for further research at all levels of influence on breastfeeding. There is a paucity of research into the health benefits of continuing to breastfeed; despite the difficulties in undertaking work in this area it would be beneficial - to breastfeeding women, those working with them, and researchers - to have more knowledge and information. I have confirmed that there is a need for increased understanding about how to make breastfeeding at a range of ages more culturally acceptable: to families, communities and society in general. Removing social stigma, and the associated taboo, is challenging and more work may be needed to understand why these attitudes persist and are so pervasive. Increasing understanding of how liminality, stigma and taboo interact could be also used to investigate the experiences of other marginalised groups. I have also identified a need for further work on the nature and extent of discrimination against breastfeeding women, especially those who breastfeed long-term.

A range of issues have been identified relating to women's experiences and support for long-term breastfeeding. Further work is necessary to consider how these findings might be used to influence the training and/or practice of health staff to enable them to support breastfeeding women. Further work is

also needed to understand whether achieving UNICEF BFI status improves relationships between long-term breastfeeders and health professionals.

This is an under-researched area of family experience. This research raised a number of points about the experiences of fathers and grandmothers, including difficulties in their relationships with children who were being breastfed long-term. Further research might help to develop understanding about how to make long-term breastfeeding more acceptable to all family members, and how to increase support for women in these families.

12.2 Conclusions

This study has used ethnographic methods to address a range of research questions. It demonstrates both a contribution to new knowledge in this area and to methodological and theoretical approaches. The study has focused on women's experiences of long-term breastfeeding, the difficulties encountered and support received. I was interested in what enabled women to sustain this behaviour, unusual in our culture and society. The study considers what can be learned from women's experiences, and whether this knowledge could be used to help other women breastfeed for longer. A further aim developed - to consider conceptual approaches that might help to increase understanding of the experiences of these women.

I have demonstrated the usefulness of having an insider perspective to investigate this issue. This was at times challenging for me personally, but I also valued the opportunity to reflect on my own breastfeeding experiences through contact with other women who shared similar experiences. In this thesis I show how undertaking research as an insider can facilitate access to investigate a sensitive topic, and demonstrate the importance of reflexivity in undertaking this.

A combination of methods have been used to generate rich data on this topic. The use of online asynchronous interviews via email correspondence to gather data contributes to the body of work demonstrating this to be a suitable method for researching sensitive issues.

The findings, categorised in the themes of 'Deciding', 'Living with the commitment', 'Challenges' and 'Being supported', are rich and complex. They both reinforce previous work in this area and add new knowledge about what the day-to-day experience of breastfeeding long-term is like for women and their families. The findings show that women who breastfeed long-term are determined and committed, sometimes continuing despite considerable personal and social sacrifices. Long-term breastfeeding is sometimes a secret activity. Many women, however, do not hide their continued breastfeeding, and develop a range of strategies to make it more comfortable for themselves and others.

The importance of support has been highlighted. Given the absence of social and cultural support, women find support from communities of other long-term breastfeeders. Most participants in this study did not find health professionals supportive of long-term breastfeeding. Likewise mothers and parents-in-law were generally perceived to be unsupportive (although this was not universal). Many women see breastfeeding long-term as a natural way of being with their child, and associate this choice with a range of other parenting decisions. Participants found that, over time, supportive connections with others were as much about other parenting issues as about breastfeeding. Books and the internet were identified as important sources of support but for most women contact with others was crucial. Retaining friendships with women who had made different infant feeding choices was unusual and generally not perceived as supportive.

The normalisation of long-term breastfeeding and the removal of social coercion to wean during the first year are shown to be important factors in supporting women to breastfeed beyond six months. Incongruence between health policy and cultural norms and expectations is also highlighted.

The use of the concepts of liminality, stigma and taboo to think about experiences of breastfeeding long-term is new and has been shown to be useful, productive and interesting. Women who breastfeed long-term have been shown to be in a liminal space and place, engaging in a stigmatised and taboo activity. This thesis has also demonstrated how the Social-Ecological Model can be used to analyse the social and cultural constraints within which women breastfeed long-term. The model has been used to structure a review of the contextual literature, and as a framework to underpin thinking throughout the thesis.

The experiences of women who breastfeed long-term have been explored in two complementary ways. This thesis is about the experiences of the women whom I met, talked, listened and wrote to. It is also about my experiences whilst researching this topic.

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Appendix A – Ethics documentation

A1 Letter from Faculty Graduate Studies Sub-Committee, 28th September 2007



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Our Ref: DP/djj/deb/sep07/dowling rd1letter

28 September 2007

Ms S Dowling
14 Seymour Avenue
Bishopston
BRISTOL BS7 9HJ

Dear Sally

**RESEARCH DEGREE REGISTRATION: EXPLORING THE EXPERIENCES OF
WOMEN WHO BREASTFEED FOR LONGER THAN SIX MONTHS**

I am pleased to inform you that the Faculty Graduate Studies Sub-Committee, Research Degrees (FGSCRD) has approved your application for PhD project registration.

It raised the following issues for you and your supervision team to consider:

1. There may be merit in going beyond just using reflexivity and including auto/ethnography as part of the mixed method given the centrality of your own story and experience to the study.
2. You may wish to consider your sampling strategy in the light of the research questions posed and the transferability of the findings.

At Progression Examination, this letter will be forwarded to the examiners who may wish to ask you questions about these points.

Your period of registration is from 01/05/07 to 01/05/12. Please note that you must re-register as a student with the University in September each year until completion of your candidature. It is a condition of registration that you, and your supervisors, produce annual reports on your progress. You will be sent the relevant form each spring term. If your progress is shown to be satisfactory your student registration for the next academic year will be authorised.

Continued/...

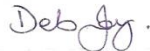
Confidentiality: It is rare for a research student's thesis to need to be kept confidential (for a limited period). Grounds for such confidentiality appear in both the Academic Regulations and Academic Procedures Handbooks. If you have not applied for such confidentiality, and, as your work progresses, you or your collaborating establishment come to consider that confidentiality may be necessary, you should discuss the matter with your supervisor, and, if necessary, make a special application immediately. Please note you **should not** wait until you actually submit your thesis for examination before requesting confidentiality.

You will be required to undertake a progression examination within 12 months of the date of your project registration, that is by 01/05/08. A copy of the Progression Examination Procedure and Progression Report Guidelines is available on the Faculty's S drive (PRPROC and PRGUIDE respectively) and I would suggest you discuss this with your supervisory team at the earliest opportunity. Please note that the examination process is likely to take 4-6 weeks.

The Faculty website includes a section for research degree students. Please provide a synopsis of your research by email to Deb Joy for inclusion thereon. The layout can be accessed on the S drive at S:hsc/Faculty Info/Research/Studfms.

Please feel free to get in touch with me if there are any administrative matters which you would like clarified, or any other help I can give.

Yours sincerely



Deb Joy on behalf of Dr David Pontin
Director of Postgraduate Research Studies

cc: Dr David Pontin, Director of Studies
Jennie Naidoo, Supervisor
Dr Jane Powell, Supervisor

A2 Letter from Faculty Ethics Sub-Committee, 5th November 2007

Our ref: SE/lt

05 November 2007



Faculty of Health
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Dear Sally

Application number: HSC/07/10/80

Application title: Exploring the experiences of women who practice extended breastfeeding

Your ethics application was considered at the Faculty Ethics Sub-Committee meeting of 30th October 2007. It was not given ethical approval at this stage, and you are invited to revise and resubmit it for the next available Faculty Ethics Sub-Committee on 27th November 2007. The deadline for re-submitting your application to this committee is 20th November 2007. Please inform your supervisor of this outcome.

In your revision you should address the following issues:

1. Please describe the purpose of the observations, what data will be collected and how it will be analysed.
2. Please confirm that written consent will be obtained for observation from group participants.
3. Please clarify what will happen if any of the group does not consent to observation.
4. The application mentions recruitment from 'other support' groups. Please clarify what these other support groups are.
5. Brief mention is made of diaries and/or letters to aid in triangulation. Please provide further details of this part of the methodology.
6. B11 – How will non LA Leche League participants be supported?
7. UWE guidelines recommend that data be kept for 3 years. If you propose extending this please explain why?
8. Are mothers who are under 18 excluded from the research?
9. UWE lone researcher policy recommends using work telephone and e-mail rather than personal ones.
10. Applicant should consider offering a summary of the research findings to all participants.
11. Please provide an interview schedule.

University of the West of England, Bristol

A3 Additional information to support re-submission of application to Faculty Ethics Sub-Committee November 2007

The issues the committee advised me to address are considered in turn. Changes have also been made to the application form, which should be read in conjunction with these points.

1. Please describe the purpose of the observations, what data will be collected and how it will be analysed.

My intention is to carry out an ethnographic project using appropriate, well-established and academically sound methods. In using participant observation as a method of data generation I hope to be able to augment the data from the individual interviews. The use of the two in tandem is common in ethnographic work, indeed ‘...there are distinct advantages in combining participant observation with interviews; in particular, the data from each can be used to illuminate the other...’ (Hammersley and Atkinson, 1995, p.131). Observation allows for a different sort of data collection than that obtainable from interviews, including talk/conversation, body-language and an understanding of the ways in which people relate to each other in particular settings. I am interested in the ways in which women talk about their breastfeeding experience when they are in a totally supportive, but public, forum. In addition, I will carry out this research from the position of an insider as I am already a member of the group and thus am able to use my observation, my reflexivity and my own personal experience in a powerful combination, providing ‘...access to the rich, deep data, that the qualitative researcher seeks...’ (Birch and Miller, 2002, p.92).

The data that will be collected will be in the form of unstructured observations of the group, of individuals within it and my reflexive account as a participant and an observer. In addition I could use other documents I may have access to, such as the group newsletter. The data will be analysed using a thematic analysis supported by NVivo and my field work notes and reflective diary.

2. Please confirm that written consent will be obtained for observation from the group participants.

3. Please clarify what will happen if any of the group does not consent to observation.

I am not planning to obtain written consent from each of the group participants. It is not in the tradition of ethnographic work to seek written consent from each person when undertaking observation as there is a risk of alienating potential participants and damaging trust relationships (Miller and Bell., 2002, p.65). To do so in this case would be detrimental to the group dynamics and to my position, both as participant and as a researcher. I have itemised my plans for gaining access and consent in sections B1, B3 and B6 of the application form. It is possible that some people may not want to participate in my research and also possible that some will not have seen the information attached to the email newsletter as the composition of the group changes over time. This is why I intend to introduce myself and my research at the beginning of each group thus enabling women to modify their behaviour, remove themselves from the group or request not be included in my analysis if they so wish. If anyone states that they do not consent to be part of the research study, all information concerning them obtained from observation will be deleted from my records and will not be included in any subsequent analysis of data.

4. The application mentions recruitment from 'other support groups'. Please clarify what these other support groups are.

It is known anecdotally that women who breastfeed for longer than six months are not catered for in formal NHS networks of breastfeeding support (usually aimed at supporting women in the early days and months). There are, however, self-organised groups of women who meet in informal networks (arising for example out of National Childbirth Trust 'Bumps and Babes' groups – see <http://www.nct.org.uk/local/branches>). It is these groups that I would like to access, if possible, and thus to recruit women who do not attend the La Leche League group.

5. Brief mention is made of diaries and/or letters to aid in triangulation. Please provide further details of this as part of the methodology.

When interviewing individual women I may consider asking them to keep a diary recording their contemporaneous experience. The women will keep ownership of their diaries and, with their consent, I will take a copy to use, in conjunction with interview data, for analysis. Diaries are recognised as generating information which '...complements other data sources in the field...', particularly '...in eliciting information about the personal and the private...' (Hammersley and Atkinson, 1995, pp.163-164). Those who do not wish to keep a diary may be interested in corresponding with me via email or letter. The use of correspondence as a method of data generation has been written about by Kralik *et al.* whose research was guided by aims which resonate with mine, '...feminist principles of collaboration, reciprocity and disclosure...' (2000, p.909).

6. B11 – how will non-La Leche League participants be supported?

See alterations to application form (B11- B16).

7. UWE guidelines recommend that data be kept for 3 years. If you propose extending this please explain why?

The current Faculty of Health and Social Care draft guidelines (June 2005), available on the 'S' drive say that:

'...It is suggested that researchers consider retaining their research records and data for a period of **12-15 years** unless required otherwise by a LREC/MREC...'

I am planning to store anonymised data, after destroying the data key, in line with these guidelines and as outlined in Sections B23 and B24 of the application form.

8. Are mothers who are under 18 excluded from the research?

No. However, from my personal observation of attendance at LLL meetings, women who breastfeed for longer than six months are usually in their thirties and forties. I have never seen a teenage mother attend a La Leche League meeting. In addition, the latest Infant Feeding Survey (Bolling *et al.*, 2007) showed that breastfeeding rates are lowest amongst women aged 20 and under. If in the unlikely event that a woman under 18 was recruited to the study, either as a group member in the observation or for an individual interview, she would be able to give her informed consent to participation if over 16. It is good practice in research to use the principles of 'Fraser competency' and 'Gillick competency' when considering consent from under 16s and 16/17 year olds and to remember that the Children Act, 1989, says that young people have a right to give their consent for participation in research (Children Act, 1989; Wheeler, 2006). I would also consider the issues raised by Alldred and Gillies who discuss the point that consent from young people to participate in social research should be '...affirmed or renegotiated throughout the research process...' (2002, p.158).

9. UWE lone researcher policy recommends using work telephone and email rather than personal ones.

I have not given my personal email address as a reading of the relevant section of the form will show. I have only given my home phone number and address for the purposes of the application (Sections A2 and A4); it does not appear on any participant information. I have given my personal mobile phone number after a careful risk assessment and a judgement that this is a low risk decision. I do not work at UWE full-time and have a shared telephone in Blue Lodge. Mobile phones are not at present available to PhD researchers. I am a member myself of LLL and some other members will already have my mobile phone number. I would like women to be able to contact me, to arrange, cancel or re-arrange interviews; my home land-line number is ex-directory and I consider use of my mobile number to be safe (I can see who is ringing me and choose to answer or not and can easily change my number if unanticipated problems arise).

10. Applicant should consider offering a summary of the research findings to all participants.

My participant information sheet makes it clear that I will offer this to interview participants. I have amended the application form to make it clear that this includes feedback to observation participants also. In addition I will offer to write a one-page summary of my research findings for the local LLL newsletter.

11. Please provide an interview schedule.

I am planning to carry out in-depth unstructured interviews with my general area of inquiry being women's experiences of breastfeeding for longer than six months. It is not appropriate to have an interview schedule for this type of interview although I will consider in advance issues to be covered (Hammersley and Atkinson, 1995, p.152). As is common in ethnographic research the focus of individual interviews may vary and change over the course of the research as the analysis develops '...feed..[ing] into research design and data collection...' (Hammersley and Atkinson, 1995, p.205) but I have provided some examples of possible questions and the general areas I hope to cover (see attached).

Sally Dowling, November 15th 2007

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Appendix B: Consent forms and participant information sheets

B1 Information sheet sent to all corresponding participants

(A very similar one was given to all interviewees).



Faculty of Health & Life Sciences
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Glenside Campus
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Bristol BS16 1DD
Tel: 0117 3288796

Study title: Exploring the experiences of women who practice extended breastfeeding.

Invitation to take part:

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of this study?

I am a PhD student at the University of the West of England (UWE). I have a UWE Bursary to undertake this research from May 2007 – April 2010. I have a background in Public Health and have myself been breastfeeding for the past five years. Breastfeeding is an important public health issue and there is much research that shows that it is good for both mothers and children. In this country few women breastfeed their children for as long as the Department of Health and the World Health Organisation recommend. I am

interested in the experiences of those women who do breastfeed their babies/children for longer than is usual in the UK – what it has been like for them and what made it possible, as well as what was difficult.

For the purposes of my research I will be observing La Leche League meetings in Bristol between January and July 2008. I would also like to interview women who have breastfed for at least six months. I hope to interview between 20 and 30 women during 2008 and to correspond with a small number of others.

Why have I been chosen?

You have been chosen because you have told me, or someone else has told me, that you have been breastfeeding for at least six months. I am interested in corresponding with you about your experience of this.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect our future relationship or contact we may have through La Leche League or any other support organisation, in any way.

What will happen to me if I take part and what do I have to do?

If you decide to take part I will agree with you a mutually convenient date to commence our email correspondence. This will last as long as you feel happy with. I would like you to write to me about your experience of breastfeeding for longer than six months – I will ask you some questions but mostly you will be free to write about it in whatever way you like.

What are the possible disadvantages and risks of taking part?

It is important that you know that, although it is unlikely, I may need to break your confidence. This would only be if you told me something about a criminal offence, professional misconduct, or if I thought a child was at risk. If I need to do this then I will tell you and explain what action I am taking.

What are the possible benefits of taking part?

It is unlikely that you personally will benefit from taking part in this study although you may enjoy writing about your experience.

I hope that other women may benefit in the future if this study contributes to better understanding about extended breastfeeding.

What if something goes wrong?

If you are unhappy about anything that happens during my contact with you please contact my supervisor, Dr David Pontin, using the following address or 'phone number:

Dr David Pontin
Director Post-graduate Research Studies / Reader in Nursing & Professional Practice
Faculty of Health & Life Sciences
Glenside Campus
UWE
Bristol
BS16 1DD
Tel: 0117 328 8503

Will my taking part in this study be kept confidential?

All information that has been collected about you during the course of the research will be kept strictly confidential. Any information I collect (such as copies of our emails) will be identified using an anonymous name and separated from any information that could identify you (including your email address). I will keep all personal information about you secure and private and will not share this information with anyone else. When the research project is finished I will destroy any information that can identify you. Anonymous information will be kept for a number of years longer in case it can be helpful in future research.

What will happen to the results of the research study?

When I have completed my research it will be written up and submitted to be examined as part of the requirements of my PhD. After this the written work will be available for anyone who would like to read it and you will be able to obtain a copy by contacting me. Aspects of the work may also be written up for publication in academic journals or in other publications such as those of La Leche League. You will not be identified in any report or publication. If I use quotations from our correspondence I will only use those in which you are not identifiable. I also hope to be able to talk about the results of the research at a meeting for breastfeeding mothers – perhaps at one of the regular La Leche League meetings.

Who to contact for further information

If you have any questions or would like to discuss this further please contact me:

Sally Dowling
PhD Student
Blue Lodge, Glenside Campus
Faculty of Health & Life Sciences
School of Health & Social Care
UWE Bristol BS16 1DD

Tel: xxxx xxx xxxx Mobile: xxxxx xxx xxx
sally2.dowling@uwe.ac.uk

Thank you for taking part in this study. This information sheet is for you to keep. You will also receive a copy of a consent form, which you will sign, to keep.

Sally Dowling, 14th January 2008

B2 Consent form sent to all corresponding participants

(This form was also used for all interviews).



University of the
West of England

Faculty of Health & Life Sciences
School of Health & Social Care
Glenside Campus
Blackberry Hill
Stapleton
Bristol BS16 1DD

CONSENT FORM

Exploring the experiences of women who practice extended breastfeeding

Please read the following and place a tick in the box to show your agreement.

1. I confirm that I have read and understood the information sheet dated 14th January 2008 for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.
3. I agree to the audio recording of any interview I take part in.
4. I agree to take part in the above study.

Name of participant.....Date.....

Signature.....

Researcher...SALLY DOWLING.....Date.....

Signature.....

(one copy to be retained by participant; one by researcher)

Appendix C: Letters to Bristol LLL members via e-group December 2007

C1 Letter from Sally Dowling to local LLL Leaders (sent by email December 2007)

Research project: Women's experiences of extended breastfeeding

Dear

I am writing to you all, as the Leaders of the (...) La Leche League group, to request your support regarding some research that I am carrying out into the experiences of women who breastfeed for longer than six months.

You may remember that I am a member of the (...) group, although I have not been able to attend meetings for some time. I received particular support from the group when I nursed through my third pregnancy; from (...). (...) and (...) when having problems with early latching on with (daughter); and then again from the group when tandem feeding. I am still nursing (daughter) (now three years and three months).

I have become very interested, through my own breastfeeding journey, in the experiences of women who breastfeed their babies/children for longer than is the norm in this country. My professional background is in mental health nursing and, since 1999, in public health. I have been lucky enough to be granted a three-year bursary from the University of the West of England (UWE) to undertake a PhD looking at the experiences of women who breastfeed for longer than six months, and I have a very supportive and interested supervisory team. I'm particularly interested in what motivates women who breastfeed for longer than six months and in their (positive and negative) sources of support. I hope that my research will add to the

knowledge we have about what might help more women to breastfeed their babies for longer.

I hope to undertake my research using a number of methods. These include undertaking in-depth interviews with women who have breastfed for longer than six months to find out about their experiences and to allow them to tell me their breastfeeding stories. I would also like to observe some La Leche League meetings and that is why I am writing to you. La Leche League is unique in the support offered for extended breastfeeding and I am particularly interested in your meetings as I know, from first hand, that many women who breastfeed for longer periods of time get valuable support from them.

With your permission (and of course, the permission of the women in the group) I would like to come to a number of meetings and observe what happens in the group (in research terms this is called 'participant observation'). I would like, with everyone's permission, to record the meeting and take notes but would try to make this process as unobtrusive as possible. My purpose would be to listen to how women talk about their nursing experiences when they are in a setting where this is completely accepted. I will have to think some more about my own situation as I may wish, as a nursing mother, to join in discussions, rather than be in a purely observing role.

What I would like to do is to attach a letter to one of the email newsletters that go out to the (...) group, explaining what I am doing. In this way women who attend regularly would have some idea of who I am before they attend meetings. I know that women also come to meetings having never attended before and for this reason I think it would be a good idea for me to also briefly introduce myself at the beginning of each meeting.

I would make sure that anything that I see or hear at meetings or in interviews is kept confidential. When writing about it I would give people

names that are different to their own and would withhold any personal information through which they might be able to be identified. I will keep all information and records which might identify people in accordance with Data Protection guidelines and destroy any personal information when I have finished my research.

Another researcher (not a breastfeeding mother herself) has recently undertaken observation in LLL meetings in London (and Paris) and as far as I am aware there were no difficulties that arose as a result. I am sure I could find out which group(s) she attended if you felt it would be useful to talk to those Leaders about their experience. When I have finished my research I could briefly talk about my findings at a meeting if you think this would be useful. I hope to be able to write some papers for academic journals as well as other publications while I am doing my PhD as well as after I have finished. I will make these available to yourselves and anyone in the group who is interested.

I am currently in the process of gaining ethical approval for my project from UWE and would hope to be able to start observing and interviewing from November/December.

I would be grateful if you could give this some consideration. I have written to you all individually and know that you will want to think and talk about this before giving me a response. Please feel free to contact me if you would like to discuss any aspect of my research further.

I look forward to hearing from you.

Best wishes,

Sally (my telephone contact numbers given here)

C2 Letter from Sally Dowling to local LLL members

Research project: Exploring the experiences of women who practice extended breastfeeding.

Dear (...) La Leche League members,

My name is Sally Dowling and I'm a member of the (...) group (some of you may remember me although I haven't been able to come to many meetings recently). I have three daughters, the youngest of whom (daughter, three and a half) is still nursing.

I have become very interested, through my own breastfeeding journey, in the experiences of women who breastfeed their babies/children for longer than is the norm in this country. I have been lucky enough to be granted a three-year bursary from the University of the West of England (UWE) to undertake a PhD looking at the experiences of women who breastfeed for longer than six months. I'm particularly interested in what motivates women who breastfeed for longer than six months and in their (positive and negative) sources of support. I hope that my research will add to the knowledge we have about what might help more women to breastfeed their babies for longer.

I hope to undertake my research using a number of methods. These include undertaking in-depth interviews with women who have breastfed for longer than six months to find out about their experiences and to allow them to tell

me their breastfeeding stories. I would also like to observe some La Leche League meetings and that is why I am sending this letter. La Leche League is unique in the support offered for extended breastfeeding and I am particularly interested in the meetings as I know, from first hand, that many women who breastfeed for longer periods of time get valuable support from them.

I would like to come to a number of meetings and observe what happens in the group. I would like, with everyone's permission, to record the meeting and take notes but would try to make this process as unobtrusive as possible. My purpose would be to listen to how women talk about their nursing experiences when they are in a setting where this is completely accepted. As I am also a nursing mother I don't anticipate that I will observe in silence as I may also have things I want to say!

I would make sure that anything that I see or hear at meetings or in interviews is kept confidential. When writing about it I would give people names that are different to their own and withhold any personal information through which they might be able to be identified. I will keep all information and records which might identify people in accordance with Data Protection guidelines and destroy any personal information when I have finished my research. If anyone attending a meeting is unhappy about taking part in my research they should make me aware of this and I will not use anything that they said, as part of any discussion, when looking at other information from that meeting.

I hope to attend the meeting on 9th January to observe for the first time and then to attend as many meetings as I can for about six months. If you have any questions about anything in this letter please contact me before the meeting on sally2.dowling@uwe.ac.uk or (mobile number), or talk to me before or after the meeting.

If you are happy to be interviewed about your breastfeeding experience, or can put me in touch with someone else who would, I would also be interested to hear from you.

I look forward to meeting as many of you as possible in the New Year.

With very best wishes,

Sally

C3 Copy of eletter4bristol sent to local LLL members 18th December 2008:

From: email address

Sent: 18 December 2007 08:39

To: email address

Subject: [eletter] News of research from LLL (...)

Attachments: letterforLLLnewsletterDecember2007.doc

Dear All,

We have news of some exciting research!

Some of you may remember Sally Dowling, who is still a member, but hasn't been able to get to meetings for a while. She has been granted a bursary from The University of the West of England to explore the "experiences of women who practice extended breastfeeding."

Attached to this eletter and in the files section of the Yahoo website is a copy of her letter. This is really exciting research and we urge you to read her letter.

Sally is hoping to be at the meeting in January and will be able to answer any questions you have then. She has also has her contact details at the end of her letter.

This project is not officially endorsed by LLL, so you will have to make up your own minds as to whether you wish to get involved personally, but we feel that it is a very worthwhile project and we wish Sally all the best with it.

With Best Wishes,

The (...) Leaders

Appendix D: Summary of information about all interviewees

D1 Online interviews

All information about participants and their children relates to the time that the interview took place.

Judith

At the time of the interview Judith was 40 years old. She has a PhD and works four days a week as an NHS scientist. She is originally from North America (as is her partner) and has lived in the UK for over ten years. She lives just outside the city where I live. She had a sixteen month old daughter (whom she weaned aged fifteen months) and was pregnant with her second child. Judith had been an occasional LLL attender (we had never met) and had offered to be interviewed by emailing me in response to my letter in the LLL e-newsletter. She found the email interviewing process difficult to fit in with working, looking after a toddler and being pregnant and withdrew after a short while.

Sarah

When she first emailed me Sarah was 38. She has a PhD and was not at the time doing paid work, although experiencing some difficulties in how she felt about herself in relation to this. She is North American; her partner is from the UK. He works full time as an academic in a local university. She had worked as an academic until her daughter was 14 months old; at this time the family moved to the UK. They lived in cramped rented accommodation in a fairly affluent area. At the time the interview began Sarah's daughter was three and a half years old (almost the same age as my youngest daughter at that time); by the time we finished she was four (and still breastfeeding).

Sarah had attended LLL meetings, both before moving to England and in her home town. We had once been in the same LLL meeting but had never spoken to each other. She had offered to be interviewed by emailing me in response to my letter in the LLL e-newsletter. Sarah took part enthusiastically in the online interviewing process and contributed the greatest number of emails, a number of them of significant length. By the end of the time that we were corresponding with each other she had begun to engage a little in academic work again and was feeling good about this.

Christine

At the time of the online interview, Christine was 47. She was a single parent living in a village outside the city with her son, who was then 11. She had breastfed him until he was six and a half years old. She was educated to degree level although did not complete her studies. She is also North American and has lived in the UK since she was in her early 20s. She home educates her son, who has autism, and works from home as an unpaid volunteer for a number of charities. She is a trained LLL leader and works for the local LLL branch although does not attend meetings. We have never met each other.

Jess

Jess was 35 at the time of the interview. She has a DPhil and works full time as an academic. She went back to work eight weeks after the birth and often took her baby to work with her. Her partner is a stay at home father. Her daughter, who was still breastfeeding when we corresponded, was three and three-quarters at the beginning and had her fourth birthday during the process. Towards the end of the interview Jess was pregnant with her second child and planning to tandem feed.

Jess was not an LLL attendee; she had some support from the NCT and her mother but was linked into a number of online support groups (mostly in relation to parenting rather than specifically about breastfeeding). Jess was introduced to me as a potential participant by Sarah. We have never met.

Table showing main characteristics of online interviewees

Woman (pseudonym)	Age	Highest educational qualification	Occupation	Nationality	Number of children?	Child age?	Still breastfeeding?
Judith	40	PhD	NHS Scientist	North American	1 (and pregnant)	16 months	No (stopped during pregnancy)
Sarah	38	PhD	University Lecturer (not currently working)	North American	1	3 ½ years	Yes
Christine	47	First degree (not completed)	No paid work at present (home educating/voluntary work)	North American	1	11 years	No (stopped age 6 ½)
Jess	35	PhD	University lecturer	UK	1	3 ¾ years	Yes

D2 Face-to-face interviews

All information about participants and their children relates to the time that the interview took place.

Tina

Tina was forty when we met for the interview. She is a health professional and was working in a research role three days a week. When we met she had recently completed a Master's Degree. At that time she was thinking about stopping breastfeeding her son, who was four years and three months old. She lives with her husband; he was not working at the time due to chronic ill health. They live in a relatively affluent area in the city.

Tina and I knew each other from having previously been part of the same NCT group and through having been LLL members. Since the interview Tina has given birth to another son.

Lucia

Lucia was 42 years old at the time of our interview. She and her husband came to England from Europe five years previously. Lucia has a first degree and many years of experience working for multinational companies; she has done a lot of voluntary work since having her children but not paid work. Her husband works full-time. They live in a suburb with some affluent housing and some areas of deprivation and social housing.

When we met she was still breastfeeding her third child who was two years and two months old. She had breastfed her eldest child until she was eighteen months and her second for fifteen months. She has had experience of breastfeeding during pregnancy and of tandem nursing. She gained a lot of support from very early on from breastfeeding support groups and has

trained as a breastfeeding counsellor. She was helping to run her local breastfeeding support group. English is not her first language and this is reflected in the way some of her experiences are expressed.

Lucia and I had met previously very briefly during one of my LLL observations. She had offered to be interviewed by emailing me in response to my letter in the LLL e-newsletter.

Mandy

Mandy was 32 years old when I interviewed her. She has a first degree and stopped paid work when she had her son. Her husband works full-time. They live in an area of the city which has recently seen a move from a traditional working class population to a more affluent one, although the area remains very socially mixed. Her son was three years and four months when we met; she was heavily pregnant with her second child and had stopped breastfeeding him during the pregnancy when he was just over three.

Mandy and I had met during the observations I carried out at LLL; she offered to be interviewed in response to my letter in the LLL e-newsletter. When we met she was training as an LLL leader. As well as our LLL contact, Mandy and I had both used the same independent midwives.

Josie

Josie was 31 years old at the time of the interview. She had studied to HND level. She was not working outside the home when we met; her husband was working full-time. They live in a small town not far from a large city. She was breastfeeding her eighteen month old son at the time of the interview. She had offered to be interviewed by ringing me following one of the LLL observations. She has since moved to live in the city (she talks about her

desire to be living near more 'like-minded people' in the interview) and given birth to a baby daughter.

Josie was present at most of the LLL meetings I observed; we also had ~~the~~ used the same independent midwives.

Sam

Sam was 27 when I interviewed her. She lives in a relatively deprived area of the city with very low breastfeeding rates. She left school at 16; prior to having her son she worked in an administrative role. She lives with her husband, who works full-time. She left work when she was pregnant and was not working outside the home when I met her. She was breastfeeding her 19 month old son at the time of the interview.

Sam had very positive experiences of breastfeeding support groups and had trained as an ABM breastfeeding peer supporter. I met her through my observations at Babes and approached her to ask if I could interview her. Since the time of the interview she has given birth to a baby daughter.

Jane

When I met Jane she was 28. She lives in another city. She trained as a healthcare professional. She has four daughters (aged 6, 4, 2 and 6 months at the time of the interview) and is home educating the older ones. She breastfed all of them, fed during the last three pregnancies and tandem fed all except her fourth child. Her first two daughters breastfed until they were about three, the third weaned herself at eighteen months. When we met she was breastfeeding her youngest, aged four months, but no longer breastfeeding any of the older girls.

I was put in touch with Jane by one of my online interviewees (Jess). Jane has trained as an NCT breastfeeding counsellor and does some paid work in relation to this role.

Table showing main characteristics of face-to-face interviewees

Woman (pseudonym)	Age	Highest educational qualification	Occupation	Nationality	Number of children?	Age of youngest?	Still breastfeeding?
Tina	40	MA	Health Professional	UK	1	4 years, 3 months	Yes
Lucia	40	First degree	Not currently working	European	3	2 years, 2 months	Yes
Mandy	32	First degree	Not currently working	UK	1 (and pregnant)	3 years, 4 months	No (stopped during pregnancy)
Josie	35	HND	Not currently working	UK	1	18 months	Yes
Sam	27	GCSE	Not currently working	UK	1	19 months	Yes
Jane	28	First degree	Not currently working	UK	4	4 months	Yes

Appendix E: Examples of emails

E1 Opening email to all corresponding participants

Hi XXXX - First of all I'd like to say thank you very much for agreeing to correspond with me about your breastfeeding experience.

The emails between us will form part of my data collection and so I may use some words from them when I write up my final thesis but I'd like to reassure you that I won't ever do this in a way that could identify you. If you have any questions about this, please ask me. I'm anticipating that we might do this for a few months but we can review it as we go along and I'd like it if you could tell me if you are finding it too onerous or feel that you need to stop for any other reason.

I'd like to get started by learning a bit more about you, so when you have time to reply it would be helpful to know your approximate age, your highest educational qualification and whether you are currently doing paid work (and if not what you did when last did paid work). Add anything else you think would be of interest! Then I'd like to know a bit more about your breastfeeding experience - perhaps starting with whether you were breastfed yourself and whether you had much experience of seeing/being with other women who breastfed before you had your child.

Please don't feel that you have to answer all this at once, or even at all. Tell me what you feel comfortable with and we can take it from there.

If I'm asking about you I think it's only fair that you know a bit more about me. I'm in my mid-forties and have three daughters (22, 5 and 3). I was only breastfed for a short while. I trained as a mental health nurse, then worked in sexual health, then public health at Primary Care Trust level. I left the PCT to do my PhD last April. My first daughter was only breastfed for three weeks (looking back on it I think I had very bad advice, but also I was young and had no other support about breastfeeding), the second was fed for three

months on expressed breastmilk (for lots of reasons), then a mixture of expressed milk and breastfeeding, then formula as well from six months but she breastfed until she was three and a quarter. My youngest, after a shaky start with latching on, has breastfed beautifully, never had a bottle of formula or expressed milk and is still nursing at 3 and a half. I got a lot of support from La Leche League when I was tandem feeding and with Abby's latching on problems.

I think that's enough for now - I look forward to hearing from you.

best wishes,

Sally

E2 Excerpt from emails from 'Judith'

15th May 2008

Hi Sally,

I'm so sorry that I haven't replied sooner. I'm at work at the moment so I can't reply properly now. I really am very interested in your research, I just don't have much energy in the evenings to reply (if I think of it I say to myself "I'll do it tomorrow"). I will try to reply this evening when I'm at home.

Judith

1st March 2008

Hi Sally,

I'm sorry it has taken so long to reply about your research. I really do want to do it, I've just been tired with this pregnancy and to be honest I keep forgetting about it...

...When we started solids I started feeding on a schedule. I found various different opinions about how often I should breastfeed her once she was on solids. I never found anything that recommended how often to breast feed after 1 year of age. Everything I read suggested that after 1 year breast feeding is not necessary...

...At 1 year of age I breast fed her first thing in the morning and before bed. Gradually she took less and less milk, and showed less interest in feeding and never asked for it...after I got pregnant was not feeling so well, I decided to stop altogether when she was 15 months old. She didn't seem to notice at all and I was happy that it was the right time to stop.

Judith

E3 Excerpt from email from 'Sarah'

14th February 2008

Hi Sally,

...I haven't thought much about giving our nursing relationship a label in part because I no longer have to explain it to anyone. If I didn't think about it I would say extended breastfeeding but I think full-term breastfeeding is a more accurate description.

I guess it is simply the virtual contact with breastfeeding mothers that makes a difference for me. I'm very bookish and rather shy so having a sense of community through publications is what works for me. LLL meetings have been very important for me here because I needed some sort of social contact and this way Janie would be around others who were nursing. Now that I think back I remember I was more worried about other children making comments to her than I was about adults making comments to me. For various reasons I never took Janie to toddler groups, so LLL was a place where she could begin to get used to being with other children. It was a big shock to her one day when she learned that not all children breastfeed.

Your question is something that I have asked myself. I just couldn't give Janie a bottle. We tried it once (with expressed breastmilk) and it gave her such a stomach ache that I felt awful and never did it again. Being a stay-at-home mom is very difficult for me, I'm a very driven person and am used to accomplishing a lot during the day. I would have seemed to be someone who probably wouldn't have children and certainly would have put a baby in daycare. Even before I found out that a natural birth would be risky I was quite adamant that I would breastfeed, that Janie would never have formula and that I would never give her solids before 6 months. I felt awful that I didn't follow through. I guess I found it nearly impossible not to do what I knew was best for my baby's development physically and emotionally. I was extremely concerned about the effects of having a scheduled cesarean and

was even more determined to get breastfeeding right. Attachment parenting seemed to be the best way of raising a baby and I couldn't think of doing things any other way. Luckily Mark agreed with me. He did, however, think that daycare would be good for Janie because he and I are both a bit socially reserved and didn't have many friends as children. He thought she could also have a babysitter at home when she was young (school starts at age 6 in the US) and I could just express my milk. But after she was born I no longer had to present arguments as to why I didn't want to do this. We were both so moved at the sight of Janie and both felt so much intense love for her. How could I not continue breastfeeding on demand for as long as she needed to, even if she needs to until she is 5 years old. As we got to know Janie this desire to give her what she needed grew deeper. She is a very very sensitive child. We began to realize that early on. I knew that breastfeeding and having the security of mommy always there would be essential for her.

Now that I think of it, I think our feelings of being estranged from the community helped a bit. I was embittered against the city and wanted to leave for our sake and for Janie's.. I never felt that we fit there and so I didn't really care what the nurses thought. They kept telling me to put Janie down and to stop using my breast as a pacifier, offering to get a pacifier (a dummy) in case I didn't think of bringing one with me, etc.

I enjoyed reading about your experiences. I want to amend what I said earlier - it does help to have actual contact with people in part because it helps me to remember that one can never be perfect, that there is no perfection when it comes to mothering and breastfeeding. That has been a bit hard for me to accept and I often feel horrible about the mistakes that I made. But they weren't mistakes, they were difficult decisions that I had to make. I forgot that when I went to meetings in Bristol I was still having trouble with postpartum depression. They really made a big difference because I felt so much better about my mothering after each meeting. This time seems so remote to me now that I had almost forgotten about it. So yes, the meetings were almost vital to me when I first arrived in Bristol.

I very much hope to make the next meeting. I haven't been as motivated to go since they are no longer toddler meetings and I was unsure about whether or not going made sense. Additionally Janie is sometimes disturbed by the complaints other mother have and she has often worried after meetings that she is bothering me with some of the things she does when nursing, such as twiddling. In a way it gets harder to go to meetings as Janie gets older.

enjoy your short holiday,

Sarah

E4 Excerpt from emails from 'Christine'

5th July 2008

Hi Sally

...back to your questions, I don't think I was every really bothered by John thinking that my breasts were there for him. I knew that he would either grow out of it, or find another women with breasts and marry her one day. He has grown out of it. He no longer has to kiss them, which seems to be common for kids that wean late, or feel sorry for them for not being used anymore. in fact it was sort of touching that he was so concerned about them!

And as for the comment, 'I am not just a pair of boobs.' I think I knew that that was all John saw me as when he was little. His first smile was at my boobs, not at my face! ...So yes, I was just a pair of boobs to him, but I didn't mind. That was what they were there for.

I don't know, I guess I was always of the mind that breasts are only there for one thing, to feed a baby. I remember my neighbour telling me that while I was pregnant. Although I enjoyed the sexual feelings I got from having my breasts handled by men, I knew that that wasn't really what they were there for.

Does that make any sense?...

Christine

23rd July 2008

Hi Sally

...I have enjoyed taking part in the research and it has been a pleasant experience. Each time I go back and look at our nursing relationship I see things in a slightly different way, as time and age passes. I can see the influence the nursing had on my son from the point of view of an 11 year old,

which I couldn't see when he was 8 for instance. It also gave me the opportunity to explore his feelings about it now that he is older.

Nursing a child of 6 is a very different experience for both the mother and the child, and revisiting that time is always a pleasure for us....

...I hope you have a great summer too, now that it has arrived!

Love Christine

E5 Excerpts from emails from 'Jess'

From a number of different emails

Dear Sally

...I read a lot of the articles in the TCS journal, on the TCS site and on the TCS list; I found like-minded online community, I have read various other consonant books and sites, like Jan Hunt's Natural Child Project, like a lot of Deborah Jackson's writing. Alfie Kohn is kind of TCS-lite...

I have seen how this kind of interaction with my child has shaped our relationship, and is sensitive both to her needs and mine....

...Just occasionally, I have been frustrated (usually on those nights where a bf child feeds and feeds and doesn't drop off to sleep but the mother is more than ready to sleep herself) - but that's not really to do with bfing, it's to do with a) the horror of the occasional late nap and b) when the breast is available, that's the relaxation of choice. But I always know I could go and be in another room and she'd be fine to fall asleep without me nowadays...

...We always intended to follow the lead of the child on this [home educating]...The decision to go to school or not is completely unconnected in my mind with when my child weans. In both cases, it is a matter of establishing what her preferences are, and what our preferences are, and then finding a common preference...I agree with every word of this. I think the extended bf-ing community and the HE community overlap significantly because both are expressions of family life which takes the needs and wants of the children as seriously as the needs and wants of the parents.

Jess

4th April 2008

Dear Sally,

...We used nursing to help with the 2 year-ish injections, and the (Sikh) GP practice were completely comfortable with it. I have recently had a GP (in the practice we are registered with) recommended to me by a breastfeeding friend who says that his own children are/were extended breastfed. I suspect these things often work by word of mouth.

Did I tell you about the Health Visitors asking me to go in for a 4-month weaning talk, and I went in all guns-a-blazing armed with the WHO recommendation of exclusive breastfeeding until 6 months, and the health visitor said "yes, that's why we have the chat at 4 months, to try to head people off from weaning too soon...". *blush*

I've never had any pressure to wean from health professionals. I think it is partly down to not having had much illness, and partly down to confidence on my part - by not really quite grasping that anyone could have a problem with it, they find themselves unable to have (or at least to articulate) any discomfort. Rather like dealing with strange dogs, I understand. The more confidence one has, the less likely they are to bite.

(Sally: ...I wonder whether you could tell me whether you think breastfeeding has got harder or easier as time has gone on?)

The mechanics of it easier and easier in many ways. I felt an incipient blocked duct in the night last night, so I simply offered that breast next and ca-boom it was gone in seconds.

The hard bit is no longer being able to carry a feeding child when they get too big - it used to be such an easy way of getting away from a difficult situation. So there is negotiation going on about that, and me learning to slow down and take things at child's pace rather than taking the opportunity of a feed to set off briskly walking towards the bus stop or whatever.

(Sally: And whether you would still want to be breastfeeding now if it was entirely your choice? - would you have preferred to have weaned before now?)

That's a really hard one. I think I would like to be no longer feeding in public, and I am working on ways to make feeding in public less and less necessary. Not bothered about feeding at night - I'm asleep! So no, I don't mind that my child hasn't weaned. I have occasionally spoken to people who say what a tie breastfeeding is - that the mother has to be close by. And the answer I wish I had thought of before to say is "yes. That's right. the mother of a small child OUGHT to be less than 24 hours away, honestly, and if you don't want to be at someone's disposal on a daily basis you should get a dog instead". (this is a very dog-themed discussion for some odd reason). And of course that doesn't take into account a mother having to go into hospital or some similar emergency, but I definitely don't think you should wean just in case you have to go to hospital for a couple of days in an emergency at some future date.

(Sally: I know that you have mentioned some things but could you say a bit more about what you like about breastfeeding and what, if anything, you dislike?)

I don't really think about it with emotions that much. I like the comfort it gives my child. I like the nourishment it gives my child. I like it that there is a physical manifestation of the continuation of our relationship from the very first moments after she was born. I like how it smells on her breath. I like it that she can feed at night without waking anyone. I like it that the length of most day time nursing sessions is less than 20 seconds. It's just docking at the mother ship to refuel.

Jess

Appendix F: Examples of interview transcripts

F1 Excerpt from interview with 'Sam'; 16th July 2009

...SD: And does it help kind of, as time's gone on...somebody else said to me that it didn't matter so much if she actually met other people who were breastfeeding, it was enough to **know** that there were other people who were breastfeeding two year olds, or whatever...or would you...

Sam: I don't know, 'cos obviously I'm in the position where I **do** know people and...I think I might like...I would probably be quite lonely...I dunno, 'cos you do feel you've got to justify it to people a lot of the time anyway so knowing that you've got friends that...

[stops to talk to son]

Sam: ...knowing that you've got people out there that, that do it as well, then it's kind of...I don't know...it's like you don't feel like...I don't know, you just don't feel so much alone, 'cos you've got people there that know the problems you go through and you can talk to, like I said, you know, if I've got a problem with him, like when he was biting, then, you know, my sister went through the same thing afterwards, you know, so then I managed to kind of say, 'well this is what happened with him...'

SD: So how old is your sister's?

Sam: Seventeen months.

SD: Mmm. And she...so, younger than...

Sam: Yeah, yeah. She's three months younger.

SD So do you feel like you've been a role model for her?

Sam: I do. I don't think she would have...like we've spoken about it and she definitely wouldn't have carried on if she hadn't have known, obviously, if I

weren't doing it with [son] at the same time because...the same for her, because she breastfed, like I said, her middle one, for three months, the first one she didn't breastfeed at all and...I think it's just getting her head round it because I think when she did it before she was like 'oh I can't imagine breastfeeding a child with teeth and all that'...

[both talk to little boy]

SD: So, going back to you...I think I remember talking about this at one Babes meeting...did you have any goal when you started, of how long you thought you'd go on for?

Sam: Not that I can really remember. I don't know, um...[pause]...'cos I didn't really, it didn't ever really occur to me to think about when I end...I just, I just assumed that there must be a time that everyone stops, that, you know, you...that's it and then that's that, but it never really occurred to me what I would do to stop it or anything like that. So...but I never knew what that age was, I suppose either six months or twelve months, I didn't really know, it just never...

SD: And so you, did you find it just happened and, you know, then it was six months and then it went on and then it was a year and then it just kind of, has gone on?

Sam: Yes, I suppose...it just, I couldn't imagine not feeding him, you know, like just then, he would have gone into a full-blown tantrum...

[indicates son, who is now breastfeeding]

Sam: ...but, you know...makes you happier, makes you calmer, doesn't it? [to son]

SD: And do you, do you remember when you first saw somebody else breastfeeding...I mean, do you know anybody who's breastfed anybody older than him? And where would you have seen it?

Sam: I know...well I know [girl's name], [woman] breastfeeds [girl's name] and I know her from...I actually met her from doing the singing and signing but she goes to the Tuesday Babes, and [girl's name] has just turned three...and then obviously yourself, I think you're the person I've seen breastfeed the oldest, 'cos she was four at the time wasn't she? But not, apart from E and [woman], no...nobody. So I suppose...

SD: So they've been similar...

Sam: ...I suppose [girl's name], I haven't seen her feed for ages, I mean she must have been about two, just around two when I last seen her feed, so...

SD: And do you remember what you thought, when you first saw an older child...

Sam: Weird. I was like – 'look how big that child is!'

[laughs]

Sam: 'Cos he was only a tiny baby at the time still, it just seems weird, having this child that's walking around and just like comes on over, it's like ohhhhhh. You know, kind of just takes up your whole lap and demands some milk. Weird.

SD: Because you hadn't seen it before? Or shocking, or...

S: I don't know. It would probably be a bit of both. Like I didn't...like weird because I hadn't seen it before, definitely, because...

SD: Because you don't!

Sam: Yeah, you don't and...where do you look, you don't know, do you? Especially because they are fidgets and...

SD: It's not like when they're babies and they stay in one place!

Sam: Exactly...so...and then, and maybe shocking because I've never, I never thought about feeding them that...you know, it just never even occurred to me...

SD: It's always hard to imagine a stage beyond the stage your child's at anyway, isn't it, whatever, whether it's talking or eating or...

Sam: Yeah!, yeah.

SD: And the other thing I was interested in is because, obviously you live in an area where hardly anybody breastfeeds **anyway**, never mind breastfeeds this age [indicates son] – so what's that been like? [pause] When he was little did most people you knew who had babies bottle feed?

Sam: Most of them, yeah. Yeah, it was only people I met, obviously, through Babes, and then my sister, who breastfed, so...

SD: And then did you find it hard to... 'cos sometimes when women, I think women find that they make friends with women when they're pregnant, and then they have their babies and then they make very different choices about how they look after them and then it can be quite hard sometimes to be around each other...not always, but...

Sam: I was going to say, we, I think we've been quite lucky with...I mean to be fair, I think...I...

[stops to take off son's wet top and to settle him again. This takes a few minutes]

SD: So you were saying you think you've been quite lucky?

Sam: Yeah, I was really lucky, 'cos Emma's antenatal group...'cos there's only really the girls from antenatal I know that's had babies...and her antenatal group, she didn't really get on well with them so she kind of gate-crashed mine. So...I think one, two other people breastfed in our group, one of them only breastfed for a week and the other one breastfed for about three

months then she went back to work and stuff so she went back to bottles. Um...and I think if I didn't have Emma there it probably would have put me as an outsider or something but because she's there and obviously she's still breastfeeding as well, when we meet up, like there's a group of us that meet up on a Tuesday every week, there's five of us. So out of the five of us, me and Emma still breastfeed so it's like...

SD: So you're not in a minority?

Sam: Yeah, exactly. So, and they understand, they kind of accept it, you know, they still see us and we breastfeed...

SD: 'Cos they've known you all along...

Sam: Yeah. So I think we, we have been **really** lucky in that respect because they have just accepted it and I think even, like I know now one of them's pregnant again, she wants to definitely breastfeed until six months, I think she doesn't...after that's a bit er er er still, but, and then the, another one, she said she might even try giving it a go...she had an operation on her breasts before and so she thought she couldn't and so she said she might give it a try next time, so, you know...definitely helping the cause, I think!....

F2 Excerpt from interview with 'Jane'; 19th March 2009

....S: There is that huge pressure in our society, isn't there, to...get back to normal, to get into a routine...to do all that stuff, with your baby sleeping on their own through the night, from an early age, and...and, and...you talked about people not questioning your choices because you feel like maybe you give off a...something that says 'don't'...I mean, one thing that women talk about often is that, that it's something in them that enables them to breastfeed a long time, like being determined, or being...I mean, how would you describe it? What is it about you that's...

J: I think I'm, I'm very confident, I've always been quite a confident person and I'm pretty...I'm pretty brave as well and I've got good self-esteem so I think that sort of adds up to me going 'well, I don't really...care what other people think'.

[laughs]

J: As long as I'm not hurting anyone and the people who I love are happy, then that's the main, that's the most important thing. And I'm star...you know the more of a parent I've become...

[giggles]

J: ...the longer I've been a parent for, the more, the easier it is to feel that way. And I've got friends with children a bit younger than mine, one of my friends has got a, a daughter who's four, four and a half and another friend who's got, her oldest is three, and although they're both, the mums are both older than me, there's quite a lot that I can see them doing that I did...and see them feeling what I did and...I've got a friend with a toddler and when he has tantrums she gets really, really bothered by it, understandably, I remember I used to be really upset by [eldest daughter] having tantrums and yet when [third child] has a tantrum I just kind of...my whole focus is on how to make her happy...and it, it doesn't even enter my head what other people

are thinking, it's just not an issue at all, but it's a really big issue with, with your first...and...

[laughs at something the baby does]

S: 'Cos I was, I was looking at your email last night and I was trying to work out how long it is you've been...how many years you've breastfed for? You had a break, when you were pregnant with...

J: Yeah, over a couple of months, break of a couple of months.

S: And, and you talked about how that surprised you, that [third child] weaned when she was...

J: Yeah, it did surprise me, because obviously [eldest daughter] and [second child] had fed through pregnancies, all the way through. I think [third child], she's fed on occasions since she weaned...but she doesn't know what she's doing so it hurts. I've done it a couple of times to get her out of a complete meltdown where she just can't, you know, nothing's working at all. Some...I mean it's one of the things that fascinates me is that if I say, you know, 'do you want some mummy milk?' – that will sort it out! I mean, you know...

[laughs]

J: Even if she's not...

S: Even if she's not...

J: Wow! You know, I just think it's such a, such a powerful thing! And she doesn't get any milk but it's something about the comfort of the breast, it's just so...

S: Mmm. Being offered that closeness...

J:strong. It's amazing. And she sometimes asks for milk and, um, just very occasionally, you know, once every couple of weeks, and once or twice I

said to her 'oh, do you want, could you have milk in a cup?' and she goes off, she's so funny, 'cos [fourth child] only feeds on one side mainly, doesn't like the other side, so it gets quite engorged so I express it sometimes and give it to [third child] 'cos she likes it, and so a couple of times I've said 'could you have milk in a cup instead?' and she goes 'ok' and she walks off in the kitchen and, um, the couple of times she's done it [husband's] been in there and he goes 'what are you pointing at?' and she's pointing at the cupboard where the breast pump is!

[both laugh]

J: She's expecting me to just express the milk for her, so she actually likes the milk as well but when, when she feeds she can't get the milk...she doesn't know what she's doing, so there's obviously two aspects to it, there's the nice drink and there's also the, the comfort...

S: ...the comfort...yeah, my six year old asked if she could have a taste recently and I gave her some on my finger, 'cos she didn't want to suck it from me, and she didn't like the taste.

J: No, [first daughter] and [second child] hate it, they go [makes face]...where's the real thing?

S: Yes...mmm....um, so going back to...if you, if you...kind of, what do you think has helped you the most, we talked about coming from a family where it was ok, and having a very supportive partner, if you had to sort of pick out...some people find that support groups are what keeps them going, what would it...or is it just you?

J: I don't know...it's difficult to say what helped me the most...I mean probably in a way it was the support groups because if I hadn't gone to the support groups and trained as a peer supporter, I probably wouldn't have trained as a breastfeeding counsellor...but then on the other hand...I mean, when I, when I started meeting with other home educators I met lots of other longer term breastfeeders...so I think once you start making...I think

probably the biggest thing is, is being with other people who have done it...or are doing it...

S: Who understand the choices...

J: ...and understand it's normal. And I do remember thinking, very strongly when I went to, the first home ed meeting we went to was at a soft play place and loads of other parents of older children as well, some our age, and [eldest daughter] was two and [second child] was just four months and I remember feeding [eldest daughter] there and thinking I wouldn't have done this if it had been any other sort of meet but because it was of home educators who had already made, you know, a really alternative choice...I just kind of felt very, um...just kind of, it didn't occur to me that it wouldn't be ok...to do it and so I think, you know, the more time I spent with people who I know won't have an issue with it, I think that's...yeah, so, in a way the support groups, yeah, it would be, yeah definitely actually, having said that, yeah. You know, mum's fantastic, but I think you need to have confidence to keep going and to...particularly feeding in public, feeding with other people...

[S talks to baby, who has dropped a toy]

J: ...'cos, you kind of read about people who want to keep feeding but, you know, they just do it private...

Appendix G: Examples of observation transcripts

G1 Excerpt from transcript after observation at LLL, 9th July 2008

The recording starts with Marie part-way through talking about the founders of LLL, the beginnings of the organisation and how it is now worldwide....

...She reminds people that they should attend to their own and their babies needs and feel free to move around if necessary. She does the usual LLL preamble about what might be seen and heard at the meeting and reminds women to take from it what is helpful for them.

She suggests we do a round of introductions, focusing on the question 'what was your biggest challenge in getting here today?' and I remind her that there are some people present who don't know me. I introduce myself as I usually do, adding that I may not be able to be present at the next few meetings but that I will let the Leaders know if I am intending to stop coming.

Woman A introduces herself and her seven and a half month old son; her biggest challenge in getting to the meeting was that she was feeding her son 'all night' and is 'quite tired':

'...and I woke up this morning feeling quite overwhelmed with everything I had to do...'

Marie reminds people that the topic is 'Breastfeeding challenges – bumps along the road' but if they have any other questions or issues they want to raise, to say those too. Woman B introduces herself and her two and a half year old son; she is very pregnant and says that her biggest challenge at the moment is feeding 'with a bump' which has given her many challenges along

the way. Marie says something about finding different positions to feed in and she says:

‘...yeah there’s that and a little bit of pain and a little bit of ‘is he going to give up? soon’ and how do we both feel about it, and all that kind of stuff and how am I going to tandem feed – I’m tired with one, let alone with two! So, who knows... day by day stuff, really...’

Josie introduces herself and her fifteen month old son. She says that her biggest challenge (and I notice that people are thinking about challenges in relation to their breastfeeding experience and not in relation to getting to the meeting – which is what I think Marie meant) was that her son slept quite well until he was about four months old and then:

‘...at about four months he started waking every hour for a feed every two hours and I had to wrestle with myself ‘cos I know a lot of people at that point then decide to put their children on solids and all sorts of things and do ‘cry it out’ and I didn’t feel up to any of those things so I then agreed to co-sleeping and it was just the acceptance I think, acceptance was the biggest thing. And he still didn’t sleep through the night! And so it’s kind of been my biggest challenge, but yeah, acceptance...and not listening to all the [indistinct] and the advice...’

Woman C introduces herself and her fifteen month old son. She says that she is also breastfeeding her three year old daughter (not at the meeting at the moment – she says she may be along later ‘when she and nanny have had enough of the park’. Someone says ‘in this rain?’). She says that she has had quite a lot of ‘bumps’ and that many will be familiar with them (this may be a reference to the previous meeting when she spoke quite a lot and was quite upset)....

...Woman D introduces herself and her four month old and two year old sons. She says that she is due to go back to work in a few months’ time and at the moment her baby doesn’t take solids or a bottle and she says – ‘having been called back last night when I was out’ - she is now a bit anxious about that:

‘...delighted that the breastfeeding is going well, which it is but actually I’ve now got other issues really. And also he is waking more...when to introduce solids...as soon as, in fact before he was sixteen weeks people again were saying ‘Ooh...’ and, you know....and I was shattered and so actually I was quite liking the idea that might

help but having read some more, he's not ready in lots of ways but just, I think, knowing when he is...'

Someone asks how old he is and she says 'eighteen weeks'. Josie says something about how people will say that they'll stop waking if you give them solids.

I speak at this point, saying that Woman D came in after I introduced myself and the fact that I was recording the meeting. I tell her briefly what I am doing and let her know that I am recording the meeting (she is ok with this). I tell her about myself and that I am still breastfeeding a four year old. She says quickly that she isn't breastfeeding her two year old:

'...I gave up when I went back to work. At five months...'

Fran introduces herself and her nearly three year old son (not still breastfeeding – 'he stopped round about his second birthday'). She also has a seven year old daughter. She says that any bumps are long enough ago to be 'a bit hazy' and that her journey here was surprisingly quick, given the rain....

...Woman H introduces herself, she is pregnant with her second child. Her eldest is twenty-seven months old; she said she had a lot of problems feeding him and so she wants to see if things can be different this time. She had problems with latching on and with sore nipples and found it very 'challenging' and so is really hoping that this time it will be easier. Marie talks about it is easier the second time around as you already have more knowledge than you had with the first one....H talks about also having the support that she didn't have the last time and she and Marie agree that part of that is that she is at this meeting. H says that her son usually sleeps through the night but he didn't the previous night and so they are both quite tired this morning.

Woman J introduces herself and her fourteen month old son. She says that, apart from 'lots of pain at the beginning' they haven't had too many challenges:

'...I'm quite lucky we haven't had too many negative comments recently whether that's because I don't feed quite so much in public anymore...I've stopped meeting up with friends I know will say anything about it...I've given up trying to explain it...'

[there is quite a lot of baby and child noise here and it is hard to hear exactly what she says]

Marie comments that J had asked a question about feeding in public at the last meeting. She asks Jenny if she wants to introduce herself and reminds her of the question (Jenny has been out of the room). She explains about her long involvement with LLL.

Woman K introduces herself, her three month and two and a half year old daughters; her biggest challenge was 'getting out of the house'. She says that she regrets giving up breastfeeding her eldest daughter when she was about five months old and wants to carry on breastfeeding her baby for longer. She thinks that stopping before was associated with weaning, sleeping longer and less breastfeeding, but this time would like to carry on 'even up to a year'. She says that as her baby is now fourteen weeks old she knows that it won't be long before she starts weaning and she doesn't want the same thing to happen again. Marie asks her if she's heard of 'baby-led weaning', she hasn't and various people in the room start to explain. Marie knows that Josie did it and so asks her to explain. She tells about her experience, of waiting until six months and then offering her son finger foods. She says that it took a long time but she thinks there are benefits – he now eats with them, it's less messy, she has been more relaxed. Marie talks about a book and a dvd and how baby-led weaning is like breastfeeding 'on demand'. She says that she will organise an evening about this.

Someone else raises the point that there are implications if you are putting children into child care/with a child minder etc. Josie thinks that you could combine methods. Another woman thinks that she has heard that children weaned like this are less fussy although she's not sure how you know that they wouldn't have been anyway. Josie talks some more about her experience with weaning her son. Someone else talks about using a mixture of approaches.

Marie asks the women in the group to think about what was the funniest or bizarre advice or suggestion given to them just after birth. She gives the example of her mother-in-law suggesting that she give her son sugar water when he was having problems latching on. Woman C says:

'...I can't actually remember the newborn days, but, this was a bit later on, my mother-in-law, earlier this year when I was...we stayed with them for a week and I was quite ill, it was like my body took that opportunity to just throw out nasty stuff, and her advice was – and I was having issues with my older daughter wanting to feed all the time as well – and her advice was that I needed to wean [son] 'cos if I weaned [son] then [daughter] wouldn't see me feeding him and then she wouldn't want to feed either...'

[there is incredulous laughter]

Marie asks how she responded:

'...well I was shocked so I didn't actually respond that much...she wanted to justify why she hadn't fed my husband...it all very much came up that it's her stuff...'

**G2 Excerpt from notes made after observation at Babes,
12th June 2008**

I arrived much earlier this week, getting there before anyone else apart from Helen (at just about 1.00). This was good as it gave me a chance to talk more to her, having not been able to do that last week....She told me that she breastfed her son until he was five. We talked about the difference between the women who attend this group and those who come to LLL.

Other women gradually arrived but fewer than last week – altogether there were six of us, including me and Helen. The others were Fran and then the 26 year old from last week with her 6 and a half month old son (A) and the woman with her three week old baby son (B). There was also a woman who I hadn't met before (C), breastfeeding her two year old daughter (she also had a three year old son who was present).

The tiny baby fed on and off. B looked much more relaxed than last week and said that it was going well; the baby had put on eight ounces since last week. She'd taken him to an osteopath and was pleased with the consultation. She is sometimes finding it hard to feed him when she is looking after her other two children (who are both under 4). She talked about being determined to succeed now 'this is it until he has cow's milk'. At one point, near the end, Helen took her out of the room to teach her some expressing techniques and I held the baby, who slept on my shoulder and exuded that sweet, breastfed baby poo smell.

The rest of us chatted. I felt like part of the group and joined in the conversations. At times I found it hard work but I think that was because of feeling very tired.

The six month old played on the floor and breastfed a few times; the last while his mum sat in a chair and he went to sleep. The two year old came

onto her mum's lap and breastfed on and off, maybe about three times ('mama booby', lifting up top); once she started breastfeeding and saw the plate of biscuits – she decided that a chocolate digestive was better that time.

We talked about a range of topics – one strand of conversation around sleeping (two of the women are co-sleeping) and breastfeeding at night. A was interested in whether I'd done this, how often (my daughter) feeds now etc. ...

...C talked about how she had family pressure to wean and some disapproval that she was breastfeeding a two year old. She said that she was breastfed herself. She comes from an area where 'no-one' breastfeeds and yet she is breastfeeding a toddler. She told a funny story about trying to get out of bed with a recent bad back, ending up on all fours trying to stand up with her daughter under her reaching up saying 'booby, booby'. When I left her daughter was blissfully breastfeeding – would have made a beautiful picture – and next to her A's son had finished and was totally relaxed asleep in that wonderful post-breastfeed way.

C agreed to be interviewed. I wish I'd asked more questions – does she breastfeed her two year old in public in (area)? What sort of reactions has she had from friends? Partner?

Driving home I thought about how my stereotypes were being challenged. I didn't think I'd meet long term breastfeeders in (area), thinking that I'd be lucky to meet those still breastfeeding at 6 months. But, two weeks in a row and I've met two different women breastfeeding toddlers! Plus several co-sleepers. And a complete openness and interest when I talk about breastfeeding a practically four year old. So many of the issues are the same as the LLL women. C talked today about deciding not to return to work after having had children and managing on less money – again a stereotype but I thought I'd meet many who would have to return to work, unlike many LLL

women who don't seem to have that financial urgency. And A talked about not wanting to return to work as she wanted to be the one to look after her son....

G3 Excerpt from notes made after observation at BIB, 2nd July 2008

...Altogether during the two hours of the meeting there were 12 women present, including me. There were 10 of us to start with, and then A left but another woman arrived. Fifteen minutes before the end another woman also joined the group (late because she'd had an appointment elsewhere). This is a different group to some others I have been to as most women don't have their children with them (so I was not unusual). There were four babies in the room in total during the group (but not all at the same time) – A's for a short while (feeding, then asleep), a nine month old boy (feeding, playing, sleeping), a three month old girl and right at the end a smaller baby boy (unsure of age, not newborn). One of the women (B) has three children in the crèche but her 13 month old daughter came to join her, upset, after about an hour. Of the twelve women present, apart from me, Fran and A, there were two workers from the children's footprints centres (one later says that she is observing the other) and one maternity support worker.

It felt ok to be there but hard to talk to many women other than those sat right next to me (Fran and B). I think I need to go more and work harder at introducing myself. I have got used to Babes which has a very different feel. Helen makes sure that everyone knows who I am whereas at BIB it was hard to know exactly how to behave. I didn't feel uncomfortable, just unsure of the best way to play it. Perhaps the group is unsettled by the changes in A (she didn't stay long but with a new baby I would imagine it's hard for her to focus, especially if she's very tired).

I talked quite a lot to B (who I met last time). She has three children close in age...She has recently weaned her thirteen month old daughter and talked quite a lot about this. She said that she initiated it as her daughter had been eating very little solid food and she was worried about this. She also said that she felt that she was breastfeeding a lot 'just for comfort'.

[but if she wasn't eating much she must have been breastfeeding lots for nutrition too! – and, 'what's wrong with breastfeeding for comfort?' I wanted to say, but settled for saying that I knew that a lot of people went on doing it just for that reason for quite a long time].

I asked her if it her daughter had found it hard and she said not really, except once when she fell over and wanted to breastfeed for comfort (she did). She talked about wanting her body back but finding it hard that there were hormonal changes that went along with stopping bf (like spots) – she has been told that this may last for about three months. She also talked about finding it hard emotionally as this might be her last baby and so letting go of breastfeeding might be the last time she does this. I asked her if she had been under pressure to wean from anyone else and she said only really from her mother-in-law who had found it very hard that she breastfed eldest son until he was seven months and has found the longer breastfeeding of the next two even harder. No pressure from husband who has been very supportive.

Women chat to each other and some eat – toast and fruit. There is a lot of cake around (a lot in a box for future meetings!) but no-one seems to be eating it this time. We have two rounds of tea making and drinking.

Not much talk about breastfeeding...

Appendix H: PhD outputs

H1 Conference papers

Dowling, S. & Brown, A, (2012) '*Representing long-term breastfeeding: what are the issues and why does it matter?*' Paper presented at the British Sociological Annual Conference, Leeds University, 12 April.

Dowling, S. & Brown, A, (2012) '*Representing long-term breastfeeding: what are the issues and why does it matter?*' Paper presented at the RCN Research Conference, London, 24 April as part of a symposium '*Keep on keeping on? Issues relating to duration in women's breastfeeding practice*' (Symposium abstract co-ordinator Dowling, S).

Dowling, S. (2011) '*Online asynchronous and face-to-face interviewing: Comparing methods for exploring women's experiences of breastfeeding long-term*'. Paper presented at The British Sociological Association Annual Conference, The LSE, 7 April.

Dowling, S., Naidoo, J. & Pontin, D. (2010) '*Breastfeeding in public: Women's bodies and the public control of sexuality*'. Paper presented at the Symposium Breastfeeding and Feminism 2010: Informing Public Health Approaches, University of North Carolina, Greensboro, United States, 20 March.

Dowling, S. (2010) '*Breastfeeding older babies and children: taboo, stigma and prejudice in contemporary British breastfeeding experience*'. Paper presented at the British Sociological Association Annual Conference, Glasgow, 7 April.

Dowling, S. (2009a) '*Dear Sally...*' *Reflections on using email correspondence as a method of generating qualitative data in health and social care research*. Paper presented at the 2009 RCN International Nursing Research Conference, Cardiff, 1 March.

Dowling, S. (2009) *Breastfeeding older babies and children: taboo, stigma and prejudice in contemporary British breastfeeding experience*. Paper presented at the Nutrition and Nurture in Infancy and Childhood: Bio-Cultural Perspectives, Grange-over-Sands, 1 September.

Dowling, S. (2008) *Researching women's experiences of extended breastfeeding*. Paper presented at the 2008 VELB-ICLA Conference - A World Wide View on Breastfeeding, Vienna, Austria, 1 October.

H2 Invited presentations

Dowling, S. (2009) *Women who breastfeed long-term: researching their lives from an insider perspective*. Paper presented at the Association of Breastfeeding Mothers Annual Conference, 2009, De Montfort University, Leicester, 1 June.

Dowling, S. (2012) *Breastfeeding to six months and beyond: Why breastfeeding support in the early weeks really matters for babies and children later on*. Presentation for Bristol Breastfeeding Peer Support Service Enrichment Day, Bristol, 2 February.

Dowling, S. (2012) *Long-term breastfeeding: some thoughts and issues*. Presentation for Breastfeeding Peer Support Enrichment Day, Weston-super-Mare, 29th June.

H3 Journal article (peer reviewed)

Dowling S. (2009) Inside information: researching long-term breastfeeding. *The Practising Midwife*, 12(11):22-26

Dowling, S. (2009) Women's experiences of long-term breastfeeding. *The Practising Midwife*, 12(10):22-25

Dowling, S. & Brown, A. (2013) An exploration of the experiences of mothers who breastfeed long-term: what are the issues and why does it matter? *Breastfeeding Medicine*. 8(1):45-52.

H4 Book (chapter)

Dowling, S., Naidoo, J. & Pontin, D. (2012) Breastfeeding in public: Women's bodies, women's milk. In: Smith, P. Hall, Hausman, B. & Lobbok, M. eds. (2012) *Breastfeeding and feminism: New ways forward for public health*, New Jersey: Rutgers University Press, pp.249-258.

Dowling, S. (2011c) Online asynchronous and face-to-face interviewing: Comparing methods for exploring women's experiences of breastfeeding long-term. In: Salmons, J. ed. (2011) *Cases in online interview research*. Thousand Oaks/London/New Delhi: Sage Publications, pp.277-296.