'Linking as One': An intimate breastfeeding moment

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ABSTRACT

Breastfeeding is more than the act of providing nutrition to an infant. It is a dynamic interpersonal process, frequently suggested by both women and authors to be an intimate activity. Health professionals have tended to explore the biophysical aspects of breastfeeding largely ignoring the breastfeeding woman's perspective and the effect social and psychological processes have on breastfeeding success. This grounded theory study drew on a range of data sources to describe breastfeeding womens' experience of intimacy. Data included interviews with twenty women participants, observational field notes, theoretical memos, drawings, literature and pictorial work. The study supported the premise that women experienced moments of intimacy when breastfeeding. Breastfeeding is represented in the basic social psychological process 'linking as one'. Linking as one is the intimate act of gifting, for comfort, pleasure and growth, human milk and human contact to a baby or child. 'Linking as one' is mutually exclusive and mutually satisfying to both participants. It is not all women's experience nor is it associated with every breastfeeding encounter.

The findings support a substantive descriptive model of the breastfeeding process that represents and facilitates intimate breastfeeding moments. The model provides a framework for theoretical research, which may lead to further conceptual refinement. The model also provides a framework for education curricula and nursing clinical practice. Clinical application includes the use of concepts as prompts from which to explore interpersonal breastfeeding dynamics with breastfeeding clients. The concepts include breastfeeding comfort, ownership of the breast, mutual gifting and knowing. Exploration of these concepts may enable breastfeeding women to maintain and promote successful breastfeeding experiences.

ACKNOWLEDGEMENTS

PREFACE: The personal and the professional

As with many research projects, a personal commitment to the research topic is often born from the researcher's own experiences. This is certainly the case with this study. I often tell people I breastfed my three children. However, if anyone were to ask if I was successful I would have to admit that my breastfeeding experience with my first child was not something I would describe as a particularly successful or pleasurable experience. As with many new mothers I was keen to breastfeed my baby. As a child health nurse I had advised other women about breastfeeding and the many benefits it offers for both mother and infant. Indeed, as a child health nurse I had read widely and learned about the various types of interventions which helped women overcome breastfeeding difficulties. It was therefore, not ignorance about the problems associated with breastfeeding, neither was it a lack of commitment to breastfeeding, that contributed to my unsuccessful experience; rather an unexpected lack of appropriate assistance when it was needed most.

On reflection, my breastfeeding experience is not unique and I have subsequently heard of similar experiences from clients. It seemed to me that my experience was compounded by the fact that I was at the time a child health nurse. My expectations of a low intervention, natural childbirth were not met. My baby was born by forceps, after I had been administered an epidural anaethestic. I required an episiotomy and thus suture for repair after delivery. While I realise this experience is not unusual for a first birth; I was disappointed with myself. This level of intervention at delivery resulted in a temporary paralysis and numbness from my waist down. I was therefore unable to move about for some hours after the birth. I did not get to hold my baby after she was born.

By the time I got to the post-natal ward I was anxious to hold her, touch her, have her to myself and put her to the breast. I asked the nurse who was caring for me if I might have my baby to myself and be 'left alone' with her. The delivery staff had told me I could not be alone with my baby until the epidural had worn off. The simple request to be left alone was recorded in my medical records, in the nursing notes, along with the fact that I was a

child health nurse. As a result during my entire hospital stay and at that very initial breastfeeding time I was left alone, quite literally.

The problems started early on, I had trouble latching the baby to my breast and by day four, post birth, at discharge from hospital, I had cracked sore nipples and a very poor let down while feeding. I would let down once the baby had been removed from the breast. By week three my baby was losing weight, the abrasions on my nipples were bleeding and I was breastfeeding for hours at a time, in tremendous pain, having tried all I knew to fix the problems.

I vividly remember my husband telling me to smile at the baby while I was breastfeeding her or she would think I didn't like her or enjoy it. "Enjoy it"! I replied " I feel like I am being beaten up and robbed". Over this terrible time I remember feeling desperate for any help and advice which might work. The child health nurse who visited me was a colleague and friend and knew as much as I did about breastfeeding. She sent another health worker to my home, who knew even less about breastfeeding and assured me the baby was swallowing, so must be latched on.

I made the obvious choice to bottle-feed when I had exhausted the available help and felt I had run out of time, because the baby's health was compromised. I weaned to a bottle and my baby thrived. I felt a sense of failure, loss, guilt and sadness. I felt that I must be something less than a good mother because I had failed to breastfeed. I worried that I would not bond to my baby and might love her less. That worry proved to be unfounded, but concerned me at the time. I understood that breastfeeding was most important for bonding, particularly that breastfeed just after delivery.

Thus, it is not surprising that I developed an interest in breastfeeding. By the birth of my second child I had undertaken to study breastfeeding in a more formal way. I enrolled in an undergraduate multidisciplinary university paper in breastfeeding. I missed the first lecture of the paper as I was in the hospital for delivery of my second baby. It was neither because of that paper, nor despite it that I breastfed like a real professional, both that

second baby and the following, my third baby. I can now comment on a number of factors that may have influenced my breastfeeding success. Factors such as, my more realistic expectation of an infant's behaviour, my more relaxed attitude toward my baby, and the fact that as a result of my studies I was a better-informed mother. It is therefore understandable that my initial considerations on breastfeeding reflected a somewhat simplistic assumption. I assumed that some form of appropriate and timely social support could improve any problematic breastfeeding experience.

This assumption was reflected in my clinical work as a nurse and subsequently as an academic. I developed a strong commitment to listening to and validating my clients' perspectives. I became aware of the difference between the problem as stated and the reality of living through the experience of that problem. That is, it is one thing to recognise that your nipples are cracked, it is another to live through the pain and suffering. I was careful to ascertain the most appropriate support for my clients to help with any breastfeeding difficulties. I found that I was concerned for the emotional welfare of my clients. As a health professional I had always been careful to offer a range of advice and choices for my clients, so they could select the most appropriate option. I found after my own breastfeeding experiences, that I was interested to hear what options the breastfeeding client might consider to be best for her and her baby. I developed a tremendous respect for women's intuitive or common sense ability to problem solve, and a tremendous respect for an individual's ability to react to their own body cues.

During this time of both personal and professional discovery I became increasingly aware of the relationship between a mother and breastfed infant. I was able to reflect on my own experiences and make comparisons between my first baby and subsequent children. Successfully breastfeeding my second baby was a completely different experience to the first baby. I felt a closeness and connectedness, particularly during breastfeeding, that I had not experienced with my first child. I had not felt that same connection during any bottle-feeding interaction with my first baby, rather that closeness was experienced during other times, like cuddles in bed or cuddles in the bath. On reflection, the close non-breastfeeding times occurred when close physical contact was afforded. I did not

voice or even consciously recognise the relationship aspects of my breastfeeding experience until my attention was aroused by other women's reports of their breastfeeding. As I listened to my clients share their breastfeeding stories and verbalise their emotions I began to recognise the very significant and pivotal role the mother-infant dynamic plays in breastfeeding success.

I continued to expand my own understanding of breastfeeding, speaking to other health professionals on breastfeeding issues. I have been most concerned with the concept of social support and breastfeeding and the mother-infant dynamic. As a health practitioner and academic I have actively engaged in breastfeeding research (Beasley, Chick, Pybus, Weber, Mackenzie, & Dignam, 1998) and have spoken to a range of health professionals and lay health workers. I am a professional member of La Leche League. In any of these more formal forums I hold to the position that women are better able to breastfeed their infants if they can access appropriate and timely support, and are engaged in positive mother-infant dynamics. I encourage other health professionals to respect and attend to the messages breastfeeding mothers share with them. These are some of the lessons I learned from my own breastfeeding experiences and have observed over time with my clients. It is not surprising then, that these basic premises are foundational to this study, as they are foundational to me.

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Chapter 1: Background to the study

1.1 Introduction

As outlined in the preface a combination of my own personal breastfeeding experiences, clinical nursing experiences and the more formal academic exploration of breastfeeding prompted this study. As a result of my interest in breastfeeding and the role nurses and health care workers might play in facilitating breastfeeding I initially explored the literature in order to consider the influence of social support. I also considered the influence of historical infant feeding practices on contemporary infant feeding practices, and the range of factors that impact on breastfeeding women's perception of breastfeeding success. It became apparent that one of those many factors, notably the mother-infant breastfeeding dynamic, has to date been poorly considered. As I explored further the literature concerning mother-infant breastfeeding dynamics a recurrent description was noted. This description reports breastfeeding to be an intimate relationship between mother and breastfed infant (Dettwyler, 1995; Kearney, 1988; Maclean, 1990; Van Esterik, 1994). In order to understand more fully the scope of a concept such as intimacy, I reviewed literature about breastfeeding and intimacy, including intimacy as a concept. The review of the concept of intimacy led me to consider the importance of intimate relationships on breastfeeding success. As a result of these considerations the prime research question in this study is concerned with *understanding intimacy as experienced by breastfeeding women*.

This chapter presents the background to the study providing the rationale for drawing on the concept of intimacy as a starting point for understanding breastfeeding women's experience. The chapter introduces the aims of the study and some of the language and definitions associated with breastfeeding. The benefits of breastfeeding for both mother and infant are reviewed, in order to make explicit the importance of promoting and protecting the practice of breastfeeding. It is clear from the review that the psychological benefits of breastfeeding for both mother and infant are least well researched, with the literature strongly influenced by the theories of bonding

(Bowlby, 1971) and attachment (Klaus & Kennell, 1982). The lack of attention to the psychological benefits and limited understanding of interpersonal processes of breastfeeding identified in this review supports, in part, the rationale for undertaking this study. The description of breastfeeding as an intimate activity provides one way of re-framing the interpersonal dynamic of breastfeeding beyond the traditional and inadequate approach of bonding and attachment. To conclude the chapter an overview of the thesis is provided.

1.2   Breastfeeding and intimacy

Supporting the breastfeeding woman is a concern for all health professionals (WHO/UNICEF, 1990). How best to provide support to breastfeeding women was my initial concern. In reviewing breastfeeding literature it became evident that a number of authors had commented on the intimate nature of the breastfeeding relationship. Van Esterik (1994, p.71) indicated that,

> Breastfeeding and breasts are powerful metaphors for talking about and understanding many abstract concepts such as reciprocity, sexuality, intimacy, and sharing.

Breastfeeding was presented as an "intimate process that requires psychosocial adjustment as well as technical skills" (Kearney, 1988, p.98). Dettwyler (1995, p.190) recognised that even in the infant formula literature "breastfeeding is often described and portrayed as a 'quasi-sexual' behavior, an intimate, private experience between mother and child". Riordan and Auerbach (1993) support this position, suggesting it is the intimate quality of breastfeeding that makes it a practice difficult to accomplish in public. Morris (1971) elaborated on the breastfeeding act suggesting that the presentation of the nipple and the sensation of feeding added "another very basic comfort- a primary intimacy" (p.25) to the newborn infant's life. According to Kitzinger (1987) "Breastfeeding is not a matter of filling a baby up with milk as you might fill the tank of a car. It is an intimate dialogue between two people" (p. 97). Each of these authors does not explain the breastfeeding woman's perception of intimate encounters. The authors identify intimacy as a relationship characteristic, private and pseudo-sexual when applied to breastfeeding. What is common between these authors, is a description of breastfeeding as intimate.

Maclean (1990, p.95) suggests that for women the rewards of breastfeeding are derived from an emotional satisfaction and the "unique intimacy" between mother and baby. Maclean's comprehensive study of mothers' breastfeeding experiences cites one respondent who reported that breastfeeding is "just so easy, so comfortable and the intimacy of the relationship when you are together is so nice" (p.95). Golub (1978) noted that personal gratification was one reason women chose to breastfeed. Choosing to breastfeed has been found to be associated with the idea that breastfeeding is enjoyable (Stamp & Crowther, 1995). Certainly, maternal satisfaction, perceived infant satisfaction, closeness and success are influences on the practice of breastfeeding (Duckett, Henly & Garvis, 1993). In reviewing these authors' work I developed the position that the recognition and experience of enjoyment and pleasure associated with breastfeeding, may well be part of an intimate relationship experienced when women are breastfeeding. It was on this premise that I sought to formalise a study that might provide breastfeeding women an opportunity to share their intimate experiences.

1.3   The study

This research uses grounded theory method to explore intimacy as experienced by breastfeeding women. The breastfeeding participants' intimate experience with others is explored by use of in-depth interviews, observation, drawing and literature. The intent is to better understand and describe, by theoretical abstraction, breastfeeding women's understanding and experience of intimacy. Thus the aims of the study are essentially threefold;

1)   to allow breastfeeding women's perspectives on intimacy to be heard,
2)   to describe, by inductive substantive analysis, intimacy as perceived by breastfeeding women, and
3)   to develop a grounded theory that describes intimacy as experienced by breastfeeding women.

It was my original position, that from the intimate experience of breastfeeding women a theory may emerge to assist nurses to better understand and support the practice of breastfeeding. This position I still hold. It is also my position that

breastfeeding is a practice to be fostered with benefits to mother, infant, family, community and society as a whole.

A range of health professionals including midwives, lactation consultants, medical professionals and health workers, have contact with breastfeeding women. In the New Zealand context we support breastfeeding women with an infant between the age of eight weeks to five years old as clients. Clients are visited by child and family nurses, such as Plunket[1] nurses, practice nurses and public health nurses. Throughout the thesis reference is predominantly made to the implications of the study for nurses.

Throughout the thesis I use the first person to refer to my actions, assumptions and rationale. Writing in the first person is consistent with a qualitative research method and appropriate for disclosing personal judgement, a position supported by Webb (1992). Webb notes that use of the first person is essential to illuminate the research process indicating how researchers do influence, exercise choices and make decisions about the directions of their research and the conclusions they draw. Webb further asserts that writing in the first person is an approach that is reflexive and enables researchers to discuss honestly and fully what the influences, choices and decisions were, unlike the use of third person which conveys an impression of objectivity.

Throughout this document the term 'breastfeeding' is used - breast-feeding or breast feeding (as in two words) is parallel terminology to bottle-feeding and fails to locate the essential distinction between the two methods of feeding, that is, the interconnectedness of the breastfeeding act. The use of the term breastfeeding is consistent with the position that breastfeeding is a process (Auerbach, 1991). The importance of language in shaping perceptions is acknowledged in the use of breastfeeding as one word, in that the absence of space or disruption between the two words is somewhat symbolic of the nature of the practice of breastfeeding. The terminology bottle-feeding indicates a device and action; this is quite distinct from

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[1] Plunket nurses are so named after the original Patron of the Royal New Zealand Plunket Society Inc. These nurses are New Zealand registered nurses and hold a certificate in child and maternal health.

the act of breastfeeding. Given that this study is concerned with understanding an interpersonal and relationship characteristic such as intimacy, it is congruent to use an appropriate terminology.

Breastfeeding for the purpose of this study was defined as any contact that constitutes the act of breastfeeding. Thus, the breastfeeding contact by definition ranges from token breastfeeding[2] to full exclusive breastfeeding[3] (Labbock & Krasovec, 1990; Armstrong, 1991). The study participants needed to have very recent experience of the breastfeeding act in order to have recall from both the immediate and the past and in order for observation of breastfeeding to be included as data in the study. While frequency and duration of breastfeeding may affect intensity of the experience, these factors will not necessarily affect the ability of women to reflect on and articulate the experience, an aspect that remained imperative to this study.

The following sections review the literature addressing the benefits of breastfeeding benefits for babies, women and the community. It is important to consider the benefits of breastfeeding in order to acknowledge the importance of promoting, protecting and supporting breastfeeding (Auerbach, 1990). This range of benefits provides an essential platform for considering any breastfeeding study as a health practice.

1.4 Health benefits for baby and mother

Breastfeeding provides well-documented health benefits for both infant and mother (Campbell, 1996; Cunningham, Jelliffe & Jelliffe, 1991). These include infant protection against gastrointestinal infections, pneumonia, bacteraemia and meningitis, not to mention a reduction in some chronic diseases later in life (Cunningham, et al., 1991; Fergusson, Horwood, Shannon & Taylor, 1981; Howie, Forsythe, Ogston, Clark & Du V Florey, 1990). Breast milk is able to confer anti-infective properties, augment the immune system, and provide antibacterial

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[2] Token breastfeeding is defined as minimal, occasional, irregular breastfeeds

[2] Full exclusive breastfeeding indicates the infant receives no other liquid or solid.

protection and anti-inflammatory components (Riordan & Auerbach, 1993). The dynamic and living composition of body fluid known as breast milk is unique from woman to woman and is biologically specific to the human species and individual (Ebrahim, 1991). Breast milk confers considerable nutritional benefit to the recipient with optimal bioavailability and specific growth factors (Janke, 1993; Riordan & Auerbach, 1993). Less substantiated claims suggest that breastfeeding may enhance the infant's social development and intellectual capacity (Forsyth, 1995; Horwood & Fergusson, 1998; Wung & Wu, 1996). The physiological processes associated with breastfeeding enhance jaw and dental development (Farsi, Salama, & Fouda, 1997). Though the gross composition of breast milk is relatively well defined it is the complex interactions and trace components which are poorly understood and not yet completely determined (Riordan & Auerbach, 1993). Although artificial formula mimics the composition of breast milk and has been considerably modified over the years, never the less it remains a gross representation of breast milk (Minchin, 1989). The bio-chemical aspects of breast milk are well recognised as optimal for infant growth and development and there is little disagreement that breastfeeding should be encouraged as a health practice.

The prime maternal health benefit from breastfeeding is lactation amenorrhea. Full breastfeeding can provide a biologically natural contraceptive effect. Study has been undertaken in this area and a lactation amenorrhea method of contraception is available to breastfeeding women (Labbok et al., 1994). Literature supports further benefits of a lowered incidence of breast cancer, ovarian cancer, bone loss and maternal bone depletion (Campbell, 1996; Hollander, 1996; Kennedy, 1994). Other claims include the promotion of uterine involution (Lawrence, 1994) and the less substantiated claim of improvement in postpartum weight loss (Dewey, Heinig & Nommsen, 1993).

1.5   The economic and ecological benefits of breastfeeding

A more recent approach to understanding and promoting breastfeeding has been the ecological perspective. The conservation of the planet's resources provides a compelling platform from which to extol the ecological benefits of breastfeeding.

The main arguments advanced from this perspective include the following aspects; breastfeeding saves food resources, does not require packaging, saves on energy and fuel, needs no washing up, impacts on hospital and drug utilisation, provides natural contraception, and promotes human health (Breastfeeding; Nature's Way, 1982). World Breastfeeding Week took up the ecological position in 1997, with the promotion of the theme *Breastfeeding: Nature's Way.* The theme encompassed the idea of conservation of both natural and economic resources (New Beginnings, 1997). Van Esterik (1989, p.210) presents the position for sustainable practices in at risk economies. She asserts that sustainable development requires a new approach, and breastfeeding is able to contribute to this. A similar theme is espoused by Baumslag and Michels (1995, p. 141); "From an ecological point of view, breast milk could not be greener". Palmer (1988) also poses the ecological soundness of breastfeeding. She takes the position that breastfeeding has ecological power (p.284); this position is reliant on making a case for the economic contribution to societies.

Increasing attention is being given to the economic impact of breastfeeding (Smith & Ingham, 1997). These Australian authors considered the economic value of breastfeeding by measuring the value of breast milk production. Volume was estimated by drawing on daily breast milk production levels as consistent with researched breast milk volume and production. Drawing on this and other data such as that of the number of infants of relevant age, rates and daily volumes at market value or price (determined by the shadow price of infant formula) an estimate of economic value was calculated. It was estimated to represent some 2.2 billion Australian dollars a year. The authors present a strong case for the economic impact of breastfeeding on a national economy. Bell and Rawlings (1998) note that in America, "The nation could save an estimated $3 billion to $4 billion per year..." (p.102) by increasing breastfeeding rates. The intention to raise economic awareness of breastfeeding benefits is reflective of the dominance of economic rationalism and market forces.

Evidence of how fashionable this approach is, was reflected in the theme for the 1998 World Breastfeeding Week, *Breastfeeding: The best investment* (WABA, 1998). The aim of the theme's designers was to raise economic awareness about the beneficial contribution breastfeeding makes to economies. The information from

WABA specifically identifies the economic value of breastfeeding versus bottle feeding, health benefits, the illness savings for family, at employer and government level, and the economic impact on importing formula products with foreign exchange (WABA, 1998).

Subsequent work by Bevin (1998) estimates that New Zealand women contribute $180 million to the economy annually. This figure is based on the calculated value of estimated breast milk production from New Zealand women as approximately nine million litres of milk every year, the estimated worth of breast milk per litre is $20. In part this work represents an attempt to quantify the economic impact of breastfeeding which has been an invisible contribution to the economic status of the nation.

Breastfeeding is presented as beneficial for ecological and economic conservation. Both perspectives provide a useful framework for arguing the case 'breast is best'. Both perspectives fail to locate the woman's experience, or dynamic process of breastfeeding as a central concern. While it may help some women to consider breastfeeding in these ways it is unlikely to be enough reason to maintain the practice of breastfeeding. Research to date does not indicate that either economic or ecological concern features as a significant influence in the decision to start or stop breastfeeding.

1.6   Psychological benefits of breastfeeding

A review of health promotion and research literature indicated that the psychological benefits of breastfeeding for both mother and baby are mostly supported by the concepts of attachment and bonding between mother and infant (Bowlby, 1971; Klaus & Kennell, 1982). Some mention of the development and strengthening of relationships between mother and infant is linked to the increase in maternal caretaker behaviours, as a response to hormonal influences (Whittlestone, 1976). These two positions, breastfeeding enhances bonding and attachment, and breastfeeding affects maternal hormone-related behaviour, are dominant in the literature as the psychological arguments for supporting breastfeeding. The more recent evidence indicates that emotional attachment can be advanced by early and

close contact (Armstrong, 1995). It is this author's work that supports the position that breastfeeding, enhances attachment. There is however significant work about maternal satisfaction that is largely ignored in contemporary breastfeeding literature.

It has been reported that those women who report successful breastfeeding experiences are more likely to perceive the infant as satisfied and find the breastfeeding experience a satisfying, enjoyable, close experience (Basire, Pullon & McLeod, 1997; Beske & Garvis, 1982; Duckett, Henly & Garvis, 1993). This may not be all women's experience and Minchin (1989) reminds us that for many women breastfeeding can be a devastating experience, "when their child is unhappy, fails to thrive, rejects the breast, or causes intense pain" (p.171). The point is this, often when women experience breastfeeding the psychological impact is considered to be related to attachment and bonding between mother and infant. However, maternal satisfaction is also a psychological benefit for some breastfeeding women.

Literature about maternal role attainment and motherhood suggests that infant interactions and temperament affect maternal satisfaction and identity (Crnic et al., 1983; Kaye, 1982; Levitt, Weber & Clark, 1986; McHaffie, 1990; Mercer, 1985). In order to explain the complex interaction between mother and infant and psychological benefits, breastfed infant behaviour is often reported as infant temperament (Minchin, 1989; Riordan & Auerbach, 1993). This conceptualisation is not specific to breastfeeding encounters but rather is encompassed in developmental and psychological theories. The psychological benefit of breastfeeding for identity development and maternal role attainment is not a feature in the contemporary health promotion literature.

Overall the research literature makes very little mention about the psychological benefit that might be accorded to the infants from their involvement in the breastfeeding process. This is not surprising given the delicate nature of the inquiry. It would be problematic to argue a psychological benefit by noting a distinction between breastfeeding and bottle-feeding. For many women the argument might negate personal choice, a right highly valued in contemporary society. It is also difficult to determine emotional satisfaction in a newborn. In many of the original studies on the development of mother-infant relationships, bottle-feeding was the

dominant mode of infant feeding and thus the characteristics of feeding (position, eye contact and closeness), were expounded rather than feeding method (Rubin, 1963).

Despite the evidence in support of breastfeeding as psychologically beneficial, particularly for maternal satisfaction, the psychological benefits of attachment and particularly bonding are most often listed alongside the physiological benefits in the health promotion material. These benefits are held to be something of a truism. The bio-medical dominance of reporting on physical benefits of breastfeeding (Beasley, 1991; Ryan & Beresford, 1997) has marginalised the psychological benefits of breastfeeding. Influenced by the bio-medical dominance in literature health professionals promote the health and emotional benefits of breastfeeding without questioning the evidence or substance of the claims (Gordon, 1995; Janke, 1993).

Health professionals may ignore the importance of maternal satisfaction in favour of the more rational argument for physical breastfeeding benefits. This marginalises the importance of psychological benefits. It has been demonstrated that immediate physical concerns/ benefits may not be the factors that influence women either to continue or stop breastfeeding (Fahy & Holschier, 1988). Duckett, Henly and Garvis, (1993) and Leff, Gagne and Jefferis, (1994) support the association of maternal satisfaction with breastfeeding success.

1.7 Breastfeeding benefits and the implication for health professionals

In New Zealand nurses and health workers are directed by national and international policy. It is important to grasp the extent and direction of such government-directed policy as this significantly shapes nurses' perceptions and expectations about breastfeeding, which are ultimately reflected to the client. Most breastfeeding policies and promotional strategies have been influenced by international breastfeeding policy. Breastfeeding is considered a public health strategy, the individual experience is less imperative to policy makers. This is a concerning perception, one that influences nurses and others to consider breastfeeding as solely a population-based health promotion activity. In considering breastfeeding as a

population-based health strategy nurses may negate individual difference and ignore the less tangible psychological and emotional benefits of breastfeeding.

1.8　Overview of the thesis

The benefits of breastfeeding are also inherent in breastfeeding policy and the nurses' role in enacting national policy is presented in Chapter Two. In that chapter I explore in greater depth the impact that policy and trends have had on the promotion of breastfeeding by health professionals in New Zealand (NZ). The historical influence both nationally and internationally of infant feeding practices are presented in order to locate the more contemporary impact on women's breastfeeding practices. The influence of medicalisation on breastfeeding is introduced, in order to locate this study within the dominant perspective informing the body of knowledge on breastfeeding. Particular reference is made to health professionals and the attitudes they hold. This work provides the rationale for my interest in the interpersonal dynamics, experiential aspects, and the worthiness of, breastfeeding as a topic of study.

In Chapter Three I present the ideas associated with an earlier work (Dignam, 1995), which locates my thinking about breastfeeding social support and intimacy prior to the data collection and interpretation phase of this study. The literature that indicates and describes breastfeeding as an intimate activity is also presented. I consider that this description, breastfeeding as an intimate interaction, might provide a lens through which to explore and theorise about breastfeeding.

Chapter Four answers the question, why theorise about breastfeeding? The benefit of theory and the application to practice disciplines is introduced. Theories that currently influence breastfeeding thinking, such as attachment, bonding and imprinting are presented and their inadequacies to represent breastfeeding are raised. Associated theories that hold some conceptual merit for breastfeeding are presented. Rubin's (1977, 1984) theory of binding-in and Mercer's (1985) theory of maternal identity are explored for relevancy to the breastfeeding experience. Theoretical positions drawn from biological anthropology, medical anthropology, sociology and women's studies and feminist studies are also considered. It is argued that, while the

distinctive and essential nature of the breastfeeding experience can be explained by these various theories or perspectives, breastfeeding is not represented in any of these perspectives. That is, breastfeeding fails to be accounted for in any current theory or descriptive framework. I argue that there is no conceptual map from which to understand the breastfeeding process. There is currently no breastfeeding theory from which to understand, or develop an understanding of the breastfeeding act or experience. The discussion in Chapter Four presents breastfeeding as a psychosocial process and locates the practice within the current literature.

The method of grounded theory is introduced and explained in Chapter Five. The suitability of the method to enable theory development is presented and the reader is introduced to the study design and process.

The findings from the study are presented in Chapters Six, Seven and Eight. Chapter Six, provides a brief outline of the model and the assumptions that underpin the study. I then present one of the categories, 'being with' which is inclusive of the concepts, 'mutually exclusive actions', 'mutually exclusive awareness' and 'mutually gifting'. In this chapter I argue that being with the baby is an expression of mutual engagement and exclusivity. Chapter Seven presents the category 'coming to know self'. This chapter elaborates on the concepts 'contextually defined breast', the 'physically defined breast' and 'adaptive breastfeeding'. The central thrust of this chapter is the impact of breastfeeding experiences on altering perceptions of the breastfeeding self. In Chapter Eight I present the category 'coming to know baby'; this includes the concepts 'reading the contact', reading communication' and 'reading and knowing'. The central concern expressed in this category is the perception that the breastfeeding pair knows and understands each other.

Chapter Nine offers a theoretical explanation of the grounded theory, 'linking as one', arguing the impact of the socially located breastfeeding act on women's perceptions of intimacy. The basic social psychological process 'linking as one' includes the categories 'coming to know self', 'coming to know baby' and 'being with'. In this chapter I present the commonplaces of the theory and make explicit the antecedents and contextual characteristics associated with the model. I present the

substantive evidence to support the theoretical understanding of breastfeeding as an intimate activity.

Chapter Ten considers what the theory 'linking as one' might mean for those, such as nurses who work in the practice area of breastfeeding. I weave together an explanation for the subjective experience of the breastfeeding act and the clinical implications of this experience. Consideration is given to the immediate application of key questions and issues that might be explored with breastfeeding women. The theory is presented as a framework for curriculum development and educational delivery for breastfeeding study. A call for further refinement on the theory is made, and specific strategies are suggested such as concept development, assessment tool development and instrumentation testing. The limitation of this work is addressed and further units of study for theory development are suggested. This chapter locates the nurse and health professional and the implication of nursing acts for breastfeeding clients.

1.9 Conclusion

The physiological health benefits of breastfeeding are numerous for both mother and infant and often presented in the literature as the predominant reasons for supporting breastfeeding, rather than the positive emotional and psychological aspects of the breastfeeding encounter. The mother-infant breastfeeding dynamic, from the psychological, emotional and interpersonal perspectives requires further research attention. The failure to understand the interpersonal processes and dynamic of breastfeeding may impact on the effectiveness of health professionals, such as nurses to protect, promote and support breastfeeding. While significant evidence suggests the benefits of breastfeeding as a health activity, traditional approaches of a population-based health promotion strategy have failed to account for the individually located experience of breastfeeding. Drawing on a grounded theory study this thesis presents a model that reflects the interpersonal processes of breastfeeding as reported by breastfeeding women.

Chapter 2: The New Zealand Context: Breastfeeding, policy and trends

2.1 Introduction

In Chapter One I introduced the recognised benefits of breastfeeding for both mother and infant, making a case for the worthiness of breastfeeding as a health activity. I also suggested that, in the health promotion approach to breastfeeding the health strategies are population-based rather than individualised interventions. I argued that the psychological benefits were least asserted in the health promotion literature.

In order to support these assertions, I now review the policy development and historical context of infant feeding in New Zealand, drawing on international influences as they affect New Zealand breastfeeding policy. I note that a strong lobby (by breastfeeding interest groups and health professionals) has advanced breastfeeding policy. This lobby has not been consumer directed, that is, the breastfeeding women of New Zealand have not lobbied for breastfeeding policy reform or rights. In order to demonstrate that occurrence I review some of the history of policy implementation, such as the New Zealand Baby Friendly Hospital Initiative and the Monitoring of the Code for the Marketing of Breast Milk Substitutes (1981).

The public health approach to breastfeeding as a health promotion activity has been focused on breastfeeding targets and health promotion strategies. Health professionals have defined the targets and strategies and these negate the breastfeeding woman's perspective. In support of the position that breastfeeding women's perspectives must be attended to I introduce the more recent call for breastfeeding research locating the woman's perspective and experience as the central concern. An example of attending to breastfeeding women's perspectives is given in the presentation of the literature about breastfeeding success. This literature offers the alternative definition of successful breastfeeding, success that is defined by breastfeeding women.

2.2   The history of infant feeding in New Zealand

The influence of policy on nurses and other health professionals, who work with breastfeeding women, is superimposed on the history of infant feeding in New Zealand. In order to understand the reality of any woman's breastfeeding experience I found it helpful to consider the historical influences on infant feeding practices in New Zealand. This is particularly relevant when the nurse engages with a breastfeeding woman to support her breastfeeding.

The international history of infant feeding is well documented (Fildes, 1986). However, Ryan and Beresford (1997) have presented the history of infant feeding in New Zealand as a background to Ryan's (1999) doctoral thesis. Ryan has undertaken a comprehensive review of the New Zealand literature around the topic of infant feeding research between 1945 and 1995. Using a classification system, studies were categorised according to design, perspective and paradigm. Essentially studies were classified as descriptive, correlation or intervention. They were then located within a methodology or paradigm, either biomedical or socio-cultural. Finally, the studies were classified according to quantitative or qualitative research method.

This review of infant feeding research has highlighted the overwhelming emphasis toward biomedical quantitative research in New Zealand infant feeding studies. It further illustrated a lack of infant feeding research that takes either a socio-cultural, or qualitative perspective. Ryan's work locates infant feeding within the wider move towards "Domestic science". Much of the existing literature is the work of medical practitioners. This is not surprising when one considers that medical researchers have traditionally attracted funding for health research. Medicalisation of infant feeding was most significant after the Second World War. Apple (1994) asserts that " in both the United States and New Zealand, the medical profession holds a pivotal place in the move from breastfeeding to artificial infant feeding" (p.33).

2.3   Medicalisation and breastfeeding

The entire process of infant feeding underwent something of a scientific revolution, with the advance of human science and technology. Obermeyer and Castle (1997) recognise this in the following statement. "From the mid-nineteenth century, the commercial availability of breastmilk substitutes was to usher in a new phase in patterns of infant feeding, marked by the professionalisation of feeding, the scientific approach to children's needs, and the increased role of experts in defining the domain of breastfeeding" (p.50). It is this tripartite endeavour (technological advances, professional expertise and science as a dominant philosophy) which facilitated the medicalisation of infant feeding and decline in international breastfeeding rates.

In the United Kingdom the first processed milks were marketed in 1883 (Obermeyer & Castle, 1997). Medical experts quickly accepted and endorsed the practice of artificial infant feeding. The American Medical Association, in 1930, approved and offered detailed instructions for the preparation of infant formula. This approval was issued with the proviso that the formula preparation was restricted to doctors only. "The new product was presented as powerful yet reliable, and its preparation required an elaborate paraphernalia that symbolised the modern world of progress and the faith in technology" (Obermeyer & Castle, p.50). Consistent with the scientific philosophy of the time was the notion of mechanisation, regularity and schedule. The theory of mechanisation and reductionistic explanation was applied to childcare practices and breastfeeding.

The influence of a scientific approach to childcare practices is reflected in this statement by Beekman who asserts it is, "...in the early twentieth century, [that] we find a conscious, systematic effort to actually turn the child into a biological machine" (Beekman, 1977, p.110). Beekman noted that the understanding of children in a scientific sense was restricted. However, production of milk (bovine) and the associated characteristics of regularity, repetition and scheduling were well recognised. These characteristics were easily transferable to infant feeding. Regularity was promoted as the cornerstone of good mothering, this is demonstrated in a poem entitled 'For the Young Mother',

The clock is the Baby's truest friend

As every Mother ought to know

From early dawn to evening's end,

It points the way the day should go!

'Wake up'! it says at six o'clock,

'Wake up and have your morning meal!'

And later, 'Time to bathe, (tick tock!)'

And "oh how happy you will feel!'

Then, 'Eat again' then, 'Sleep,' then

'Take your daily airing,' thus it goes-

So mother ought, for Baby's sake,

To take the clock's advice! It knows!

    (Eldren & Le Cron, 1921, in Beekman, 1977, p.109).

With the increased understanding of the biochemical composition of breast milk various feeding schedules were prescribed by the medical profession based on the science of infant feeding. Thus, a child-led event (breastfeeding) became a medicalised issue; infant feeding, breastfeeding, had become a preventive health problem, to be regulated and controlled (Beasley, 1993; Van Esterik, 1989). To this end the power to determine feeding patterns and processes was subsumed by health professionals (Van Esterik, 1989, p.112).

Obermeyer and Castle (1997) suggested that the marketing and acceptance of breast milk substitutes were due to a number of factors. They included the perceived power and prestige of the formula providers who offered a new and improved alternative to human milk. Also the privileged status accorded to men was conferred to formula feeding women. Now women could be free from the biologically determined role of breastfeeding. The resumption of sexual activity, associated with non-lactation was also perceived to be a beneficial outcome from the use of infant formula.

This new product, infant formula, bolstered doubts about human milk as the optimal product. In the early 1900s the British Empire spread the good news of a readily available protein source (cows' milk) for the colonial nations (Obermeyer & Castle, 1997). This good news was well received by New Zealand, as one of the colonial

outposts able to produce large quantities of cows' milk for the British market. The scientific emphasis toward mothering was perpetuated by medical approaches toward infant feeding. It was this ideology (mothering as a science) that was promoted in New Zealand as a central concern of the Royal New Zealand Plunket Society.

2.4 Royal New Zealand Plunket Society

Founded by Dr Truby King, in 1907, the Royal New Zealand Plunket Society was established as a national infant care provider (Davidson, 1984; Parry, 1982). Dr King was concerned with the state of infant health in the nation. The racial decline (of European New Zealanders) and the low rate of births for middle classes constituted a concern in the new colony (Parry, 1982, p.17). The fashion for the upper classes not to breastfeed, contributed to a poor survival rate for infants in the first year of their life. These concerns sparked interest in safe and appropriate artificial infant feeding methods. While early documentation about artificial infant feeding was in existence (Davidson, 1984, p.7) the full impact of artificial feeding literature was not evident at the turn of the century. Dr Truby King, originally a medical superintendent at Seacliff mental hospital, had developed an interest in the effect of diet on health. Dr King's application of the new scientific methods for farming demonstrated good results with livestock raising and plant growth. Dr King sought to apply the same scientific approach toward infant health (Davidson, 1984). Convinced that good nutrition effected mental health Dr King set about humanising cows' milk as a scientific option for infant feeding (Parry, 1982, p.18). Despite some medical resistance to Dr King's methods, infants who had been failing to thrive on pap based infant foods thrived on 'humanised milk'. A comic jingle at the time reflects this,

> Hark the Herald Angels sing
> Glory to our Truby King.
> he has humanised the cow,
> She will feed our babies now.
> joyful all ye people rise,
> Fattest brat takes Plunket prize.
> Hear his lectures, read his tracts,

study all his latest facts;

Then unite with us to sing

Glory to our Truby King. (Parry, 1982, p.51).

Thus, began a long association of the Royal New Zealand Plunket Society with milk marketing industries. This started with the small scale bottled product of humanised milk in 1906 from the Dunedin outlet, Peninsula Milk Company, and culminated in the development of Karitane Products Society in 1927. Karitane Products was a company which manufactured a variety of infant feeding products and contributed funds to the Royal Plunket Society (Davidson, 1984).

The Royal New Zealand Plunket Society, named after the patron Lady Plunket, gained respectability through association with the influential members of New Zealand society. It was the concern of the Society that mothers be properly directed in the most scientific approaches to infant health. This sentiment was espoused by the patron, Lady Plunket, in one of her recorded speeches

> Instinct becomes weaker and weaker as civilisation increases, being replaced in mankind by the higher power of reason and understanding. The maternal instinct is not even a sufficient guide for the mother who nurses her baby, and it is no guide at all to those who resort to bottle feed (cited in Parry, 1982, p.46).

Scientific feeding gained rapid credibility, the training of Lady Plunket nurses and a nationwide network of volunteer members supporting health nurses and hospitals soon became entrenched in the nation's health system. It must be mentioned that Dr King did not oppose breastfeeding, rather the opposite, he proposed it as the most suitable of infant feeding methods. However, this endorsement of breastfeeding was qualified; scientific principles of regularity, amounts and duration must be applied to the practice of breastfeeding. This practice was an appropriation of artificial feeding management to the practice of breastfeeding, not an entirely compatible position. As Apple (1994) explains, Plunket nurses enforced the rules of medicalised feeding, such as fixed feeding schedules. This commitment to rigid rules often resulted in advice to wean breastfed babies to artificial bottle feeding rather than breastfeed more regularly. This practice had impact on breastfeeding rates in New Zealand, despite which the Plunket Society had a dramatic beneficial effect on the mortality

rates of infants. The advancement of family hygiene and emphasis on appropriate food preparation along with nursing interventions and childcare redressed many of the social concerns of the time. Only a few years after the inception of the Plunket Society the national mortality rate was halved to 40 per 1,000 live births (Parry, 1982, p.50).

2.5 Hospitalised births

Although the Royal New Zealand Plunket Society had influence on the infant feeding practice in New Zealand, this was not exclusive, as medical practice and therefore hospital practices exerted their own pressures on breastfeeding. A dramatic shift to hospitalised births occurred in New Zealand. In 1927 some 60% of confinements were in maternity hospitals; in 1936 the percentage had risen to 80% (Apple, 1994). This change was a reflection of the wider move to the scientism of private domestic life. It was during the 1950s-1980 that breastfeeding declined most dramatically. Infant feeding practices during this time reflected the adherence to bottle feeding principles. These principles are reflected in the practice of rigid feeding schedules, restricted suckling times, separation of the mother and baby at birth combined with complementary bottle feeds, a ban on night breastfeeding and test weighing (p.35). These rules, combined with an often impersonal approach, reinforced the perception of women as incompetent and health professionals as expert (Apple, 1994; Hercock, 1991). As the breastfeeding rates declined and artificial feeding reached its zenith, researchers turned their attention to understanding the trends and rationale for breastfeeding.

New Zealand health professionals embraced artificial infant feeding at a cost to breastfeeding. This was reflected in a profound statement by Hood, Faed, Silva, and Buckfield (1978); "The primary source of post war decline in breastfeeding in New Zealand is considered to have been mismanagement of lactation by health professionals" (p.275). In 1945 a marked decline in breastfeeding rates sparked some concern by health professionals. Not until 1960 did the decline halt and the trend reverse (Ryan & Beresford, 1997). Starling, Fergusson, Horwood, and Taylor noted in a 1979 study that over 80% of mothers intended to breastfeed their infants however only half of these achieved their goal. It is worth noting that the first year

of increase in breastfeeding coincided with the start of the La Leche League in New Zealand (p.276). Indeed Starling et al., (1979) concluded that, "…the likelihood of successful breastfeeding might be increased by rooming in, avoidance of unnecessary complementary feeding, and the greater support and education of the mother" (p.273).

Medicalisation of infant feeding combined with a comprehensive marketing strategy for infant formula was a powerful influence on the feeding practices initially in western countries and more latterly in the third world countries. It was not until evidence of health demographics from third world countries became a public concern that international policy makers responded. The application of reductionistic mechanical and scientific theory by way of artificial feeding practices to the practice of infant feeding from the breast had come with a price.

2.6 International breastfeeding policy

The development of NZ government breastfeeding policy is a relatively recent event in the history of infant feeding. There are records of more ancient international policies. According to Fildes (1995) the Koran indicates a weaning age of two years, and documents on the regulation of wet nursing have been dated at c.1728-1686 BC. It seems that society has historically managed breastfeeding as a socially defined practice subject to rules and laws.

With the decline of breastfeeding rates in the western world and an increasing trend to decline in developing countries (Coates, 1993) three significant events, each interrelated, started to impact on modern breastfeeding policy. The first was a significant lobby by pressure groups (primarily from the United States of America (USA) and Australia), for governments to regulate the commercial infant formula companies. The second was the development, by international forums, of a policy to support, protect and promote breastfeeding and finally, the impact of health workers and health services delivering care to breastfeeding women. These three factors have shaped the current New Zealand governmental policy for health professionals on breastfeeding.

2.7   The breastfeeding lobby

During the 1970s, in the USA, a surge of negative public opinion impacted on the commercial infant formula companies, resulting in a proliferation of non-governmental international pressure groups (Van Esterik, 1995). Groups such as the Interfaith Centre for Corporate Responsibility (ICCR), the Infant Formula Action Coalition (INFACT), Baby Milk Action Group, Geneva Infant Feeding Association (GIFA) were all networked to an integrated group known as the International Baby Food Action Network (IBFAN). The networked groups collected data on the multi-national formula companies and were instrumental in the boycott of Nestle's products in the early 1980s (Van Esterik, 1995).

The campaign by these pressure groups combined with the lobby of health professionals for the development of guidelines on infant feeding, in forums such as the Protein-Calorie Advisory Group (United Nations), added increased pressure to the need for the development of breastfeeding-related policy. The combination of rising public opinion, pressure groups and health professional interest resulted in an initial meeting convened by the World Health Organisation (WHO) and United Nations International Childrens' Emergency Fund (UNICEF) (1979) to develop an international code to regulate the marketing of breast milk substitutes.

2.8   Code to regulate the marketing of breast milk substitutes

This code was finally produced as the *International Code of Marketing of Breast-Milk Substitutes* (WHO/UNICEF, 1981). According to Bevin (1992, p.16) the code "... provides a framework for action and for the formulation of a breastfeeding promotion strategy, and it spells out the obligations of governments and health workers alike". It was adopted in a vote of 118 countries. Interestingly there were three abstentions and one negative vote, the latter being the USA vote. This negative vote, by American representation, was surprising given the considerable American involvement and initiation of the process (Van Esterick, 1995). New Zealand voted

and signed the 1981 recommendation of the code (Bevin, 1992). The document is dominated by an attention to aspects of commercial marketing, yet the code has far wider scope than those aspects alone.

The pre-amble in the code makes a number of statements of intent regarding the implementation of the code by consenting countries. One salient statement (within the code) asks signatories to appreciate that social and economic factors affect breastfeeding and indicates that governments should create an environment that fosters appropriate family and community support. In this respect the code seeks to actively promote and encourage breastfeeding.

Van Esterick (1995, p.155) elaborates that the code is not a code of ethics but rather a set of rules for industry, governments and health workers to regulate the marketing and promotion of baby foods. It is worth noting that this document was produced in consultation with the industry, specifically the International Council for Infant Food Industries (ICIFI) (Palmer, 1993, p.237), which represented the commercial concerns in the development of the code. Thus, the document of the code embodies, for many of the lobby groups, a compromise and represents a minimum standard (Van Esterik, 1995).

Enforcement of the International Code for the Marketing of Breast Milk Substitutes has been problematic, as the onus has rested with manufacturers and distributors to self-regulate the industry. Some countries have passed legislation to enact various elements of the code but generally the code was subjected to disagreement about interpretation (Van Esterik, 1995).

Compliance with the code is voluntary and it was not until 1983 that a New Zealand Breast Milk Substitutes Monitoring committee was formed under the auspices of the Department of Health (later to become the Public Health Commission). The committee while able to respond to violations of the code was unable to exert any enforcement authority. However in 1990 the monitoring committee was disbanded due to a lack of funding. The Public Health Commission assumed the task of monitoring the code and receiving information on international monitoring of the code and breastfeeding promotion (Alexander, 1994).

Clearly the code was less than adequate in directing the active promotion of breastfeeding. In recognition of the need for a document to address the active promotion of breastfeeding WHO and UNICEF convened an international policy-makers meeting. This group formulated the international document entitled the *Innocenti Declaration*[1] (1990).

2.9 Innocenti Declaration

This declaration was based on the policy statement `Protecting, Promoting and Supporting Breastfeeding: The role of the maternity services' (WHO/UNICEF, 1989). The Innocenti Declaration (1990) outlines four goals; the first concerned with the establishment of national breastfeeding co-ordinators. The second goal, the implementation by the maternity services of the Ten Steps to Successful Breastfeeding, thirdly the implementation of the WHO code and finally the enactment of laws for protecting the breastfeeding rights of employed women (WHO/UNICEF, 1990). The declaration has been widely adopted by health agencies and is the international mandate to encourage the practice of breastfeeding.

The Innocenti Declaration explicitly notes that efforts should be made to increase women's confidence to breastfeed. It further notes that empowerment involves removal of constraints that influence or manipulate the perceptions of, and behaviours towards, breastfeeding. This direction to increase women's breastfeeding confidence has been largely ignored in any subsequent policy development.

The Department of Health (DOH) in New Zealand endorsed the 1990 Innocenti Declaration. At much the same time as the Declaration was endorsed (March, 1991) the New Zealand Lactation Consultant Association (NZLCA) was formed. With a ground swell of La Leche League (LLL) membership and the formation of the

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[1] The Innocenti Declaration was produced and adopted by those who participated in the WHO/UNICEF policy makers meeting. This meeting was entitled "Breastfeeding in the 1990's: A global initiative". The meeting was held at Spedale degi Innocenti, Florence, Italy, 30th July-1st August 1990 and was co-sponsored by the United States Agency for International Development (AID) and the Swedish International Authority (SIDA).

NZLCA combined with the Innocenti Declaration (1990) some pressure was exerted on the Department of Health to respond to the monitoring of the code.

A report from a postal survey of the New Zealand situation with regard to the code (Bevin, 1992) provided information about the lack of compliance with the code. This survey combined with the pressure from LLL, NZLCA and the Innocenti Declaration added support for governmental action. The Bevin (1992) report surveyed 45 relevant bodies (health boards, organisations such as the Royal New Zealand Plunket society Inc, and educational institutions). The 36 replies indicated donations of free or subsidised infant formulae were relatively wide spread (p.16). In her final summation Bevin stated "There is a continuing need for the International Code of Marketing Breast Milk Substitutes in New Zealand today, but it needs empowerment through legislation and education of those who can bring its goals to fruition" (p.17). In response to this report and pressure from health professional groups the Department of Health, in December 1991 (Annandale & Bevin, 1996), convened a meeting to reconsider the monitoring of the code.

From the time of the meeting in December 1991 until the implementation of the monitoring body for the code (1998) lobbyists expended considerable energy to promote the goal of establishing a formal monitoring body. Interested groups developed a Health Sector Code of Practice, while the New Zealand Institute of Formula Marketers Association (NZIFMA) developed an Industry Sector Code of Practice. These practice codes were released for public submission in April of 1996 (Implementing the World Health Organisation International Code for the Marketing of Breast Milk Substitutes, 1996). Gordon (1996, p. 5) notes that this production of policy by way of a code of practice is not consistent with the original call for a group to monitor the code in 1994. While countries are urged to tailor the code to their own needs and locate the code within a wider strategy for promotion, protection and support of breastfeeding (Clark, 1996), it seems that New Zealand has lacked a commitment in terms of will and financial resources to monitor the code.

Even with the establishment of a compliance panel (March 1998) to monitor breaches of the New Zealand interpretation of the code concern remains about the lack of any formal mechanisms to enforce the code in New Zealand. The body

within the Ministry of Health has only recently supported the outline of health workers' responsibilities within the code (Martyn, 1999; NZCOM, 1999).

The slow uptake and monitoring of the code prompted the formation of an international lobby group. The group World Alliance for Breastfeeding Action (WABA) was convened in 1991. A global network of organisations and individuals, WABA acts on the Innocenti Declaration (1990) in liaison with UNICEF. This group has some prominence in New Zealand with the annual event of world breastfeeding week August 1st –7th. World Alliance for Breastfeeding Action also contributed to the breastfeeding policy initiative entitled *The Baby Friendly Hospital Initiative* (BFHI).

2.10 The Baby Friendly Hospital Initiative

The Baby Friendly Hospital Initiative (BFHI) is based on a ten-step plan outlined in a WHO/UNICEF document, 'Ten Steps to Successful Breastfeeding' (Grant, 1991; McIntyre, 1993). The ten step plan involves the demonstration of breastfeeding policy, training for health care workers, pregnancy counselling, early initiation of breastfeeding, practical breastfeeding support, rooming in, infant led feeding, the fostering of support groups and the restriction of artificial nutrition or pacifiers (Coates, 1993). The steps were formulated on existing research, research that offers limited evidence for the individual steps, but non-the-less is sensible and self-evident (Vogel & Mitchell, 1998, p.173).

The BFHI has been well received and implemented in many countries, with over 1000 hospitals world-wide approved as baby-friendly by 1994 (Van Esterik, 1995) and a staggering 8,041 by August 1996. The spread of countries adopting BFHI and being accredited as baby friendly hospitals is also growing, from just 12 countries in 1992 to an impressive 171 countries (with some 10,373 BFH) by February 1997 (Vogel & Mitchell, 1998). The latest figures from the World Alliance Breastfeeding Action group (P.R. Abdul Razak, personal communication, November 24, 1999) report an official 14, 546 Baby Friendly hospitals in the world.

The accreditation process for Baby Friendly hospitals has been facilitated by various mechanisms to monitor and enable the implementation of BFHI. One such mechanism is the national report card on breastfeeding and the adoption of BFHI. This is a mechanism for countries to monitor breastfeeding rates, policy, and the development of BFHI, and compliance with the International Code for Marketing of Breast Milk Substitutes (Annandale & Bevin, 1996; WABA, 1995). Many countries (Australia, Canada, United Kingdom and the United States of America) have also established national BFHI authorities to facilitate the implementation of the BFHI (Annandale & Bevin, 1996).

With the launching by WHO and UNICEF of the global Baby-Friendly Hospital Initiative in March of 1992 many national and international forums were instigated. In April of 1992 the NZLCA was invited to Australia to discuss BFHI but was unable to attend due to lack of funding. Throughout 1992, the theme of BFHI was dominant, both in health promotion material from the Department of Health and as the WABA breastfeeding week theme. Not until 1992 did national policy on the protection, promotion and support of breastfeeding occur, this initiative coming from the then recently formed College of Midwives. The documentation was a handbook entitled *Protecting, promoting and supporting breastfeeding* (New Zealand College of Midwives, 1992) and was adopted by many of the nation's maternity services. The Royal New Zealand Plunket Society Inc. also adopted this handbook as national policy, then later developed their own breastfeeding policy, *Royal New Zealand Society Breastfeeding Policy* (1996).

In February 1994 the Ministry of Health invited some twenty participants to an inaugural BFHI meeting. At this meeting the BFHI was endorsed. Subsequently in 1996 a taskforce, the New Zealand Initiative BFHI Task force (NZBIT), was established with lines of responsibility to the Ministry of Health, the Public Health Commission and the New Zealand committee of UNICEF. The BFHI was consequently referred to in at least three of the 1993-1994 Public Health Commission's (PHC) advice documents to the Minister of Health. Specifically BFHI is mentioned in the documents *Sudden Infant Death Syndrome (SIDS)* (1994, p.10, 16,18); *Food and Nutrition* (1995, p.15); *Child Hearing Loss* (1994, p.15, 17). The Public Health Commission (1994) also acknowledged the benefits of breastfeeding

as healthy practice and called for breastfeeding to six months as a national health goal. Subsequent Public Health Commission documents, *He Matariki A strategic plan for Maori public health*, (1995, p.86); *National Plan of Action for Nutrition*, (1995, p.54, 65, 74); *Parenting*, (1995, p.18, 41) *Prevention of child hearing loss*, (1995, p.52) and the National Health Advisory Committee document *Tamariki Ora*, (1993, p.20) have recognised the importance of breastfeeding. The most explicit of these is the document *Food and nutrition guidelines for healthy infants and toddlers and healthy breastfeeding women* (PHC, 1995) which acknowledges the role of the WHO/UNICEF Ten steps to Successful Breastfeeding and the WHO Code for Marketing of Breast Milk Substitutes document. The food and nutrition guidelines direct New Zealand health policies "To promote breastfeeding to health professionals and mothers... to encourage breastfeeding and control promotion of infant formulas and other aspects of bottle feeding to prevent unnecessary use of breast milk substitutes" (p.4). No further mention of the adoption or implementation of these policies into health service delivery is made throughout the 44-page document.

Breastfeeding advocates, both volunteer and health professionals, have continued to lobby for the BFHI in New Zealand. A review of Auckland hospitals and their compliance with the 'Ten steps to successful breastfeeding' was undertaken in December-January 1994-1995 (Si, Chong, & Mitchell, 1995). In a report on the study it is noted that "the study concluded that the compliance of the hospitals reviewed fell well below the Global Criteria levels" (Vogel & Mitchell, 1998, p.184). A New Zealand Breastfeeding Authority (inclusive of the existing NZBIT), was established (MOH, 1998) to facilitate the implementation of the BFHI; this was fully functional by 1999. Survey of the status of a sample of New Zealand hospitals to determine the BFHI readiness and identify aspects for improvement has been undertaken (Pownall, 2000).

Nurses who are involved with the care of breastfeeding women are directed by policies such as the Baby Friendly Hospital Initiative, Ten Steps to Successful Breastfeeding, the Innocenti Declaration (1990) and the International Code for the Marketing of Breast Milk Substitutes (1981). The mandate to protect, promote and support breastfeeding is generated from international organisations such as the

World Health Organisation (WHO) and UNICEF. The World Health Organisation (1995) issued an international statement about breastfeeding, in which it recommended that infants should be exclusively breastfed for the first four to six months and after this period they should be breastfed (not exclusively) for up to two years of age and beyond. These policies represent the consideration of public health and population based strategists. The consultation for the development of policy has been with bio-medical experts and lobby groups. There has been no ground swell of consumer voice directing these policies rather a faithful few committed health professionals voicing constant concern about a lack of governmental commitment to breastfeeding.

The Baby Friendly Hospital Initiative is still not implemented in New Zealand[2], though support for the initiative is active. A newly appointed compliance panel (MOH, 1998, p.41) currently monitors the Code for the Marketing of Breast Milk Substitutes. It has been because of international pressure and the lobby of breastfeeding advocates that BFHI and code compliance has been given resources within the Ministry of Health; historically the lesson has been that such constant pressure is imperative. The World Health Assembly's advice (May, 1996) to Member States is that they should ensure that no conflict exists to impede the WHO/UNICEF Baby Friendly Hospital Initiative and the application of the monitoring of the International Code, particularly any commercial influence.

The development of these international policy statements is indicative of a population-based approach to health care. Policy formation can be directly associated with lobby by various health professional and nutrition groups. An underlying current between health care workers and commercial infant formula

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[2] In March 2000, a Breastfeeding Authority (BA) was established through the Northern Health Funding Authority and was resourced for the training of BFHI assessors and trainers. Workshops in Auckland, Wellington and Christchurch were established to inform health professionals and consumers about BFHI accreditation and furthering their BFHI goals. The BFHI was launched throughout New Zealand in August 2000. The scheme is to be self-funded with institutions who wish to explore accreditation paying for training and assessment. As of January 2001, no hospitals have made a formal request for BFHI assessment.

companies is evidenced as a tension to comply with international policy recommendation. In keeping with the BFHI 'Ten steps' health workers are to receive education and training in breastfeeding issues and practices. It might be expected that this policy would contribute to a demand for breastfeeding education and the development of expertise in breastfeeding, however this has not been demonstrated.

It has been a few committed health workers who have actively engaged in breastfeeding specialisation. Some health workers and breastfeeding advocates who are particularly committed to promoting breastfeeding practices have undertaken specialist education and developed a specialist role.

2.11 The development of breastfeeding specialists

The lactation consultant as a specialist health worker came into existence in 1985. Auerbach and Riordan (1993) suggest that the lactation consultant was a product of the increasing interface between the art of breastfeeding and the science of lactation (p.543). The rationale for the development of a lactation consultant, at the time, was that the La Leche League (LLL) recognised the explosion of scientific studies and the emergence of a new allied health worker, mostly from the ranks of LLL membership. Indeed the original work toward developing a training program for lactation consultants recognised the need to validate the expertise of the breastfeeding volunteer worker, while also setting a minimum standard for those who were already formally gaining recompense for lactation consultant work (Auerbach & Riordan, 1993, p.544).

The LLL made a commitment to develop standards for breastfeeding support workers. This commitment initially took the form of a consultant department established in 1982. Drawing on the expertise of some 60 specialists (mainly medical) from a variety of geographic locations, the competencies and the scope of practice for a lactation consultant were developed (Scott, 1993). The result of this development was the founding of an independent body to regulate the certification of lactation consultants.

The International Board of Lactation Consultant Examiners (IBLCE) conducted the first examination in 1985 and has been monitoring and certifying lactation consultants since (IBLCE, 1996). It was during the mid 1980s that the La Leche League (LLL) New Zealand membership had huge support, to the point that in 1988 New Zealand had the highest number of groups and leaders per capita in the world (Gordon, 1998).

Specifically the lactation consultant is credentialed to, "provide quality breastfeeding care; develop and implement a breastfeeding protocol; improve the lactation knowledge and skills of other staff; enable the institution to become accredited under the Baby Friendly Hospital Initiative" (International Board of Lactation Consultant Examiners, 1996, p.4). For many volunteer breastfeeding support workers the advent of the lactation consultant credential offered an opportunity to formalise their expertise and validate their practice in such as way as to make it possible to trade as an independent consultant and thus gain paid employment.

For many lactation consultants the opportunity to work in the field without a nursing, midwifery or medical qualification provided an opportunity to promote a breastfeeding philosophy more akin to the woman-centered La Leche League mother-to-mother support. The philosophy expressed by the La Leche League values and promotes the benefits of breast milk for infant health and is summarised in the statement that, "Mothering through breastfeeding is the most natural and effective way of understanding and satisfying the needs of the baby" (Gigante, 1997, p.53).

For some lactation consultants the departure from medical dominance, characterised by medical opinion as expert opinion, was considered a major breakthrough. Statistics indicate that the number of lactation consultants who are nurses, midwives or doctors is significant both internationally and within New Zealand (Auerbach & Riordan, 1993; Walker, 1996). Thus, in the New Zealand context the credential of lactation consultant is usually complementary to some other health professional credential, such as that of registered nurse, Plunket nurse or midwife.

Between the formation of the New Zealand Lactation Consultants' Association in 1991 (Annandale & Bevin, 1996) and 1996 over 111 IBCLCs in New Zealand were

successful with the certifying examination (Walker, 1996). A survey representing 70% of the lactation consultants in New Zealand, found the two largest groups of these health workers are the Plunket nurses and midwives, the greater of these two groups being midwives (Walker, 1996, p.25). The study also found that very few (two to five) were employed as lactation consultants on an independent basis; overwhelmingly the group is employed by health service providers and only a few in that situation are employed for their lactation consultant skills alone. The data from Walker's study suggest that the lactation consultant role has not been embraced in New Zealand as a qualification for volunteer breastfeeding supporters, but as another credential for health workers.

A comment by Pessl (1996) suggests some dissatisfaction with lactation consultants' perspective toward breastfeeding advice. Pessl, states "I am troubled by the growing perception that lactation consultants are falling into the very traps of which we have been so critical -- unbending rules, and the health care professions' need to control" (Pessl, 1996, p.271). This is not a new criticism. New Zealand author, Beasley (1993) suggested that lactation consultants need to be aware of the factors that contribute to the medicalisation of breastfeeding and actively work to counteract this trend.

The result of health professional involvement in breastfeeding promotion has been a very ad hoc and variable approach to breastfeeding advice. This is demonstrated in documented research on the attitudes and the variable advice offered to women (Field & Renfrew, 1991; Lazzaro, Anderson & Auld, 1995; Lewinski, 1992; Patton, Beaman, Csar & Lewinski, 1996). These authors demonstrated that health professionals (doctors, nurses and midwives) are significantly influenced by their own personal experience of breastfeeding, focus their practice on physical concerns, are directed by the mothers' initial decisions about infant feeding, and have a recognised lack of knowledge about breastfeeding practices (Barnett, Sienkiewicz & Roholt, 1995). It is not surprising then, that health professionals are often perceived, by breastfeeding women, as offering conflicting breastfeeding advice (Bono, 1992; Chalmers, 1991). This is an important point when one considers the support nurses and other health workers claim to provide for breastfeeding women. The fact that some health professionals, (who are involved in clinical practice with breastfeeding

women) might also be certified lactation consultants has yet to impact on the outcome for breastfeeding women and is an area for further study.

Given that international and national policies exist for enabling breastfeeding and regulating infant milk substitutes, it is difficult to suggest that government and health service providers are not committed to promoting, protecting and supporting breastfeeding. While I do not wish to enter debate about effectiveness of policy and resources required to enact policy, it is important to locate the nurses within this discussion. Nurses have been instrumental in delivering policy by way of breastfeeding education and collecting data on breastfeeding trends, yet may confound and confuse the client by giving inappropriate advice and offering conflicting information. Despite policy for health professional breastfeeding education, very little real demand has been demonstrated in the New Zealand context.

Without attention to the interpersonal process of breastfeeding, health promotion strategies are a clumsy attempt to locate choice and attitude at a personal level (Gordon, 1989; Ivker, 1996). According to Palmer (1988) and Van Esterik (1989), a fundamentally bio-medical approach to policy and the enactment of this policy by health professionals, fails to account for the structural constraints associated with poverty, poor education and poor social networks. Bio-medical research, which has significantly informed policy, fails to account for the dynamic and interactive process of the breastfeeding experience. Amongst the evidence for breastfeeding promotion which is population-based and located within bio-medical research is the interpretation of breastfeeding trends.

2.12 Demographic trends

New Zealand infant feeding studies, during the 1960s and through to the 1980s, were concerned with infant feeding demographic trends (Davies, 1989; Flight & Adam, 1986; Gunn, 1984; Hood, et al., 1978; Msuya, Harding, Robinson, & McKenzie-Parnell, 1990; Perry & Trlin, 1985; Roberts, 1980; Salmond, 1974; Starling, et al., 1979; Trlin & Perry, 1982). The predominant theme in the literature concerned the incidence of breastfeeding and the factors influencing breastfeeding and duration. A

few studies during that time reflected a growing concern for Maori and Polynesian infant feeding practices and the health implications for infants in these populations (Anyon, 1976; Cantwell, 1973; Kerr, 1981; Stanhope, Tonkin & Martin, 1977). Essentially, these studies demonstrated the health risks associated with artificial feeding for Maori and Pacific Island groups. Later studies that contributed to breastfeeding knowledge were by association with other topics of interest and not studies that had a breastfeeding focus. Examples of this are a study by Johnson, Ford, Doran, and Richardson (1990) which surveyed iodide concentration of human milk and Murdoch, and Gunn (1991) on the topic of diagnosis of Down's syndrome which highlights breastfeeding difficulties for this group.

More recent influence on breastfeeding has come from research into cot death or Sudden Infant Death Syndrome (SIDS). Lack of breastfeeding has been recognised as a significant factor in the incidence of SIDS (Mitchell, et al., 1991) and has been part of a target for nationwide promotion of breastfeeding by health professionals (Mitchell, Aley & Eastwood, 1992; Scragg, Mitchell, Tonkin, & Hassall, 1993). The link between infant diet and SIDS was recognised in New Zealand literature by Money in 1978, particularly the risk associated with artificial feeding. The more recent SIDS research has been a catalyst to raise health professionals' awareness about the ethnic differences in mortality between Maori, South Pacific women and other ethnic groups in New Zealand (Mitchell & Scragg, 1994).

New Zealand has seen a demonstrable decline in breastfeeding among the indigenous people known as Maori (Ford, Mitchell & Taylor, 1993) and South Pacific women (Essex, Smale & Geddis, 1995). Indeed in the 1993-94 report to the Minister of Health, it was noted that the attributable risk by ethnicity for not exclusively breastfeeding (at discharge from hospital) was 14% for non-Maori and 22% for Maori (Mitchell, Stewart, Scragg, et al., 1993). This work contributed to the Public Health Commission's documented commitment to the Baby Friendly Hospital Initiative (Public Health Commission's Advice to the Minister of Health, 1993-94, p.16).

Much of the data that informs New Zealand health professionals about the demographic trends in breastfeeding is derived from the Royal New Zealand Plunket

Society (RNZPS) statistics. In 1946 Plunket nurses saw 77% of all New Zealand babies in the first 3 weeks, of these some 80% were breastfed. In 1969, Plunket nurses saw 83% of infants at the three-week age and the breastfeeding rate was 48% (Essex, Smale & Geddis, 1995). The Essex, Smale, and Geddis (1995) study suggests that 1993 data from RNZPS indicate that at three weeks of age 87% of infants were breastfed. It is worth noting that rates for exclusive feeding (no other fluids) are much lower than this. In 1990-91 exclusive breastfeeding rates were, 93.8% at birth, 68.4% at six weeks, 47.6% at three months and 2.5% at six months (Essex, Smale & Geddis, 1995). Keeping in mind the World Health Organisation recommendation for all infants to be breastfed exclusively from birth to six months of age (WHO, 1995), the nation's statistics were low.

Currently the RNZPS collects breastfeeding data nationally however discrepancy between the consistent use of definitions for breastfeeding between the RNZPS and other studies has made it very difficult to ascertain actual breastfeeding rates (Ministry of Health, 1998). The Ministry of Health (MOH) held a workshop in March 1998 in an attempt to determine how to improve the accuracy of collection and application of definitions of breastfeeding. The recommendations from this workshop indicated the need for clear and consistent indicators as a pivotal part of a periodic survey for monitoring infant feeding practices (Ministry of Health, 1998, p.41). The somewhat shambolic nature of New Zealand data collection for national breastfeeding rates only confuses health workers and policy planners. I suspect it has little impact on the day-to-day reality for breastfeeding women, and this is appropriate as breastfeeding women did not request the information nor is it directly relevant to them. Breastfeeding women are instead the recipients of policy enactment by health professionals such as nurses.

The MOH reported in 1998 on the progress of breastfeeding targets. The targets were 75% of infants being fully breastfed at three months, and 75% having some amount of breastfeeding at six months (MOH, 1997). The levels reported in 1997 were 48% at three months and 56% partial breastfeeding at six months (MOH, 1997). The 1998 report of the targets indicates that there has been no change in the prevalence of full breastfeeding at three months between 1994 and 1997 and no significant change in partial or full breastfeeding at six months from 1987-1996. The six-month, any-

breastfeeding amount, rates were estimated to be at 56%. The report notes that poor progress toward target breastfeeding rates has been made in both the fully breastfed by three months and fully or partially breastfed by six months. A more recent study (Vogel, Hutchison & Mitchell, 1999) drew a sample of 350 women from one New Zealand hospital and found that breastfeeding was initiated by 97% of the women. These authors found that 75% of women were still breastfeeding (some feeds) at three months and 44% were fully breastfeeding. By twelve months 30% of the women were offering some breastfeeds. The study found that the median age for cessation of breastfeeding was 7.6 months. These figures indicate that the breastfeeding targets may well be unattainable. This has prompted the MOH to consider strategies that might move the population-based figures toward the national breastfeeding targets.

The MOH report (1998) indicates six strategies to improve breastfeeding rates. Of these strategies several are policy-related in particular the New Zealand position on Baby Friendly Hospital Initiative (BFHI) and the International Code for the Marketing of Breast Milk Substitutes. The application of the policy-related initiatives is of course reasonable but it does indicate a rather cyclic and self-defeating attempt given the history of implementing these initiatives in New Zealand.

The studies and breastfeeding data that inform policy represent breastfeeding as a health act that is quantified and classified according to time and duration, rather than a dynamic interaction and the more interpersonal infant feeding practice. Demographic information is useful in directing public policy but it is not so useful for understanding personally located differences and it contributes little to an interpersonal understanding of breastfeeding. As such, demographic data offer health care workers some indication of breastfeeding within populations and the measure of a defined breastfeeding target.

Considerable energy has been located at the policy end of breastfeeding promotion, yet there remains little attention to the reality of breastfeeding within that same socio-political environment. The conflicting advice of health professionals reflects this confusion and a lack of political commitment to breastfeeding. Health

professionals such as nurses are engaged in promoting breastfeeding, though many are unaware of the documented policy. Those who are aware of policy directives interpret policy in a variety of ways, in order to deal pragmatically with individual breastfeeding circumstances, problems and concerns. Nurses are enacting the policy to support the practice of breastfeeding, yet due to a lack of evidence about the more interpersonal aspects of breastfeeding are ill equipped to determine just how effective that support might be.

2.13 Locating breastfeeding policy at the personal level

The 1998 *Progress on Health Outcome Targets* published by the Ministry of Health does acknowledge amongst the strategies for advancing breastfeeding, three strategies that may be located at the personal level. The first, "public education" (p.40), noted a list of MOH-produced documents that provide information about breastfeeding and nutrition. This strategy also lists the health promotion material such as posters that can be obtained. The second is entitled "personal health" (p.41) and recommended the increase in midwifery home visits during the early postnatal stage. This increase in home visits is hoped to provide more support for the establishment of breastfeeding. The third strategy is entitled "supportive environments" (p.41) and noted the existence of a range of health workers who may support breastfeeding women. This section also suggested that crèche facilities and parental leave are likely to support breastfeeding. Each of these strategies indicates that some attention is being given to a somewhat limited notion of personal support. I will elaborate further on social support and breastfeeding in Chapter Three, however it is useful to consider why such attention to this aspect is becoming more visible in policy documents. I would suggest that in part, this attention is due to a recent trend in breastfeeding research to the experiential aspects of breastfeeding.

In order to understand this unique experience researchers, nurses and any who may be concerned with the promotion of breastfeeding must, according to Ewing and Morse (1989), pay attention to the 'voice' and experience of breastfeeding women. Women's voice is not well recognised in the research literature. Rather, experts and

researchers contribute to a discussion that portrays the experience from various interest perspectives.

The International Lactation Consultants' Association (1992) published a position paper on infant feeding and noted that the breastfeeding experience has consequences for women's self-concern and sense of worth. The paper called for breastfeeding research into the psychosocial aspects of the breastfeeding experience. Authors have called for a move away from research that contributes a narrow, biomedical and western perspective (Beasley, 1991; Vnuk & Silagy, 1995). These authors suggest a new direction in research to a more inductive and anthropological understanding of the contextual, experiential and cultural aspects of breastfeeding. The call for women to reclaim breastfeeding and define the experience (Palmer, 1991) has started to impact on breastfeeding research and is evidenced in the more current breastfeeding study approaches. According to Bottorff (1990) breastfeeding is a deeply personal and unique experience that is best defined by those experiencing it. New Zealand authors have noted the importance of attending to the experiential aspects of breastfeeding (Bradfield, 1995; Sakulneya, 1986). This commitment to women's experience of breastfeeding has been argued within the literature on breastfeeding success.

The consideration of successful breastfeeding is important in the light of this study as it affirms my position regarding women's ability to self determine. I hold the position in this study that successful breastfeeding is that which the breastfeeding woman identifies as successful (Leff, Gagne & Jefferis, 1994). In a landmark study on successful breastfeeding Leff et al., drew on data from interviews with breastfeeding women, in order to provide a definition of successful breastfeeding that represented a breastfeeding woman's perspective. The authors found that an overall theme 'working in harmony' best represented the five categories the women in the study considered present in successful breastfeeding. The five categories are presented in the report by Leff et al., (1994, p.99) as, infant health, infant satisfaction, maternal enjoyment, desired maternal role attainment and lifestyle compatibility. Earlier work by Harrison, Morse, and Prowse (1985) had noted that the maternal-infant relationship and the mother's ability to manage breastfeeding in her social setting were aspects of breastfeeding success more frequently reported by

lay articles. These more affective aspects of breastfeeding represent infant and mother dynamics, such as satisfaction and enjoyment. The idea of 'working in harmony' is a theme that represents interpersonal and affective dynamics. Thus breastfeeding success is more about process than product.

The more usual determination of breastfeeding success is represented in the medical and research based literature, which is concerned with well-defined qualifiers of successful breastfeeding. Qualifiers of successful breastfeeding recognise temporal parameters such as four to six month duration of exclusive breastfeeding (WHO, 1995), and intensity parameters such as, exclusive to token breastfeeding (Labbok & Krasovec, 1990), which are used by health professionals and researchers.

By using these definitions researchers and health professionals have been able to establish the characteristics of a successful breastfeeder and the demographic/ social factors associated with breastfeeding success (Buckner & Matsubara, 1993; Fahy & Holschier, 1988; Fisher, 1990; Locklin, 1995). Factors that have been associated with these definitions of breastfeeding success are breastfeeding women, who have high maternal age, advanced educational attainment, increased social networks, and good economic resources. Numerous New Zealand breastfeeding studies have supported these findings (Gunn, 1984; Perry & Trlin, 1985; Trlin & Perry, 1982), and have noted that women who have a second or subsequent baby and late introduction of supplements breastfeed for longer periods (Msuya, Harding, Robinson & McKenzie-Parnell, 1990).

Definitions of breastfeeding success are more arbitrary parameters and negate the woman's own perception of the breastfeeding experience. It seemed to me that in order to support the practice of breastfeeding it is important that both the nurse and breastfeeding mother should share their respective understandings of successful breastfeeding. The available literature demonstrates that women may be more concerned with the interpersonal dynamics of breastfeeding, than the duration or exclusivity of breastfeeding. Thus, any intervention to support breastfeeding must be directed toward a mutually recognisable goal and recognise the breastfeeding woman's perception of successful breastfeeding. The more typical approach to successful breastfeeding is evidenced in an article by Shore (1996), entitled

Successful breastfeeding. This article presents success as initiation and maintenance of breastfeeding and proceeds to provide the information considered necessary to attain this goal. The information for nurses presented in the article includes anatomy and physiology, the health benefits of breastfeeding, and breastfeeding techniques. At no stage in the article is the nurse encouraged to seek direction from the breastfeeding woman about her needs, wishes or experiences.

2.14 Conclusion

The history of infant feeding both internationally and nationally has shaped contemporary policy and nurses' perceptions of breastfeeding. Historically New Zealand has reflected the world-wide move toward scientific infant feeding practices. The Royal New Zealand Plunket Society (Inc) shaped the national infant feeding culture and perpetuated the early scientific principles of artificial infant feeding. The medical dominance in research and health professional education has influenced both historical practices and the more contemporary policy on infant feeding.

Implementation, within New Zealand, of international policy such as the Baby Friendly Hospital Initiatives and the Code for the Marketing of Breast Milk Substitutes has been fraught with difficulties. These policies and those such as the Ten Steps to Successful Breastfeeding have been acknowledged by the Ministry of Health in various publications but have not received tangible and effective financial or governmental resources. Health professionals such as nurses have been directed to acknowledge and implement these policies with very little support or assistance and an overwhelming lack of national funding.

Public health policy on breastfeeding offers a population-based health strategy and has negated the individual experience of women. Health promotion literature directed at informing nurses' practice has been predominantly informed by bio-medical research. The literature informing health professionals about breastfeeding has marginalised the woman's experience and perspectives. The advent of lactation specialists (Lactation Consultants) has raised the profile of breastfeeding as a specialist field of knowledge and practice, but failed to advance the breastfeeding

woman's perspective. This is evidenced in the definitions of breastfeeding and breastfeeding success. The definitions applied by health professionals and nurses fail to recognise the woman's perspective; they serve the concerns of the health professionals.

Nurses and other health professionals are directed to enact breastfeeding policy. The nurse-client relationship and interaction represents the enactment of policy and contemporary breastfeeding knowledge. In order to explore further the nurses' effect and women's experience of breastfeeding I was drawn to consider the intervention called 'support'. The following chapter locates my own published work that considers nurses supporting women to breastfeed.

Chapter 3: Breastfeeding, social support and intimacy

3.1 Introduction

I have argued the benefits of breastfeeding and the historical and contemporary influences on health professionals to actualise policy and breastfeeding promotional strategies while largely ignoring the womens' located experience of breastfeeding. In this chapter an exploration of the literature on breastfeeding support is presented as the argument for personally located support strategies, in particular emotional support. I take time to briefly introduce the literature that addresses nurses and social support in order to highlight the emphasis in nursing practice to support the breastfeeding client. The link between social support and the concept of intimacy is then introduced. This link between support and intimacy is central to the thesis; for many health professionals the link has remained obscured by the concern for provision of tangible and physical support for breastfeeding women. The imperative for the present study is therefore highlighted. Further this chapter provides an audit trail for my considerations around breastfeeding and intimacy. The description of breastfeeding as intimate will be presented along with the rationale for further exploration of breastfeeding women's experience of intimacy.

It is not uncommon for nurses to note that the breastfeeding client would benefit from some extra 'support'. Given that breastfeeding has been demonstrated to be a worthwhile health intervention, the intention to 'support' the breastfeeding woman is usually to help sustain the practice of breastfeeding. I started my consideration about breastfeeding support, as a child health nurse, and began exploring the concept of support for my clients. I hoped to discover the most beneficial interventions for the promotion of successful breastfeeding. In the quest for an understanding of the effectiveness of breastfeeding support I identify the distinctions between physical, education and emotional support. This chapter considers the definition of support and presents the link between emotional support and the concept of intimacy.

3.2 Social support, breastfeeding and the health professional

It is an obvious assertion that 'support' may mean different things to different people. I once was painfully reminded of this, when at a study day for child health nurses, I posed the question; what supports breastfeeding? The only male in the room was keen to let me know that a good bra can be supportive! Clearly, I had not posed the question as I intended. In order to understand how nurses might 'support' breastfeeding women to a successful breastfeeding experience it was necessary to first consider a more conceptual approach to support, then review the literature that applies the idea of 'support' to breastfeeding. The following is a presentation of that work.

Callaghan and Morrissey (1993) suggest that social support as a concept is concerned with two functional positions. The first position is buffer theory and the second is attachment theory. Buffer theory, according to these authors, indicates that social support protects and buffers individuals from life's stresses. Attachment theory presents the position that social support is an adult expression of childhood behaviors, fostered as a result of attachment to another individual. Cobb (1976) supports this position and suggests that,

> Social support begins in utero, is best recognised at the maternal breast, and is communicated in a variety of ways, but especially in the way the baby is held (supported). As life progresses, support is derived increasingly from other members of the family, then from peers at work and in the community, and perhaps, in case of special needs, from a member of the helping professions (p.302).

The two positions, support as buffer and support as attachment, have arisen from the disciplines of psychology and medical sociology founded in work by authors such as Antonovsky (1972) and Bowlby (1971) and the more contemporary authors Cobb (1976), Cotton (1983), and Cohen and Syme (1985). These foundational authors have permeated the literature and shaped the applied perceptions of social support. They have provided a foundation to the nursing generated literature on social support. While these authors pose an explanation as to the effect of social support they do not readily describe what actions might constitute social support. Dimond

and Jones (1983) suggest that social support can be defined in four categories, "support as relational provisions, support as information, support as structure, and support as interaction" (p.235).

In essence Dimond and Jones (1983) are reflecting the activities of support. For example, support as relational provision includes the social networks and interpersonal aspects of support. Support as information, is information that conveys emotional support, information that leads the client to feel cared for and esteemed. Support as structure, refers to the characteristics of the client's social networks, i.e. does the client have an extended family available to help in tangible ways? Finally support as interaction, includes the types of interactions with others, the content, intensity and mutual sharing that occurs between individuals, are considered to be interaction support characteristics. What is clear from both the theory about social support and the activities associated with social support is the personal conveying of an intention, that communicates positive affect, social integration, instrumental behaviors and reciprocity (Dimond & Jones, p.238). It has also been noted that when patients' (clients') and nurses' perceptions are congruent, then support becomes more purposeful and acceptable (Gardner & Wheeler, 1987).

Social support according to Norbeck (1985) involves interpersonal interactions and relationships. These provide emotional support or actual help with patient needs. Support is both given and received by members of the individual's networks and not usually strangers or professionals. When support is not available from the usual social networks then health professionals may become the source of support (Cobb, 1976). A lack of social network or social support can influence help-seeking behaviors (Roberts, 1988). Indeed, there is a body of literature that considers social relationships as an essential component of health (Boddy, 1982; Dimond & Jones, 1983; Hubbard, Muhlenkamp & Brown, 1984; Muhlenkamp & Sayles, 1986; Maida, 1985). Nurses have contributed to the refinement of the concept and theory of social support, with studies that have reported on clinical intervention and concept measurement (Stewart & Tilden, 1995). There is no doubt that social support has become a central concern for nursing, particularly within health promotion activities (Stewart & Tilden, 1995). In 1984 the World Health Organization identified the

strengthening of social networks and social support as a health promotion strategy (WHO, 1984).

Nurses are considered by other health professionals to provide emotional support (Carlisle, 1990; Perlmutter, 1974). However, clients recognise support by nurses as, availability, physical care, moral support, problem solving, information sharing, individual care, control and confidence (Gardner & Wheeler, 1987, p.129). This perception is more in keeping with activities that nurses consider supportive, such as, information giving, problem solving, doing specific nursing tasks, reassurance, a friendly attitude and providing comfort measures (Gardner & Wheeler, p.130). A more recent work by Coffman, Levitt, and Deets (1991) noted that professional and personal supports are distinct. According to these authors it was personal support, from the person perceived to be closest to the client, that was significantly related to emotional affect and life satisfaction. The participants in the Coffman, Levitt, and Deets study did not perceive health professionals as the closest support person. This finding was congruent with the study by Coffman, Levitt, Deets and Quigley, (1991) which found that the nurse or health professional was not identified as a close support person. It seems that nurses have been slow to recognise the emotional support they might provide for a client, while other health professionals considered emotional support as part of the nurses' work.

3.3   Emotional support

The nurse who gives encouragement to her patient influences emotional well being according to Davidhizar (1991). Davidhizar suggests that strategies such as focusing on the positive, communicating respect, showing appreciation, making personal contact, avoiding a superior attitude and sharing personal experiences are emotionally supportive activities. Information that one is loved and esteemed is emotionally supportive as are expressions of empathy and understanding (Dimond & Jones, 1983). These activities are essentially those of friendship and this raises the issue of professional and personal boundaries. It has become increasingly difficult to differentiate between personal emotional support activities and the role of the nurse.

Phillips (1993) argues that in defining nursing as *caring*, nursing is presented as emotional care. This, the author argues, has resulted in the fragmentation of physical and emotional care. Phillips highlights the important fact that emotional care has now become a central tenet of nursing. While, nurses may regard caring as an emotionally supportive aspect of nursing, what of the clients' perceptions? One study on perceptions of social support networks indicated that women reported receiving more emotional support than males do (Stokes, Wilson & Grimard, 1984). Some evidence exists that clients may receive different types of support according to gender differences. These authors also demonstrated that social support was most strongly associated with the number of people a respondent felt close to and could confide in. Thus the nurse as support may be one of a social network. In order to consider this more fully it is useful to explore the role of the nurse as a support person to a breastfeeding client.

3.4 Breastfeeding: locating the nurse as support person

Support from the nurse does not always influence maternal life satisfaction or emotional affect (Coffman, Levitt & Deets, 1991). These authors recommend that nurses working with new mothers need to ascertain the close support person for each client and facilitate that person to support the new mother (p.413). The crux of this recommendation is for nurses to position their interventions more realistically, according to the woman's own perspective of the nurse-client relationship. This assertion is supported in the breastfeeding literature. According to Albers (1981) health professionals, such as nurses and midwives, have been found to be the least supportive person in a breastfeeding woman's network. The health professional is least influential in effecting breastfeeding decisions (Aberman & Kirchhoff, 1985). Indeed, health professionals may be perceived by breastfeeding women as an obstacle to success (Bergh, 1993). However, nurses may be effective support persons if they are part of a network that enables women to gain information about breastfeeding (Jenner, 1988). This is an important factor as it has been demonstrated that the receipt of informational support is higher in women who intend to breastfeed (Matich & Sims, 1992). The essential aspect here is the realistic relationship of the nurse to the breastfeeding woman.

The nurse is one person in a social network, and is not usually identified by the client as the closest support person. It is not until breastfeeding women are without the usual social networks that the nurse engages in emotional support as a more noticeable type of support (McNatt & Freston, 1992). When nurses are perceived to be emotionally supportive to breastfeeding mothers they offer encouragement, a positive attitude, empathy and concern (Albers, 1981). It is in a compensatory capacity that the nurse fills in for other more usual support persons.

Considering the nurse as a compensation support to breastfeeding women who are without usual support persons required a considerable mind-shift on my part. I had originally been concerned with effectively supporting breastfeeding women and now found that my direct support was least influential in the range of sources of support. In order to understand who is most supportive to breastfeeding women I needed to attend to the literature that represented this concern. This point is pivotal to this thesis as it demonstrates a continued commitment from health professionals such as nurses to explore breastfeeding women's reality. It is also the connection to the central concern of the thesis, breastfeeding and intimacy.

3.5   Breastfeeding and intimacy

It is the intimate support person who is most likely to affect maternal life satisfaction (Crnic, Greenberg, Ragozin, Robinson & Basham, 1983). As previously mentioned that person is likely to be described as the closest in the social network (Coffman, Levitt, Deets & Quigley, 1991). For the breastfeeding mother, the close or intimate person is most likely to be a spouse or kin (Isabella & Isabella, 1991; Ishii-Kuntz & Seccombe, 1989). The list of support persons can also include mothers, parents and friends (Albers, 1981; Basire, Pullon & McLeod, 1997; Bryant, 1982; Buckner & Matsubara, 1993). As I reviewed the literature about close support persons, the description of intimate relationships was recurrent. I noted that nurses reported intimacy as a part of care and healing, particularly demonstrated during physical nursing care and as therapeutic activities (Beeber, 1989; Burke-Draucker & Lannin, 1992; Dilorio, Faherty, & Manteuffel, 1991; Lumby, 1993; & Timmerman, 1991). Drawing on this recorded acknowledgement of intimate nursing activities I became

interested in further understanding the way nurses might be part of an intimate support network. I undertook a review of the concept 'intimacy' and published an article in 1995 entitled, *Understanding intimacy as experienced by breastfeeding women*. This work argued that,

> The concept of intimacy has much to offer toward the understanding of women's lived experience of breastfeeding. Intimacy can be explored in a framework that expands in curricular [sic] ripples outward from the woman, much like the ripples caused by a stone thrown into still water... first the point of most impact, the woman herself. The next wave is the infant-mother dyad, followed by the third wave, the woman's intimacy with a significant other such as the partner, a friend, and/or family (Dignam, 1995, p.468).

This work was speculative, in that it did not substantiate the ripple analogy, but rather posed this as one possible way of conceptualizing intimate relationships. The review highlighted the absence of any specific literature about intimate relationships as experienced by breastfeeding women. In the following sections I include key excerpts of the material from the work as outlined (Dignam, 1995). These excerpts locate both the concept and the literature, as applied to women, and intimate others, as I understood it at the time; the final aspect on the mother-infant relationship and breastfeeding, is presented in my 1995 paper. These excerpts (identified prominently in italics) locate my thinking and speculation prior to undertaking and formulating the study topic. Literature that has subsequently been reviewed, around this and other topic areas, has been included in the findings of this work as it has been directed by the analysis of the data for the present study and is therefore not located within the research background. The following quotes can be read in the context of the entire paper (Dignam, 1995) as it is reproduced with copyright consent (Appendix I).

3.5.1 *Intimacy: the concept*

Drawing on human development theories, McAdams (1988) suggested that 10 characteristics describe an intimate exchange between or among persons. These characteristics are, joy and mutual delight; reciprocal dialogue; openness; contact; union; receptivity; perceived harmony; concern for the well-being of the other; surrender of manipulative control and desire to master in relating to the other; and, finally, being

in an encounter, rather than striving or doing in the encounter. Reis
(1990) defined intimacy in similar terms:

> The intimacy process begins when one person *expresses*, through
> verbal or nonverbal means, personally *revealing* feelings or
> information to another person. It continues when the listener
> *responds* supportively or empathetically. For an interaction to
> become intimate, the disclosure must feel *understood, validated*,
> and *cared for* by the listener. Both participants' behavior depends
> on the other's behavior and *response*, as well as their own
> preexisting or situationally determined *motives, needs*, and *goals*
> (p. 16 emphasis added).

It would seem that intimacy is a qualitative characteristic which reflects
a positive motivation to surrendering control, to be defenseless, and is
therefore passive (McAdams & Constantian, 1983; Winter & Carlson,
1988). Timmerman (1991) explored the use of intimacy in nursing and
noted that "although intimacy appears a most important concept for
nursing, it is not visible in the nursing literature" (p. 21). Drawing from
the psychological and psychiatric literatures, Timmerman suggests that
(a) intimacy is difficult to measure, because it has a qualitative
dimension; (b) Intimacy is an essential aspect of human development; (c)
Intimacy is not [sic]static concept, but rather changes over time; and (d)
the experience of intimacy is gender specific. Timmerman then separated
physical intimacy from the concept of intimacy, by suggesting that
physicality may be a component but is not the sum of intimacy.

> The theoretical definition for intimacy is this: a quality of a
> relationship in which the individuals must have reciprocal feelings
> of trust and emotional closeness toward each other and are able to
> openly communicate thoughts and feelings with each other. The
> conditions that must be met for intimacy to occur include
> reciprocity of trust, emotional closeness, and self-disclosure
> (Timmerman, 1991, p. 19).

Friedman and Huls (1991) recognised the vulnerability implicit in
intimate exchanges and elaborated that intimacy involves the sharing of
the self on a most personal level and becoming vulnerable to another.
(Dignam, 1995, p. 478-479).

3.5.2 Women and Intimacy

...Ernst and Maquire (1987) considered women's mental health from a feminist perspective and recognised that intimacy for women involves identity issues. They suggested that intimate encounters dissolve the boundaries between self and other. Dowrick (1991) explored this theme, linking intimacy to self-expression suggesting that intimacy begins from inside, with the self. Goldhor-Learner (1989) also suggested that development of the self, as an authentic expression is essential for intimacy. She considered staying "connected" a healthy attribute and one that has impact on successful living. This ability to understand the authentic self via intimacy is different for men and women. Orbach and Eichenbaum (cited in Ernst & Maquire, 1987) offered a feminist analysis, exposing the need to be connected as linked to social requirements of feminine deference and submission and as a point of reference for women to formulate thoughts and feelings. That women value connectedness is illustrated in Talmadge and Dabb's (1990) finding that women were happier when they felt emotionally intimate. Research suggests that men perceive intimacy as a base for identity and value sexual intimacy more than women do; women may use intimacy as an identity tool through which self can be more fully defined (McAdams & Bryant, 1987; Talmadge & Dabbs, 1990). (Dignam, 1995, p.479-480).

3.5.3 Women and Intimate Others

It is the intimate support person who is most likely to affect maternal satisfaction (Crinc et al., 1983), and this person is most likely to be a spouse or kin (Isabella & Isabella, 1991; Ishii-Kuntz & Seccombe, 1989). Descriptive studies have elucidated cultural differences in support to breastfeeding women, and Cronenwett and Reinhardt (1987) found the source of influence to vary by ethnic background. Essentially, Anglo subjects viewed their husbands and friends as a major source of support and influence, whereas Puerto Ricans and Cubans turned to their mothers for advice on infant feeding. For Anglo women, spousal support

is a key component of successful breastfeeding (Cronenwett & Reinhardt, 1987; Isabella & Isabella, 1991) and may also be a major factor in maternal life satisfaction (Levitt et al., 1986). The inclusion of partner as influential support has been poorly addressed to date and the work by Jordan and Wall (1993) is to be commended. "Supporting the father during breast-feeding may help improve the mother's satisfaction with breastfeeding, duration of breastfeeding, and adaptation of both parents to parenting," they argued (Jordan & Wall, p. 31).

Salisbury (1992) identified communication as the factor that distinguishes intimate couples from those who have non-intimate relationships. Wynne and Wynne (1986) suggested that communication, that staying-in-touch factor, may be better developed in women as a result of their intense involvement with attachment and caregiver relationships with children. Women's better communication ability, combined with their inability to satisfy their needs by force, has resulted in the development of more subtle persuasion and responsiveness to the emotional connotations of language. In contrast, men have traditionally shouted down women, a practice that " is not the stuff of intimacy " (Wynne & Wynne, p. 390).

Combrinck-Graham and Kerns (1989) argued for the biological necessity of family's [sic] being close knit. They reminded us that intimacy in families is a matter of survival, for without intimacy the infant fails to thrive and without reciprocal intimacy the family fails to thrive. Combrinck-Graham and Kerns suggested that the confusion between intimacy and sexuality poses a threat to family intimacy. Using the example of the breastfeeding mother who is sexually stimulated by nursing her infant, they rightly pointed out that the deeper intimate relationship with a breastfed infant is similar to intimate sexual relationships. Health professionals might consider this when working with breastfeeding women. (Dignam, 1995, p.481-482).

3.5.4 Mother- infant Intimate Relationship

It is the woman's identity, shaped by her previous intimate experiences that extends to the infant at birth. This is the second ripple of intimacy in breastfeeding. At birth, the infant extends its intrauterine dependence to the external comfort of the mother's breasts. Montagu (1986) suggested that bodily contact to another provides an essential source of comfort, security, and warmth and an increasing aptitude for new experiences. This contact starts with breastfeeding, "from which all benisons flow and the promise of good things to come" (Montagu, p. 95). (Dignam, 1995, p.480).

This section of quotes from the Dignam (1995) article supports the interaction between mother and infant as characteristic of intimate exchanges. Characteristics of intimacy such as mutuality, reciprocity, being, joy, harmony, trust, emotional closeness and the physical touching of skin-to-skin contact are all evidenced in the breastfeeding experience. Many authors have eloquently described breastfeeding's symbiotic nature. Montagu (1986) spoke of suckling as an example of morphological maternal-infant reciprocity. Brazelton et al. (1974) discussed the mother-infant interaction in terms of reciprocity. Many women speak of the emotional closeness and pleasure they experience when breastfeeding (Maclean, 1990; Sakulneya, 1986). As one woman described, "Breast feeding is a very profound experience for both mother and child... I know that I'll never be as close again. And she'll never be as close to me again..." (Maclean, 1990, p.100). Although it may not be such a mutually pleasurable activity for many women, it is evident that for those that experience the intimacy of breastfeeding the desire to wean is delayed. Daniels and Weingarten (1982) suggested that the couple recognize the newborn infant as expressions of themselves, accepting the infant as an ultimate expression of 'us'. Intimacy between the couple is thus maintained by the inclusion of a self extension, the new infant. It may be that breastfeeding the infant, an observable act of connection, serves to expedite this inclusion. Understanding how the woman perceives the breastfeeding relationship and whether she describes it as intimate may

well be a clue for the health professional as to the state of the mother-child relationship.

These three areas of intimate expression namely, the women (Dignam, 1995, p.478-480), women-other (p.481-482), and women-infant (p.480-481), represented my interpretation of the literature prior to undertaking this research. It offered a preliminary discussion about the effect or impact that intimate relationships may have on women. This work, on reflection, is a somewhat naïve representation of the attachment and buffer of emotional support associated with intimate relationships. It does effectively capture the lack of theoretical explanation about intimate experience and recognises that very little of the literature about intimacy attends to the woman's perception of intimacy during breastfeeding.

3.6   Conclusion

Support for breastfeeding women can be conceptualised as informational, structural, interactional and relational provisions (Dimond & Jones, 1983). In considering the impact of emotional support on health, other health professionals associated emotional support with nursing care. The literature suggests that clients do not perceive the nurse to be the most emotionally supportive individual in their social network. Indeed, when considering nurses and other health professionals' support of breastfeeding, the imperative to identify and compensate for maternal emotional support is a most effective support strategy. Identification of the intimate support person in the social network of the breastfeeding woman may be the single most influential support for breastfeeding women. Often the intimate support person has been identified as partner, husband, spouse or maternal mother. Though the literature indicates that breastfeeding can be described as an intimate activity there has been no indication of the infant's significance as emotional support for the breastfeeding woman.

While I acknowledge that breastfeeding as an intimate experience might not be the reality of all breastfeeding women, the understanding of the concept of intimacy as it relates to breastfeeding provides a hitherto unexplored avenue for advancing an understanding of the practice of breastfeeding. Though the literature and rhetoric

implies breastfeeding is an intimate experience I acknowledge that many other activities are considered to be intimate, thus I recognised the need for women to define breastfeeding according to their own perspective.

The 1995 paper represented my position and understanding of the literature and called for research to be undertaken on the topic (Dignam, 1995, p. 483). I subsequently explored the field for a theoretical framework that would encompass the dynamic and interpersonal aspects of breastfeeding as indicated in the literature on breastfeeding as an intimate activity. The following chapter reviews the various theoretical approaches and influences demonstrated in breastfeeding and associated literature. This work contributed to my decision to utilise grounded theory as an appropriate method for this study. Grounded theory method offers a mechanism to describe intimacy as experienced by breastfeeding women, as it is a research design that facilitates theory development.

Chapter 4: Breastfeeding theory

4.1 Introduction

In this chapter I argue that breastfeeding has been described by various authors from a variety of theoretical positions. To date, no single theory provides a descriptive framework for the experience of breastfeeding. There is no breastfeeding theory per se. Various theoretical lenses can of course advance understanding about breastfeeding. It is surprising though, that in numerous texts and literature the experience of breastfeeding, the 'what is it like' of breastfeeding, is not represented in the dominant interpersonal theories about mother-infant relationships. These dominant theories are most commonly, bonding, attachment and maternal identity or maternal role attainment. Anthropological study, feminist theory and sociological inquiry have contributed to the literature on breastfeeding. Theory that seeks to account for breastfeeding has been located within the nursing and allied health literature and draws on a systems approach, stress and adaptation theory, interpersonal psychological theories and human development theories. The various interpretations, according to the perspective, render the process of breastfeeding a chameleon, ever changing in emphasis.

4.2 Systems theory, stress and adaptation theory, and human growth and development theories

Systems theory is arguably located within a particular historical theoretical trend. Dominant in the 1960s through to late 1980s, is work such as that by Bentovim (1976), which has remained influential and presents breastfeeding as a systematic product of interacting factors, namely physical, psychological and social factors. Mathews (1991) refers to Bentovim's work and elaborates on the positive and negative feedback, which impact on breastfeeding women's decisions to cease breastfeeding. Hill and Humenick (1989) provide a more contemporary example of breastfeeding systems theory in describing the determinants of insufficient milk supply. Subsequent studies (Hill & Aldag, 1991; Hill, 1992; Hill, Hansen &

Mefford, 1994; Hill & Humenick, 1995; Hill & Humenick, 1996; Hill & Aldag, 1996) support the systems model with inputs, throughputs (unidirectional relationships) and outputs (outcome of insufficient milk supply).

Systems theory conceptualises change as interactions among factors and variables, within a framework of hierarchical complexity that demonstrates input, throughput and output (Leddy & Pepper, 1989). Systems theory is usually external to the subject matter and focuses on the discrete parts (Stevens-Barnum, 1990). In applying systems theory to breastfeeding an assumption about the nature of the practice is imposed. It is difficult to identify or account for the subjective reality of breastfeeding women's experiences when a systems approach is offered as a conceptual understanding. The linear nature of the systems approach and the gross representation of determinants, such as psychological factors, fail to address the complexities and subjective differences experienced by breastfeeding women. The failure to consider subjective experience is a similar tenet of stress and adaptation theory.

Stress and adaptation theories conceptualise change as a person-environment interaction and demonstrate cause-and-effect relationships (Leddy & Pepper, 1989). Several examples of this approach can be found in the breastfeeding literature. Evans, Thigpen, and Hamrick (1969) presented work on the factors involved in the adaptive physiological aspects of breastfeeding. Taking the position that physiological adaptation to breastfeeding often presents as a breastfeeding problem, the authors seek to contribute some resolutions to enhance physical adaptation. Other nursing work (Hedberg & Sjoden, 1993) has utilised Roy's adaptation theory as a basis for their interpretation of breastfeeding interventions. This work considered adaptive roles as a framework for assessment. Other authors have also suggested that adaptation to parenting roles and maternal roles are advanced by the breastfeeding experience (Jordon, 1990; Jordan & Wall, 1993). The adaptation of breastfeeding practices is mentioned in a study on breastfeeding practices in the Fiji Islands (Morse, 1984). In this work Morse asserts that breastfeeding practices have been altered from the more traditional to a more modern approach as a cultural and biological adaptation. With each of these works the stress and adaptation perspective presents breastfeeding as a potential stress, one that requires energy and prompts

change in order to adapt, and advances a positive breastfeeding outcome. Breastfeeding is presented as a process that engenders change. The point here is that adaptation theory is not substantiated in the subjective account or description but is an interpretation of the practice of breastfeeding.

Human growth and development theories have been perhaps most pervasive in breastfeeding, nursing and medical studies as they accommodate interpersonal dynamics within a linear and progressive framework. The notions of direction, sequence of stages and progress toward a maximum potential (Leddy & Pepper, 1989) have some merit for a discipline such as nursing, concerned with maximising health potential. Breastfeeding studies are quick to propound the benefits of breastfeeding (see Chapter One). The rationale of this is linked to the idea that breastfeeding provides a means for optimal growth and development for the infant or child. It is noteworthy that nursing studies have been less dominant in demonstrating the developmental benefits of breastfeeding; it is the medical and associated disciplines that have contributed to this position. Some examples include the work by Silva, Buckfield and Spears (1978) who suggest some advantage in increased developmental experiences offered by long term breastfeeding. Forsyth (1995) reviewed the clinical evidence for the developmental and biological benefits of breastfeeding and concluded that the preliminary data indicate that breastfeeding may contribute to cortical function and intellectual development. St John (1997) reported on a New Zealand child and developmental health longitudinal study and suggested that research indicated breastfeeding for eight months or longer is associated with increased cognitive ability. Wung and Wu (1996) demonstrated that infants exclusively breastfed in the first four months differed significantly in physical and behavioral development from those not exclusively breastfed. The exclusively breastfed sample was advantaged in physical, behavioral development and immunity to infection. All of these authors have contributed toward the understanding of the impact of breastfeeding on developmental aspects. Their work is representative of many others in that the primary thrust is the developmental significance for babies or children who are breastfed.

Similar attention is given to the accurate assessment of various aspects of breastfeeding such as infant attachment to the breast and the infant's ability to suckle (Mathews, 1988; Medoff-Cooper & Gennaro, 1996; Ramsay & Gisel, 1996). The physiological assessment tools are relevant approaches to understanding the biological competence of the infant and the growth and development implications of breastfeeding. Research into the process of growth and development monitoring and the impact of this on breastfeeding (Behague, 1993), suggests that "Growth charts thus served as one of the many tangible domains onto which mothers could project their worries and measure their personal successes and failures" (p.1565).

Essentially breastfeeding studies concerning the growth and development of infants have been directed at informing health professionals, both in the assessment of infants and the promotion of the benefits of breast milk for infant growth and development. Growth and development frameworks for assessing breastfeeding have promoted a reductionistic approach, a concern with quantifiable parameters and developmental norms, often unrelated to the interpersonal processes involved in the act of breastfeeding. Studies concerning the interpersonal aspects of breastfeeding have been mostly related to the practice implications for the professionals (or nurses) as they work with breastfeeding women.

4. 3 Interpersonal breastfeeding theories

The interpersonal dynamics between the breastfeeding mother and infant are not well represented in nursing or allied literature; this concern has been most frequently addressed in the work of various authors (Ainsworth, 1989; Bowlby, 1969; Klaus & Kennell, 1976) who pose theory about mother-infant relationships. The theories concerned with explaining mother-infant relationships are attachment, bonding and imprinting; these are most frequently found in the breastfeeding literature.

The theory of maternal-infant bonding is the work of Klaus and Kennell (1976) who suggest that early contact between mother and infant has a positive effect on the mother-child relationship. Studies undertaken by these authors and their associates highlight the delight and intimacy manifested by a mother who is able to hold her infant shortly after birth (Ainsworth, 1989). Klaus and Kennell also asserted that the

period of immediate contact post delivery was critical to the occurrence of bonding, a position which was later modified as a result of further research. It was Bowlby (1969) who posed the theory of attachment. Bowlby was later able to encapsulate the ethnological perspective demonstrated in the work by Lorenz in 1935 (Bretherton, 1992). This work by Lorenz suggested that animals imprint on the caregiver and that social bonds can be formed without the caregiver as feeder of the infant. The theories of bonding, attachment and imprinting have significantly influenced nursing literature and breastfeeding literature.

4.4 Attachment

Attachment as a theory explains the infant connection to a parent, in a parent-child relationship. Bowlby asserted that an infant who is securely attached to the mother would respond to separation as a distressful event. Bowlby published an overview of this influential work in 1977 in which he locates the foundation principles of his theory in psychoanalytic thinking, ethnology, cognitive psychology and control theory. In this work Bowlby cites the following as a key point of his thesis,

> There is a strong causal relationship between an individual's experiences with his [sic] parents and his [sic] later capacity to make affectionate bonds and that certain common variations in that capacity, manifesting themselves in marital problems and trouble with children as well as neurotic symptoms and personality disorders, can be attributed to certain common variations in the ways that parents perform their roles (Bowlby, 1977, p.168).

The main variable to this hypothesis is that parents provide a secure base for the child and allow exploration from that base. The infant, according to Bowlby, employs a set of behaviours (crying, sucking, clinging, following and smiling) that ensures the parent provides the care needed for survival (Stewart, 1992).

Much of Bowlby's early work was based on a study of deprived children in the London Child Guidance Clinic where he was able to link the children's symptoms to maternal deprivation and separation (Bretherton, 1992, p.760). Subsequent studies supported his original hypothesis but major advancement to the attachment theory was not made until Ainsworth joined Bowlby's research team late in 1950

(Bretherton, 1992). Ainsworth set about analysing other research data collected by an associate of Bowlby, James Roberston. The findings supported the critical role of the female parent to effect the ability of the child to thrive emotionally. Thus attachment theory, while developed from observational studies that focused on infant behaviours, was concerned with the context of mother-child partnership, "dyadic synchronisation" (Ainsworth, 1972, p.125). The dynamics of the mother-child relationship have become more relevant in contemporary literature, however the behavioral expression of attachment has remained the central concern of attachment theory. This is demonstrated in the work on maternal deprivation.

Ainsworth, having developed an interest in maternal deprivation, as a result of her involvement in Bowlby's work, continued employing naturalistic inquiry and elaborated on attachment theory by developing an identification of attachment behaviours and phases of development of attachment (Ainsworth, 1989; Biography American Psychologist, 1990). Ainsworth notes that attachment theory has a great strength in that it focuses on a basic system of behaviour that is biologically rooted and species specific (Ainsworth, 1989). This point has real significance when considering the influence that imprinting has exerted on concepts like attachment and bonding.

4.5   Imprinting

The theory of imprinting was first demonstrated by Lorenz in the 1930s and concerns the attachment of animal infants to the caregiver and food provider. Bowlby recognised the ethnological work as relevant to attachment and embraced the work as providing support for attachment theory. Mobbs (1989) considered imprinting to be an innate psychosocial process that has direct relevance to the lactation cycle enhancing the lactating ability of the mother. Mobbs based her study on the hypothesis that if the imprinting process is part of the normal lactation cycle then it could be expected that non-nutritive sucking on objects other than the breast would result in failure of lactation. Mobbs' study supported the hypothesis in that mean duration of breastfeeding decreased with non-nutritive sucking, demonstrating that dummy and thumb sucking adversely affect a mother's chances of breastfeeding successfully. While the study demonstrates the effect on lactation of suckling on

something other than the breast it is difficult to link the theoretical position about imprinting to the findings. A case might well be made for the physiological impact of incomplete removal or one of a multifactorial set of possibilities (Gale & Martyn, 1996; Ford et al., 1994). Imprinting studies were concerned with the attachment of animal infants to the caregiver or food provider. Mobbs (1989) has extrapolated this position to include imprinting to the nipple or breast versus imprinting to the dummy or thumb. The study did not demonstrate imprinting behaviors but rather a decrease in breastfeeding.

The maternal influence on bonding, attachment and imprinting has relevance to the concern of this thesis, particularly any work that illuminates the woman's perspective of the mother-infant relationship dynamic. Closely associated to attachment and bonding is the concept of maternal deprivation, a concept that drew attention to both the infant's and mother's (caregiver's) behaviors. Maternal deprivation according to Bowlby (1982) resulted in negligent abuse of the infant, as evidenced in a mother-infant encounter where attachment behaviours were not observable. This position was initially prompted after Bowlby was commissioned to write a paper, for the World Health Organisation, about the mental health of homeless children after the second world war (Bretherton, 1992).

The work around bonding and attachment has been critiqued by authors such as Sluckin, Herbert, and Sluckin (1983). The work by Sluckin, et al. is a comprehensive critique of the position that bonding occurs only within certain critical time periods. The authors demonstrate that bonding may well be a gradual process and that the emphasis on early skin-to-skin contact might be less imperative than was first mooted. This position is reflected in work by Herbert (1996) who notes,

> Our message to the mother who harbours secret fears, lest she has not properly bonded to her infant is, 'Stop worrying, your anxiety is the result of your acceptance of the bonding doctrine. It was perfectly sensible of you to believe it when no one knew better; but we now know that research findings reveal no critical period for maternal bonding, and these findings strongly indicate that maternal attachment-like child-to-adult attachment- develops in most cases slowly but surely (Herbert, 1996, p.16).

Sluckin, Herbert, and Sluckin (1983) suggest the manner in which a parent takes care of an infant, is more important than the type of feeding the infant receives. The initiation of breastfeeding within the first half-hour of birth is step four in The ten steps to successful breastfeeding (WHO/UNICEF, 1989). In a review of the literature supporting the ten steps Vogel and Mitchell (1998) note "…no research has demonstrated a critical period during which the first feed must take place" (p.175). The authors further note that "many studies address the combined effect of early contact and early suckling, as the two are difficult to separate out" (p.175). Bonding and attachment theories are the basis for the assertion that breastfeeding benefits the mother-infant relationship. Ryan (1999) notes that the emotional aspects of breastfeeding are represented in the dominant biomedical discourse, "…such as satisfaction with baby's growth or behaviour or mention of 'bonding' (a biomedical term to denote intimacy)"(p.5).

It became apparent to me as I considered bonding, attachment or imprinting theories that breastfeeding is not central to these theories. Bretherton, Ridgeway, and Cassidy (1990) note that Bowlby recognised attachment as a survival function regulated by a behavioral system that was not subordinate to motivational systems like infant feeding or sex. Despite the recognition of attachment as a behavioral survival function, nursing and breastfeeding literature has claimed a central position, that breastfeeding benefits bonding and attachment between mother and infant. Breastfeeding literature (Eberline, 1996) and health promotion material (Ministry of Health, 1989) advance the benefits of breastfeeding as relationship building like mother-infant bonding. "Breastfeeding ensures intimate physical contact between mother and infant, an important factor in the process of bonding and later psychosocial development" (Ministry of Health, 1998, p.37). The benefits of breastfeeding for mother-infant bonding are an assertion perpetuated in nursing literature as self-evident truth, one that has perpetuated the theory of bonding as a truism. Despite critique of the concept of bonding, maternity practices and breastfeeding practices have been shaped by bonding and attachment theory (Rogan, Shmied, Barclay, Everett & Wyllie, 1997; Symanski, 1992).

4.6 Bonding, attachment and breastfeeding

Symanski (1992) notes that breastfeeding on demand facilitates mother-infant interaction and while it might enhance bonding, if over emphasised breastfeeding may also be a pressure that could exert a negative effect on the mother-infant interaction. Breastfeeding is considered as one possible mechanism for enhancing bonding and attachment. Eberlein (1996) encourages women to make feedings a time for intimacy and notes "many experts believe that breast-feeding encourages bonding" (p. 96). This assertion is presented as an indisputable fact. The comprehensive work of Hofer (1994) in particular has perpetuated the importance of breastfeeding as a mechanism to enhance maternal-infant bonding and attachment.

Hofer (1994) explored the effect of nutrient interactions within the context of biological and psychological processes. The work considers the effect of regulatory processes, including nutritive interactions on the early infant mental representations and behaviors of mother-infant attachment. This author argued that,

> As soon as associative memories begin, infants begin to function at a symbolic level, as well as the sensory-motor level, at which regulatory processes originate. In infants of species with the necessary cognitive capacities, mental representations of caretakers are formed out of the individual units of their experience...(Hofer, 1994, p.16-17).

This position then melds the interactionist perspective of psychosocial development with the bio-regulatory physiological processes. While this work is only an initial theory it places an increasing imperative on breastfeeding as the feeding method of choice, in respect of attachment and bonding. This imperative is reflected in a position held by Armstrong (1995) who suggests that breastfeeding enhances the child's ability to attach to the mother and increases parental responsiveness by facilitating bonding. It is worth remembering at this point, that breastfeeding per se was not the central concern of either attachment or bonding theory. The central concern was rather a variety of experiential behaviors and responses to infant cues of which breastfeeding might be one. Clearly, the more formal concepts of bonding and attachment have been incorporated into contemporary thinking about mother-infant relationships, the central role of breastfeeding is less clear. The lack of clarity about

the role of breastfeeding is evidenced by work on the assessment of bonding and attachment.

4.7   Assessment of bonding and attachment

It is worth noting that in contemporary literature on attachment and bonding assessment, breastfeeding is not promoted as a particularly relevant behavior. Some work has focused on clinical assessment strategies and psychometric measures (Lobar & Phillips, 1992). These authors present a three-part framework for assessment of attachment and bonding, during the first year of the infant's life. Each phase presents behaviors that demonstrate the mutual contribution made by infant and mother to advance the process of attachment and bonding. These three phases are acquaintance, attachment and bonding. While the author is careful to recognise the importance of touch, speech, and visual behaviors associated with each phase, breastfeeding is not mentioned. Yet the tactile behaviors are finger and palmar exploration, progressing to enfolding behaviors such as nuzzling and fondling without association to feeding. These behaviors are translated into an assessment tool with the following criteria listed as indicators of attachment and bonding,

> Holding -Holds infant at arm's length at lap level, no enfolding -Enfolds the infant to breast, holds infant's head in crook of arm at breast level in en-face position -cuddles infant, nuzzling to mother's neck (Lobar & Phillips, 1992, p.256).

This description is the physical position in which women breastfeed or bottle feed their infants, yet the recognition of feeding method is not articulated in the assessment tool. The term 'enfolding' is described in the above quote and originates from work by Klaus et al., (1972) and also is described in work by Rubin (1961). Neither of the studies by Klaus et al., or Rubin was undertaken at a time when breastfeeding was a dominant infant feeding practice. Rather bottle feeding behaviours would have been most frequently observed by the researchers. I would suggest that the description of enfolding was not associated with any one feeding method (as the sample were bottle feeding), thus identifying the feeding method as one possible indication of attachment was not suggested. Perhaps if the studies had included a breastfeeding sample one of the criteria for assessment of attachment and bonding might simply read- breastfeeds. I suggest this not because I believe

breastfeeding significantly advances bonding and attachment, but rather because the description of 'enfolding' is a description characteristic of observed breastfeeding behaviours. The essential distinction here is that bottle feeding can occur without an enfolded positioning.

Clearly attachment theory has dominated thinking around the early postpartum period; it is therefore not surprising that breastfeeding studies have looked to the field as a theoretical base on which to assert the benefits of breastfeeding. What is clear, in considering the original work and subsequent assessment tools, is that breastfeeding was not promoted as a specific attachment or bonding strategy. The theory on attachment, bonding and the impact of these theories on an understanding of the mother-infant relationship have been primarily concerned with behaviours expressed by both infant and caregiver. These behaviours are interpreted as indicative of a certain type of relationship, i.e. one that is attached or bonded.

Breastfeeding women frequently cite the development of close emotional bonds between mother and child as one of the reasons they choose to breastfeed (Hills-Bonczyl et al., 1994; Kendall-Tackett & Sugarman, 1995; Maclean, 1990). This perspective held by breastfeeding women might not be consistent with the theoretical concept of bonding but rather a more popular and individual interpretation of the concept. I conclude that to date no study has considered if women indeed are expressing the attributes of formal bonding theory or rather a more experiential description of breastfeeding encounters.

I was interested to see if any other theoretical work contributed to an understanding of maternal perceptions of mother-infant interactions, particularly those associated with breastfeeding. I discovered that it was the maternal perception of the mother-infant relationship that has been the concern of more contemporary work on maternal role attainment (Rubin, 1977).

4.8   Development of maternal role identity

Rubin's work (1961, 1963, 1984), located in a time where bottle feeding was at a zenith, has been significant in nurse and midwifery clinical practice and has significantly influenced contemporary writers (Mercer, 1995a).   "Reva Rubin's influence has been unequalled by any one individual in the area of maternity nursing" (Mercer, 1995a, p.184). My overall impression with this theoretical interpretation of maternal identity attainment is the lack of distinction between the two methods of infant feeding, bottle and breastfeeding.

Rubin (1977) published a significant account of the formative stages of the maternal-child relationship, which she presented as a process that occurs over a one to three month time frame post delivery. According to Rubin a pivotal concept in the process of maternal role identity is the concept binding-in. Rubin recognises this term is clumsier than attachment or bonding but distinguishes the concept binding-in as relevant to the development of maternal identity. Essentially Rubin suggests that in the postpartum period three mutually dependent processes affect binding-in. The first of these three processes are, polarisation, the separation of mother-infant at birth, which is a physical, social and conceptual severance. The second is identification of the infant as the physical reality rather than the imagined entity, which existed during pregnancy. Thirdly the process of claiming, during which the mother claims the infant as part of the family. This theory becomes relevant to breastfeeding as Rubin asserts that three variables affect the binding-in period. These three variables are, the mother's own recovery and state post delivery, the support offered to the mother during the one to three month period and the "endearing inputs of the baby itself" (Rubin, 1977, p.75). I expected that in my own study some 'endearing inputs' might be located within the infant feeding exchange.

Rubin (1977) notes that the mother initially views the infant as an extension of her "self" and this perception of "self" is influenced by any feeding difficulty. "If the baby should have difficulty sucking, grasping the nipple, burping etc., she [the mother] perceives this as more of the same, a continuation of self, another blow to her self image" (p.71). Rubin draws on the feeding experience as an example of an

orderly progression of spatial relationships that influence the mother's ability to conceptualise the infant's existence as external. Rubin asserts that the infant progresses from intrauterine feeding, breast or bottle-feeding, food and cup feeding, to chair and separate feeding. In each of these progressive feeding styles the physical space between mother and infant increases.

As previously mentioned Rubin (1977) described the breast or bottle feeding position as 'enfolding', that is, the drawing in of the infant for full body contact. Later in her work Rubin elaborates that maternal holding of the infant, can be described as "cradling in the arms across the breasts" (p.73). According to Rubin this type of holding (remarkable in similarity to breastfeeding) is to be repeated frequently but not continuously, as continuous holding would fatigue the mother. Rubin fails to recognise that in feeding the baby or infant from a bottle, the baby need not be positioned in an enfolded fashion. Bottle-feeding can be a feeding method without physical contact, indeed without the mother present at all. It could be construed from Rubin's assertion about the importance of the mother's physical separation from the infant, that bottle-feeding might be beneficial to the emergence of maternal identity.

In an earlier paper Rubin (1963) wrote about maternal touch, "A women who loves must enfold the person she loves. Her upper arms and breast ache for contact" (p.829). Yet Rubin's only reference to this essentially 'breastfeeding position' is that women who demonstrate the ability to be comfortable taking the baby to their chest are those who enjoy contact such as breastfeeding. In other words breastfeeding does have some comparability to maternal holding or enfolding. I think this is an important point, given that infant feeding can comprise a considerable amount of mother-infant interaction time, particularly during the early one to three month period that Rubin is concerned with. Though Rubin progressed her 1963 work in a 1984 presentation of maternal identity theory, the work still fails to differentiate between bottle and breastfeeding. I can only conclude that infant feeding methods were not considered an important aspect of maternal identity development.

However, this conclusion is difficult to argue when, according to Rubin (1961), maternal identity is determined by the mother's significant first mothering acts.

Significant acts according to this and later (1984) theory are the interactions between mother and infant that Rubin termed "action-interaction". Rubin suggests that "The giving and receiving of food is the primary vehicle of direct action-interaction" (1984, p.136). She asserts that in part maternal role identity is indicated when a mother achieves a 'goodness of fit' in the feeding interaction. 'Goodness of fit' is indicative of some compatibility between infant and mother, one that is positive and affirms the maternal identity. Rubin notes "Forced entry into the mouth, jiggling of the nipple, breast, or bottle, and stimulation of the cheek or other parts of the baby's body send unintended and disruptive tactile communications to the infant" (1984, p.137). This Rubin asserts does not represent "goodness of fit" in an infant feeding encounter. The language in this quote reflects the author's failure to differentiate between breast or bottle in the infant feeding interaction. The assumption that breast or bottle is capable of a similar effect on the infant is not considered as anything other than a substantiated fact.

Rubin further asserts that failure to attain maternal identity is evidenced by a failure of the woman to determine the significance of an action-interaction event. In effect, the mother does not recognise or 'see' the child. Rubin provides an example of mothering where the woman is unable to 'see' the infant or recognise the significance of the event. "The infant can be twisted into a most uncomfortable position, he [sic] may be satiated, the nipple may be out of his mouth, the milk may be inaccessible to him because it is at the opposite end of the bottle. Somehow she can not see this" (1961, p.685). The act of mothering, through bottle-feeding, does not necessitate the mother interacting in an attentive manner. The situation described by Rubin (1961, p.685) might be a result of bottle feeding practice, where neither position nor method require enfolded contact. Note the use of the word nipple, which might be generic to either breast or bottle-feeding. I find it difficult to reconcile that this type of maternal blindness would be demonstrated in the breastfeeding experience. It is further disturbing that such a lack of awareness can be evidenced in any infant feeding exchange.

Rubin asserts that the applied action of holding and enfolding are important experiences for advancing maternal identity, but fails to recognize that these experiences are offered in the breastfeeding encounter. Infant feeding is recognized

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as an opportunity to affirm distinctiveness between mother and infant. This assertion is based on bottle feeding experiences and assumes that breastfeeding is the same as bottle feeding. More contemporary work by Mercer (1981, 1985) draws on Rubin's maternal identity theory and has contributed to maternal role attainment theory. Mercer's work moves to extend the concepts posed by Rubin (1984) however this work still fails to recognise the distinctions between bottle feeding and breastfeeding.

4.9 Maternal role attainment theory

Mercer's work focuses on maternal role attainment over the first postpartum year operationalising the concepts of competence (Mercer & Ferketich, 1995), attachment (Mercer & Ferketich, 1994) and stress. Mercer draws on role acquisition theory and applies this to maternal role attainment (Mercer, 1995b).

> The maternal role may be considered to have been attained when the mother feels internal harmony with the role…Her behavioural responses to the role's expectations are reflexive and are seen in her concern for and competency in caring for her infant, in her love and affection for and pleasure in her infant, and in her acceptance of the responsibilities posed by the role. (Mercer, 1979, p.374).

Walker, Crain, and Thompson (1986) drew on the theoretical components of role attainment in relation to maternal identity and considered mothering behaviours during the postpartum period. These authors engaged in an analysis of videotaped infant feeding interactions. They suggested that infant feeding interactions provided an example or demonstration of maternal role attainment. In the analysis of the videotapes the authors assessed the mothers' sensitivity and responsiveness to their infants. The authors indicate in the study that the sample included "women who chose to breast-feed their infants" (p.353), thus I assume the feeding interaction must have been breastfeeding. Walker, Crain and Thompson conclude that for primiparas "Higher social resources indexed by SES, age, and education are related to more sensitive, responsive behaviours during feeding" (p.355). These variables were moderated for multiparas in that "...the concept of 'myself as mother' was the only subjective component of role attainment correlated with sensitive feeding behaviours at the end of the postpartum period" (p.355). It was of interest to me that in this study the indication of role attainment was demonstrated as maternal competency in infant feeding, specifically, breastfeeding. The study failed to account for the

subjective experience of the breastfeeding mother, that is the breastfeeding woman's perception of competence. It is also inconsistent with the early theoretical work by Rubin (1984) and Mercer (1985) in that the study takes no account of a bottle-feeding interaction to determine if a distinction in mother-infant interactions can be made.

Maternal identity theory and maternal role attainment theory have accounted for early mother-infant relationships, but have failed to locate breastfeeding as a significant interaction. The act of infant feeding, either bottle or breastfeeding, has been considered a measure, or indicator of maternal role identity formation or maternal role attainment. The theoretical work has failed to differentiate between the two feeding methods and has focused on the behaviors of enfolding and holding the infant. I would argue these consistent behaviors are more descriptive of breastfeeding than bottle-feeding. The foregoing theoretical work has not informed or elaborated on the experiential perspective of breastfeeding women, yet is applied to breastfeeding women as an indication of maternal competence. I consider the maternal identity and role attainment theory supports the need to explore the breastfeeding woman's perception of the breastfeeding experience.

Breastfeeding has been the focus of many studies in disciplines outside of nursing. I have chosen to present those perspectives that have been demonstrated in studies that reflect the breastfeeding woman's own perceptions of her experience. Many of these studies were located within anthropological, feminist, and sociological writing.

4.10 Other theoretical perspectives on breastfeeding

Feminist, sociological and anthropological theoretical perspectives have been applied to the understanding of breastfeeding. The following consideration of these perspectives reveals that these approaches have failed to account for the individually located experience of the breastfeeding dynamic. From the sociological approach to societal functioning to the feminist struggle to define breastfeeding practice, the lack of consideration given to women's voice is evident. Even in the dominant bio-medical approach to anthropological understanding of breastfeeding the nature of breastfeeding is culturally prescribed.

It is necessary at this point to acknowledge that the discipline of anthropology holds many theoretical perspectives and that this summary is not intended to be a comprehensive representation of the range of approaches to anthropological study. The following summary is a sample of the literature on breastfeeding that interprets the breastfeeding experience according to an anthropological perspective. I consider bio-medical anthropological work to be a dominant perspective demonstrated in the literature on breastfeeding.

According to Stuart-Macadam (1995a) "The biological anthropologist has a unique way of viewing the world: a cross-cultural and evolutionary perspective that acknowledges that there are both biological and cultural components to human behaviour" (p.1). Breastfeeding is clearly located as an activity which is culturally prescribed and biologically determined (Beasley, 1991; Morse, 1989a, 1989b; Stuart-Macadam, 1995a). The biological imperative of breastfeeding is a commonly held position of medical anthropologists. One such example is work on cross-cultural perspectives as barriers to optimal breastfeeding (Obermeyer & Castle, 1997). These authors indicate that breastfeeding can be an expression of kin relationships and moral values and these are as widespread today as they were historically. Obermeyer and Castle note that "Prescriptions for optimal health behaviour will be followed if they are meaningfully linked to the context in which they are to be applied, and to the self perceptions and social relations that they are influencing" (1997, p.56). Thus the authors argue that the cultural meaning of breastfeeding is bound to social structure. Work by Kitzinger (1987) recognises that social influence is exerted on breastfeeding and breastfeeding in turn exerts a social influence. Kitzinger suggests that the way the human body is used influences the social construction of reality.

Other theoretical frameworks have been super-imposed on the cultural location of breastfeeding, such as the feminist anthropological framework. Maher (1992) elaborates the feminist anthropological perspective on breastfeeding. In a comprehensive work she suggests that breastfeeding is much more than a nutritional or psychological event but rather an event located in economic and social conditions, which affect breastfeeding success. Breastfeeding, Maher asserts is, "not only conditioned by cultural patterns but exerts a definite influence on them..." (1992,

p.9). Using the concept of bonding as an example Maher claims that maternal bonding is western folklore that sustains cultural notions of exclusive maternal responsibility, gender roles and male political dominance. Maher argues that men frequently determine the rules for breastfeeding but women determine the day to day practice, often establishing specific relationships and symbolic values.

Like Maher, Beasley (1996) asserts that the body is a site where physical processes confront social forces, a site that is located in a social context and in issues of politics and power. As a medical anthropologist Beasley locates her work in the conflicts created in "the struggle between individual and social desire for control over the ... body" (p.11). This position recognises that breastfeeding, although culturally shaped, varies between individuals and is therefore not generalisable (Beasley, 1996). Interestingly, the French obstetrician, Michel Odent, has taken an anthropological perspective and in a reported interview (cited in Davis, 1992), indicated that women who reside in polygamous societies suckle their babies for much longer than those women who reside in western cultures and have monogamous relationships. Odent is quoted as saying that, "children would grow up healthier and happier if women, and especially new mothers, allowed their men folk to have multiple sexual partners" (Davis, 1992, p.64). Odent considers this to be a feminist position as it gives value to the feminine experience. This position largely negates the role of the male partner in supporting the breastfeeding dyad. This contentious position serves to demonstrate the wide variance in anthropological writing.

Breastfeeding studies have found that normative beliefs, cultural taboos, practices and social learning affect breastfeeding duration and success (O'Campo, Faden, Gielen & Wang, 1992; Ojofeitimi, 1981; Rodriguez-Garcia & Frazier, 1995). Blum (1993) in a feminist analysis supports the importance of breastfeeding as a representation of the cultural and 'natural' mother. This position has been one of contention for feminist writers.

Breastfeeding has been something of a problematic for feminist theory as it raises the tensions between biological essentialism and stereotypical gender-located roles. Carter (1995) suggests that perhaps the lack of a strong feminist movement around breastfeeding is due to the ambivalence and contradiction associated with differing

feminist positions. Fellow (1994) reiterates this position recognising that a consistent feminist position on breastfeeding has been lacking. In order to highlight the different feminist perspectives Fellow draws on the work of Van Esterik (1989) and reviews four essential positions; the conservative feminist position, liberal feminism, radical feminism and socialist feminism. While these positions are now somewhat dated in terms of contemporary feminist thinking they do provide a framework that reflects much of the work on breastfeeding. Each of these perspectives locates breastfeeding within a range of positions, from the natural womanly activity of breastfeeding which is to be celebrated, to an enslaving practice determined by gender and restrictive to redefining female.

Feminist theory is able to claim some relevance to breastfeeding as Van Esterik (1989) suggests it impacts on woman's ability to exert power and control over her body, and encourages self-reliance. As a woman's issue, breastfeeding provides a platform for challenging gender ideals about the breast as sexual, and women and work place issues (Van Esterik, 1989). Blum (1993) supports this position and states, "I suggest that breastfeeding provides a wonderful lens magnifying the cracks and fractures in our construction of the late - twentieth - century mother" (p.291).

Work by Bradfield (1996) utilised feminist research and feminist poststructuralism to explore issues of knowledge, power and control for women who are learning to breastfeed. "A return of power for breastfeeding women is related to gaining control of their own bodies and their own lives, acknowledging their own knowledge and expertise and challenging many dominant discourses. Midwives and nurses can partner women in this challenging of dominant discourses" (Bradfield, 1996, p. 28). Breastfeeding, according to Bradfield, can enable women to regain control. Vares (1992) found that her own breastfeeding experience was disturbingly essential and created a tension between being committed to the activity and yet wanting her 'body back'.

Drawing on this tension Vares (1992) undertook a feminist study into women's experience of long-term breastfeeding. Vares noted in her findings that, "There is a definite resistance to falling into biological essentialism. All of the women recognised the ways in which patriarchal versions of biological determinism had

been used to subordinate women" (Vares, 1992, p.29). In order to reconcile the dichotomy between biological essentialism and patriarchy Vares suggests that breastfeeding as a feminist practice has highlighted the need to incorporate the female embodied experience into feminist thought. In this respect the two positions of feminist theory and embodied experience mesh. This combined perspective is evident in the literature around breasts and sexuality, a topic that is consistently featured in texts on breastfeeding (Carter, 1995; Kitzinger, 1987; Palmer, 1988; Stuart-McAdams & Dettwyler, 1995; Van Esterik, 1989). A common position held with all these writers is the recognition of the struggle to define the body - particularly breasts.

It is in the work of McConville (1994) that the breast is considered from a feminist position. "For many women breasts are a battleground, laid claim to by men, medics and - occasionally - babies. Advertisers, porn and pin-up merchants, fashion designers, plastic surgeons and artificial milk manufacturers all struggle for control over this female place where the maternal and the erotic coincide" (McConville, 1994, xvi). Meckelburg (1994) has followed this theme and suggests that breasts are "deliciously subversive of monologic discursive 'norms' about which theories of female sexuality have been devised and elaborated" (p.10).

A body of literature has also considered the feminist critique of social policy and breastfeeding. Van Esterik (1989) has contributed to such a critique illuminating the medicalisation of the infant formula industry and resultant policy generation around that advent (see Chapter Two). Palmer (1988) also contributed to this analysis highlighting the political nature of breastfeeding. Taking the perspective of politics as not just economic and territorial power but also sexual power, Palmer exposes the economics and human implications of the artificial infant formula industry and breastfeeding practices internationally.

The value of women's productive and reproductive work has been a topic of feminist analysis, particularly with regard to breastfeeding (Baumslag & Michels, 1995; Shelton, 1994). Galtry and Callister (1995) locate breastfeeding as one unresolved issue of equity for paid leave from employment. Breastfeeding raises some issues for the participation of mothers in paid work, as is evidenced in the breastfeeding

statistics of New Zealand (Essex, Smale & Geddis, 1995). Galtry and Callister elaborate on the importance of breastfeeding and explore the implications of combining breastfeeding and paid work. Finally, these authors call for attention to the strategies that might enable choice for women to breastfeed and work in paid employment. Galtry (1997) asserts that the choice to breastfeed is constrained by employment-related factors. Galtry's work indicates that breastfeeding is one challenging factor for women returning to paid work. It is perhaps at the interface between paid work and a culture that sustains this practice that the social experience of breastfeeding becomes relevant. The sociological perspective toward breastfeeding can illuminate the breastfeeding experience of women.

In pivotal work the renowned sociologist Ann Oakley introduced the relevance of sociology to birthing and maternity. Oakley's early work (1979; 1986) raised the awareness of motherhood as a socially located and determined institution. These early works were based on a study undertaken in the 1970s and were concerned with the advent of motherhood. Feeding featured as a major theme, especially in the early weeks postpartum. Recounting women's experience Oakley was able to recognise that breastfeeding is a site of struggle between maternal success and failure. The tremendous influence of multiple advisors, family, social and health professional as well as the baby's behaviour all contribute multiple messages to the mother. According to Oakley (1986, p.165) "What goes into the mouths of babies is a mix of all these ingredients, a compromise between the different messages".

In a more recent work Maclean (1990) takes a sociological stance in a study on women's experience of breastfeeding. However, the experience of breastfeeding is not presented as a theoretical interpretation, "Because social forces are expressed in personal decision and actions of members of a culture or society, the interaction between the two must be studied together" (Maclean, 1990, p.12). Drawing on the data of some 756 interviews with breastfeeding women, Maclean was able to present the complex inter-relationships located in the breastfeeding experience. Using qualitative analysis within the interpretative phenomenology method, women's experience of breastfeeding was presented in several themes. Many of these themes feature social relationships/interactions and social support systems. Maclean (1990)

suggested that the findings of her study indicate the importance of contextual factors, most specifically structural realities and socialisation processes.

The societal function of breastfeeding is most easily recognised when viewed through the lens of another culture. Work by Bohler and Ingstad (1996) studied breastfeeding factors in east Bhutan. These authors found that there is a social function associated with breastfeeding which protected the infants when most vulnerable. While this work is located in the culture of East Bhutan the emphasis of the work is on the societal impact of decision making for weaning from the breast. "The mothers obviously experienced their own role in the weaning process as that of making choices and priorities, in order to take the best possible outcome for the interests of the child, the foetus and themselves" (Bohler & Ingstad, 1996, p.1813).

The social prescription of breastfeeding is also evidenced in work by Bergh (1993) in a study on obstacles and motivation for successful breastfeeding. Bergh found social conditions to be one of three factors affecting breastfeeding success. Specifically lack of support and certain life styles were found to have a significant impact on breastfeeding duration. Bryant (1982) found that networks and kinship inter-relationships influenced breastfeeding success in Cuban, Puerto Rican and Anglo participants. Similarly Chalmers, Ransome, and Herman (1987) in a study of some 200 coloured women demonstrated the importance of women friends, their mothers and partners as supportive of breastfeeding. A comprehensive review by Cronenwett and Reinhardt (1987) suggests that both the initial decision to breastfeed and subsequent duration are affected by social support. Studies have attempted to locate the influence of support on successful breastfeeding as it relates to variables such as attitude, life experience, education, personality, family organisation, family position, social structures, values, norms and traditions, employment, and smoking (Hellings, 1985; Nolan & Goel, 1995; Perry & Trlin, 1985; Stein, Cooper, Day & Bond, 1987). What has been demonstrated is that types of support have been identified as influential on breastfeeding duration or success. This position I have presented elsewhere, as it relates to social support and the nurses' role in supporting breastfeeding women. It is sufficient to note that though types of support might vary there is evidence to suggest that the number of social support networks are also influential on choice and duration for breastfeeding (Kaufman & Hall, 1989).

Breastfeeding as a socially prescribed activity becomes apparent when social norms are breached. An example of social violation is the practice of long-term breastfeeding (Kendall-Tackett & Sugarman, 1995; Vares, 1992). Social stigma and pressure come to bear on those women who choose to feed beyond the six months to one-year period. The need to be strong in the face of social unacceptability, was a major theme in the work by Hills-Bonczyl et al., (1994). This work reported on women's experience of breastfeeding longer than 12 months.

Breastfeeding duration and success is associated with social class. Low social class is a recognised factor associated with premature weaning to artificial feeding or decreased breastfeeding duration (Cooper, Murray & Stein, 1993; Essex, Smale & Geddis, 1995; Flight & Adam, 1986; Jones & Belsey, 1977; While, 1989). It is not sufficient to consider this variable as singularly significant as, demonstrated in a study by Grossman, Fitzsimmons, Larsen-Alexander, Sachs, and Harter (1990), multi-factorial indicators can be associated with breastfeeding success and duration. Grossman, et al. found that breastfeeding women are more likely to be more educated, married, older, have a high income, receive support from those not likely to bottle feed, be experienced with breastfeeding and attentive to prenatal care. It therefore depends on the definition of social class applied in various studies. Often social class is not well described and may well be a multifactorial concept that includes education, financial resources and marital status.

In work by Kiehl, Cranston Anderson, Wilson, and Fosson (1996), the authors considered the impact of two variables on breastfeeding duration. The first variable, social status was demonstrated by a sample of the private insurance patients and non-private insurance patients. The second variable was mother-infant time together. Neither time nor social status, as operationalised in the Kiehl et al. study, affected breastfeeding duration.

Sociological perspectives such as social status and social networks, kinship and social forces are all concepts that have been applied to the experience of breastfeeding. They indicate something of the complexity of breastfeeding. I would argue that sociological perspectives do not account for the individual perception of

the breastfeeding experience. Just as sociological theory has failed to locate the substance of women's breastfeeding experience so has the theoretical application of culture and gender.

4.11 Conclusion

Theoretical frameworks and positions have been used to interpret women's experience of breastfeeding. The nursing and bio-medical bodies of literature have accounted for the experience of breastfeeding by drawing on systems theory, stress and adaptation theory, growth and developmental theory. Each of these theories suggests a breastfeeding benefit or locates the concerns and issues relevant to the health professional or nurse. The actual experience of breastfeeding is not clearly evident in this work. Nor does this work account for the subjective and interpersonal experience of breastfeeding.

The literature on breastfeeding from other theoretical disciplines such as anthropology, feminist and sociological inquiry locates the breastfeeding experience within the perspective of each discipline. The disciplines interpret the practice of breastfeeding and the subjective experience as indicators of social, cultural or gender concerns. I do not suggest that this approach is inappropriate but rather, as it informs the practice of breastfeeding it negates the totality of the encounter. The challenge is to capture an experience such as breastfeeding without interpreting the experience from any one standpoint.

In reviewing the different theoretical perspectives demonstrated in the literature on breastfeeding, it became apparent that to date no work had captured the experiential aspects of breastfeeding as a theoretical representation. No one study or work represents a breastfeeding theory. Grounded theory method provides a mechanism for such an endeavor. In the following chapter I consider grounded theory method and introduce the study design.

Chapter 5: The research method

5.1 Introduction

> We suggest that greater account needs to be taken of the mother's perspective on breastfeeding…Observational studies and interviews with families in their home environment should be conducted. An inductive approach is best as it elicits the mother's point of view (Ewing & Morse, 1989, p.27).

In making a case for the need to contribute to a substantive, theoretical and experiential account of the practice of breastfeeding it was necessary to select a research method that would provide the best means for that endeavor. Grounded theory method is able to accommodate an understanding of both social interaction and conceptual experience. The suitability of grounded theory method is explored in this chapter. The philosophical underpinnings of the method are introduced, followed by a summary of the process of grounded theory, as it is currently understood. The historical development of the method, which has culminated in a methodological split between the two authors of the method, Glaser and Strauss, is also explained.

Having introduced the philosophical underpinnings and methodological distinctions I then explore the evolution of grounded theory method. A selection of published nursing research, as examples of literature that has used grounded theory method, is also presented as a selection that is indicative of the methodological strengths of grounded theory. This is to demonstrate that grounded theory method can illustrate both social interaction and conceptual phenomena. In the remainder of the chapter I elaborate on the implementation of this research, considering access to participants, and the research process.

5.2 Grounded theory: the philosophical underpinnings

Grounded theory is one of many qualitative approaches to research that is broadly described as interpretive research (Lowenberg, 1993). Grounded theory is a method that is founded in the Chicago School of Sociology and is philosophically connected

with symbolic interactionism (Blumer, 1969; Mead, 1934; Mead, 1964). Symbolic interactionism has formed the basis for many qualitative methods such as sociological study, grounded theory, ethnomethodology and interpretative interactionism (Lowenberg, 1993). Symbolic interactionism as an explanation of human behavior was a response to the notion of society as an ordered, unified and naturally evolving whole (Bowers, 1988). The symbolic interactionist considers the self as dynamic, interacting within a social context, and evolving over time. According to Mead (1934) the concept of self is learned through social interaction. Mead asserts that self is acquired from the ability to see 'self' from the perspective of the other; this enables an individual to hold a concept of self. "The self is formed in the same way as other objects - through the definitions made by others" (Meltzer, 1967, p.10). It is Blumer (1969) that extends this position to incorporate self directed behavior. This approach is consistent with pragmatism and determinism (Corbin & Strauss, 1990) that is, an expression of individual control in self determining choice making.

Three important assumptions about individuals underpin symbolic interactionism. These assumptions are; that humans act toward things on the basis of the meanings they hold for them; this meaning is derived out of social interactions with others and the meanings are modified by the individual as an interpretative process (Chenitz & Swanson, 1986). With these assumptions the researcher "...is primarily concerned with discovering the realities of the subjects, the nature of the objects in their world and how they define and experience their world" (Bowers, 1988, p. 39). These three assumptions are contingent upon the individual's developmental competence. That is, an adult can express by various means a subjective reality, the nature of objects in the world and their definition. A baby or child may not have the ability yet to express by verbal language the symbols and meanings usually associated with social discourse. This is a particularly important point when considering the dynamic and social nature of the process of breastfeeding. In a developmental sense both participants are not equal. It is therefore, necessary to introduce the premises of social constructionism in order to account for the infant's involvement and contribution to the breastfeeding exchange. If a strictly symbolic interactionist approach were held the infant's contribution would be marginalised, as the contribution of the infant is restricted if self determination and pragmatism are

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assumed. That is not to say the infant is not able to exert influence and alter maternal behaviors, rather it is the development of the infant associated with the breastfeeding exchange which is not well addressed in symbolic interactionist theory.

Symbolic interactionism is consistent with a social constructionist approach to human development in that the social situations enable the perception of 'self' to be reconstituted and redefined. A social constructionist approach would embrace the position stated by Mead (1934). "Meaning can be described, accounted for, or stated in terms of symbols or language at its highest and most complex stage of development (the stage it reaches in human experience), but language simply lifts out of the social process a situation which is logically or implicitly there already. The language symbol is simply a significant or conscious gesture" (p.79). The essential point here is that symbols are interpreted, ascribed meaning and that meaning is reflected back, reinforcing and completing meaning exchange. This is a position held by symbolic interactionism; put simply by Beck (1996), "…human beings influence each other as they go along" (p.2).

Lock, Service, Brito, and Chandler (1989) capture this point about symbols being ascribed meaning when they note, "Actions are constituted as gestures in the course of the interaction that constitute their meanings, and culture, through specifying the form of the interactions, determines the meanings they constitute" (p.248). The essential positions held by the social constructionist that meanings may be ascribed differently between individuals, cultures and over time, are common to the symbolic interactionism approach.

Charmaz (1994) has linked symbolic interactionism to the constructionist approach in work on chronic illness. Charmaz acknowledges the strength of the grounded theory method when a symbolic approach and constructionist approach are combined. The symbolic interactionism approach "assumes that as thinking, acting creative individuals, humans beings respond to the actions of others after interpreting these other's intent and action" (Charmaz, 1994, p.66). According to Charmaz the constructionist "assumes an emergent reality fundamentally shaped by social actions" (p.67). This combined perspective, symbolic interactionism and social

constructionist, enables the grounded theorist to study both fluid interactive processes, stable social structures and self.

5.3 Grounded theory

Grounded theory method enables the study of social phenomena by seeking to interpret the meanings of events, and the symbols used to convey those meanings. The initial question of concern to a grounded theorist addresses the illumination of process elements and seeks to ask; "What are the basic social and psychological processes that explain interaction in a particular setting or under certain conditions" (Wilson, 1989, p. 481). More simply, the question "What is going on here" is the concern of grounded theory method (Glaser, 1978). The intention of this question highlights the perspectives that underpin grounded theory method. These perspectives are based on the acknowledgement of human interaction, represented by symbolic meaning, evolving and dynamic, in response to social interactions between individuals who are self determining. Thus the philosophical approach is concerned with the located present and this forms the referral point for the phenomenon (Christensen, 1996); there is no "privileged, absolute, or timeless perspective" (Christensen, p.49). In this sense the contextual and substantive nature of the phenomenon is reflected in the representation. The claim to generalisation is not made with grounded theory; the contextual position is a reflection of the 'here and now' of the phenomenon.

5.4 Methodological development

Two sociologists, Anselm Strauss and Barney Glaser developed grounded theory, in the 1960s (Baker, Wuest & Stern, 1992). Formally introduced as a methodology for theory construction in a book entitled *The Discovery of Grounded Theory* (Glaser & Strauss, 1967) the method has been developed and refined by the original authors in subsequent major writings (Corbin & Strauss, 1990; Glaser, 1978; Glaser, 1992; Strauss, 1987; Strauss & Corbin, 1994). The authors considered the traditional approach to theory development as restrictive and often laboriously irrelevant. They suggest that verification of existing theories had stifled academic intellect.

Currently, students are trained to master great-man theories and to test them in small ways, but hardly to question the theory as a whole in terms of its position or manner of generation. As a result many potentially creative students have limited themselves to puzzling out small problems bequeathed to them in big theories...we contend, however, that the masters have not provided enough theories to cover all the areas of social life... Further, some theories of our predecessors, because of their lack of grounding in data, do not fit, or do not work, or are not sufficiently understandable to be used and are therefore useless in research, theoretical advance and practical application (Glaser & Strauss, 1976, p.10-11).

Grounded theory method was born of dissatisfaction with traditional approaches to theory development and the need to theorise in areas of social interest. The foundation authors of the method demonstrate in their writing a commitment to theory as an important scientific contributor, a commitment to explanation and prediction (Glaser & Strauss, 1967, p.8). Yet, these same authors remind the researcher that excessive concern for evidence and verification of a hypothesis can quickly stifle theory generation (p.28). The emphasis in grounded theory is development of theory by generation, not verification (p.29), that is, the emergence of theoretical abstraction from substantive data. Thus, grounded theory is essentially an inductive approach to knowledge generation. While symbolic interactionism can be considered as the basic philosophical premise of grounded theory, Glaser (1992) notes that other consistent sociological perspectives have influenced the development of grounded theory method. These perspectives are captured in the phrases which indicate the importance of an "adherence to the data", a commitment to "generative theory", and "naturalistic inquiry" (p.16). On reflection, Glaser (1992) asserts that grounded theory can represent the "complex changing variability in life" and "the interrelationship between meaning in the perception of the participants and their actions" (p.16).

5.5   The methodological split

Glaser's (1978) book entitled, *Theoretical sensitivity: Advances in the Methodology of Grounded Theory,* was an elaboration on the original method (1967) and was published as a supplement to this work. Strauss in 1987 published his own version of

the methods advance, *Qualitative analysis for social scientists,* a book that provided a much more directive procedure for undertaking the grounded theory method. Corbin and Strauss went on to publish, in 1990, a very detailed account of the method entitled *Basics of qualitative research* which prescribed methodological frameworks with which to conceptualise and interpret grounded theory data. This work proved to be the catalyst for division between Strauss and Glaser resulting in the publication of Glaser's 1992 book *Basics of grounded theory analysis*. This work was a reply to Corbin and Strauss' 1990 work and strongly refuted their interpretation of the method suggesting that "Strauss' book is without conscience, bordering on immorality" (Glaser, 1992, p.5). Glaser further asserts that Strauss and Corbin "wrote a different method so why call it 'grounded theory' " (Glaser, 1992, p.2). Glaser holds the position, that the original work or Glaserian School is grounded theory and Strauss' work represents conceptual description.

From this history of methodological split I deduced that, while Glaser and Strauss were initially concerned about the restrictive nature of deductive theory verification they have perpetuated the need for methodological review and refinement. In doing so they have inadvertently energised writing and consideration of the method thereby somewhat subverting the original calls for substantive-based research-generated theory. Stern (1994) comments on the methodological difference between Glaser and Strauss, suggesting that two types of grounded theory have emerged.

> In Glaser and Strauss we have two brilliant men who both do important work. But they go about it in different ways. The crux of the dichotomy is, I think, that Strauss, as he examines the data, stops at each word to ask "what if?" Glaser keeps his attention focused on the data and asks, "What do we have here?" (Stern, 1994, p.220).

Much of Glaser's recent work (1992, 1993, 1994, 1995) is concerned with refuting Strauss' methodological advances and elaborating on the method as it has been utilized in "good examples" (Glaser, 1993, p.1). It is the flexible and less rigid grounded theory approach advocated by Glaser (1978, 1992, 1998) that is utilized in this study. That is, an adherence to the grounded theory method as emergent theorizing rather than conceptual forcing. The Glaserian approach to grounded theory method as the application of grounded theory in this study has remained

consistent with the method as advanced in the publications, *Theoretical sensitivity: Advances in the methodology of Grounded Theory* (1978), *Basics of Grounded Theory analysis* (1992) and *Doing Grounded Theory: Issues and discussion* (1998). The following explication is therefore concerned with outlining both the process and premises of Glaserian grounded theory method.

5.6   Glaserian grounded theory

To be consistent with Glaserian grounded theory method the researcher needs to gain understanding of an experience/interaction, as the participants understand it. The researcher seeks to understand the world of the participants, interpretation of self in interaction and their definitions (Baker, Wuest & Stern, 1992). According to these authors the researcher must also put aside cherished perspectives to allow for the participants' perspectives to take precedence. The importance of the participant's perspective is highlighted by the researcher's assumption that the information given by the participants is accurate (Fawcett, 1991).

Grounded theory method (Glaserian) is an inductive qualitative research methodology. Research is directed toward the generation of a process theory via comparative analysis of the data (Glaser & Strauss, 1967). As a method it is process orientated, occurs in naturalist settings, is descriptive, and focuses on dynamic reality in social settings (Woods & Catanzaro, 1988). According to nurse researchers, Chenitz and Swanson (1986), the process of grounded theory method is constant comparative analysis of data. Interviews and data sources such as literature, field notes, memos and any other associated information are coded according to the substance of the data. These initial codes are substantive, from the substance of the symbols used i.e. words, body language, and are known as in vivo codes. These first codes are compared, constructed into groupings and categorized. As data collection continues the substantive codes and categories may grow and be refined. Families of categories may develop and with these families theoretical classifications are considered and compared, consideration of expression of process or dynamic relationships are explored. Data collection continues until categories are saturated; that is, no further new substantive codes are recognised. The idea of data saturation is pivotal to grounded theory method.

Saturation involves the use of probing questions by the researcher that provide dense consistent data for the emergent codes and categories (Glaser, 1978, p.48). According to Glaser and Strauss (1967) "Saturation means that no additional data are being found whereby the sociologist can develop properties of the category" (p.61). Morse (1995) elaborates on the significance of saturation as a key to excellent qualitative work, asserting that "Researchers cease data collection when they have enough data to build a comprehensive and convincing theory" (1995, p.148). As theoretical classifications arise they are considered with respect to the data and associated literature and a core category emerges which best represents the relationship between all other categories. The core variable/classification is called the 'Basic Social Process' (BSP) and is considered to be a fundamental pattern for that situation of study. The 'Basic Social Process' can be two types of processes,

> …basic social psychological process (BSPP) and basic social structural process (BSSP). A BSPP refers to social psychological processes such as becoming, highlighting, personalizing, health optimizing, awe inspiring and so forth. A BSSP refers to social structure in process-usually growth and deterioration - such as bureaucratization…A BSSP abets, facilitates or is the social structure within which the BSPP processes (Glaser, 1978, p.102).

The basic social process is presented in relation to the other categories via theoretical propositions and relationship statements, represented as a substantive theory. Substantive theory is developed for an empirical area of inquiry (Glaser, 1978, p.144). The process of theoretical sampling enhances this building toward abstract conceptualisation, from code to category, including the property of categories and their relationship within the theory, to a basic social process.

Theoretical sampling is, according to Glaser (1978, p.36), the process of data collection controlled by the emerging theory. The initial decisions for sampling are made based on the phenomenon of interest (p.44). The analysis of data directs the researcher to ask particular questions and access various samples and other sources of data as they contribute to the phenomenon of interest. Simply "The process of data collection is controlled by the emerging theory" (Beck, 1996, p.2). In this way, "The analyst who uses theoretical sampling cannot know in advance precisely what to sample for and where it will lead him [sic]" (Glaser, 1978, p.37). It is expected though that the phenomenon of interest remains central to the sample, particularly

for substantive theory. More formal theory development may include a sample that is theoretically directed to another unit of interest, another conceptually similar phenomenon (Glaser, 1978). A good example of the synthesis of different units of study, with a common phenomenon of interest, is the work by Stern (1996), which presents a conceptual framework of women's health as a result of using grounded theory method to determine dimensions of women's health from selected published articles.

5.7   Theory construction

Categories are, according to Glaser (1992, p. 37) and Glaser and Strauss (1967, p.36), concepts with high level abstraction, that are supported by conceptual elements of a theory and by conceptual properties. In naming a category, one supports the abstraction from the original substantive codes with constructs and in vivo words. Constructs according to Glaser (1992) are a form of theoretical writing and sensitivity to conceptualize the data, while in vivo words are the substantive data. Thus, the categories in this work are supported by concepts, which are theoretical conceptualizations of the data, and also in vivo or substantive codes. The constructs, which support a category, are able to theoretically relate the codes and concepts within a category and between other categories, thus they provide analytical substance to the theory. The in vivo codes (substantive codes) are able to provide the imagery so that illustration of the codes is not always required (Glaser, 1992, p.70).

Beck summarises the relationship between substantive codes and theoretical codes as, "Substantive coding fractures the data into pieces, whereas theoretical coding helps weave the fractured data back together again" (1996, p.5). In this way, the theoretical codes hold common integrative connections between categories. Perhaps one of the most difficult aspects of Glaserian grounded theory is the notion of theoretical families of codes (Glaser, 1978, p.74). Essentially families of codes are patterns of possibilities that the researcher might consider in order to illuminate the connections between theoretical codes. These patterns might include process, or stages, it might include strategies, like tactics, ploys or techniques. Glaser (1978, p.73) offers 18 possible types of patterns or relationships between codes as working examples and recognises that the researcher may think of others. In order to present a

substantive theory it is necessary to consider the characteristics that are associated with substantive theory.

Substantive theory is, according to Glaser and Strauss (1967, p.32), developed from the empirical or substantive area of inquiry and is usually classified as a middle range theory (p.33). Middle range theory is focused on limited aspects of phenomena (Jacox, 1974), is characterized by consideration of a number of variables, has a particular substantive focus and might be consolidated into more wide ranging theories or grand theories (Meleis, 1991, p.228). Middle range theory development is particularly applicable to nursing theory development, as it is able to provide sufficient scope for empirical testing without the restrictive and specific focus on isolated factors associated with single domain theories. Substantive theory is also able to accommodate the phenomena of nursing practice situations (Meleis, p.229; Stevens-Barnum, 1990, p.236). The substantive theory presented in this work is both descriptive and explanatory, in that it gives information about the phenomenon of interest and also begins to provide linkages and descriptive relationships between the concepts. As a descriptive, explanatory theory the structural components include the "Client's state or condition; and patterns of responses to conditions, situations, or events, analyses of the contexts of conditions and responses, and analyses of promoting and inhibiting contexts" (Meleis, 1991, p.20).

5.8 Nursing and grounded theory

The importance of theory development for nursing practice is well-documented (Fawcett, 1978; Johnson, 1974; Meleis, 1991; Stevens-Barnum, 1990). Such documentation is concerned with the application of theory to the practice discipline of nursing. Meleis (1991) notes that not until empirical modification or validation of (nursing) theory is complete can the theory be given practical validation and direction to practice. It is this tendency for practical validation, which is the significant characteristic in substantive (grounded) theory. Nurse researchers have recognized the usefulness of grounded theory as a qualitative method (Bowers, 1988; Baker, et al., 1992; Chenitz & Swanson, 1986; Morse, 1989; Wilson, 1989). It is not surprising that nursing research can find a useful place for grounded theory as the method was initially used in a nursing school at the University of California, San

Francisco. Glaser and Strauss, both members of the nursing faculty, manipulated existing sociological methods (developed grounded theory) to explore the meaning of dying (Glaser & Strauss, 1964). It was this 'tinkering'with existing methods (Stern, 1994) that resulted in the original work on grounded theory as a method (Glaser & Strauss, 1967).

New Zealand work by Christensen (1990) applied the grounded theory method to a practice concern and resulted in the generation of a nursing model entitled *Nursing Partnership: A model for nursing practice*. This exciting work is testimony to the usefulness of grounded theory method in describing the complex process and interactions of surgical patients' experience of hospitalization and elective surgery. Appropriate use of the method is in the investigation of relatively uncharted waters or to gain a fresh perspective in a familiar situation (Stern, 1980). Perhaps it is this aspect, the illumination of nursing practice issues previously un-researched that prompted such interest in the method. In a nursing conference on qualitative research Cohen (1994) notes, "More than 150 studies were published in the 30 month period between January, 1991 and June, 1993 that claim to have developed a grounded theory" (p. 206). Wuest (1995) notes that the complexity of nursing has challenged nurse researchers to consider methods, which better suit nursing concerns.

> ..., nursing scholars have embraced their [Glaser and Strauss] methodology in order to gain knowledge of problems specific to their patients, and nursing work required in helping patients solve those problems (Keddy, Sims, & Stern, 1996, p.450).

Grounded theory method enables researchers to capture the dynamics of process and represent complex social interactions. Perhaps this aspect has attracted nurse researchers to use grounded theory method. Despite the appropriateness of grounded theory method as a nursing research methodology, nurse researchers have not always adhered to the original method.

5.9 Grounded theory critique and change

Published research that claims to have developed a grounded theory has attracted much recent comment with regard to the erosion and shortfalls of the method (Baker, et al., 1992; Becker, 1993; Cohen, 1994; Skodol Wilson & Hutchinson, 1996; Stern,

1994). Primarily the critics are concerned with methodological rigor, method muddling and poor mentoring. In the more recent work of Skodol Wilson and Hutchinson (1996) new criticisms are added to the critique; the first criticism is the use of generic concepts and the second is the importing of existing concepts. These criticisms are concerned with theory generation that uses thin data or moulding the theory to existing conceptual schemes. In addressing these concerns I have provided (in subsequent text) a clear decision trail that establishes the rationale for the research process in the present study, based on the grounded theory method. This conscious action is undertaken to facilitate 'trustworthiness' (Koch, 1994) in the rigor of the method. I consider the introduction of the concept of intimacy not the end point of my analysis but rather the initial phenomenon of interest. It is to this end that my assumptions and intentions are made explicit. Similarly my consideration of existing conceptual schemes has taken place in response to theoretical direction from data analysis and has thus resulted in synthesis or redefinition of some existing concepts.

More recent writing about the method considers the reflexive and subjective involvement of the researcher. Keddy, Sims, and Stern (1996) argue that "For the symbolic phenomenon to be interactive the researcher and participants must be fully involved" (p.451). They further suggest that to date, few grounded theory researchers have acknowledged the interactive stance between researcher and participant. The exception to this is Stern (1991, 1994) who recognised the need to make explicit researcher and participant interaction. Keddy, Sims, and Stern (1996) note that,

> Most grounded theorists today check out each transcribed interview with the participant to determine whether this was the story she meant to tell, and if there is anything to add. As the analysis progresses, participants are contacted once again to see if the main story line agrees with what they consider most vital. This solves the problem of integrating multiple story lines (variables), and allows the target group to be true participants in research (p.451).

I wish to make a distinction here as recent methodological development has resulted in a method known as 'feminist grounded theory'. Feminist grounded theory holds several positions of congruence with grounded theory method. Wuest first publicly considered these in a work in 1995 and reported several similarities between grounded theory traditions and feminist traditions. The similarities between the two

traditions include an attention to the dynamic and changing reality of knowledge and both accommodate the diversity of social experience. Wuest further notes that grounded theory and feminist research is concerned with attending to the voices or subjective reality of the participants acknowledging the contextual reality of experiences. Both approaches also acknowledge the researcher's own involvement and interpretive role and provide useful knowledge that is directly accessible and applicable. Nevertheless, perhaps the most obvious congruence between feminist research and grounded theory is the researcher and participant relationship, a reflexive and relaxed relationship. Feminist grounded theory has become increasingly popular as a mechanism for nursing research (Davidson, 1995; Merritt-Gray & Wuest, 1995; Silko, 1993;Wuest, 1995, 1997a, 1997b). The researcher participant relationship is a mutual co-ownership and power-sharing relationship in feminist grounded theory. According to Connors (1988) this type of relationship belongs to a new paradigm of research not traditionally associated with grounded theory. This reflexive approach is a natural extension of the interactive nature of Glaserian grounded theory but is *not* consistent with Glaser's approach to data analysis.

Many grounded theory authors have applied a feminist analysis to the theoretical findings (Duffy, 1992; Juarbe, 1994; Lugton, 1997; Nay, 1994; Rogan, et al., 1997). The application of feminist interpretation to the *findings* of grounded theory is an acceptable and responsible position. However, the direction of theoretical questions, which are constructed around feminist positions is a departure from Glaserian grounded theory. An example of this is found in Wuest (1997a, p.50) who notes in her study, "In keeping with the principles of feminist research, efforts were made to reduce oppression in the research process…".

I do not wish to marginalise the argument of congruence between grounded theory and feminist perspectives (Wuest, 1995), but rather to recognize the emergence of a new methodology (Keddy, Sims & Stern, 1996). I did not apply feminist grounded theory to this study as the central question was not pre-determined to embrace feminist concerns. My implementation of the method was not directed by feminist concerns. I entered the grounded theory research process acknowledging that if feminist issues were of central concern they would emerge theoretically. In adhering

to this position I was acting in faith that the method would provide a mechanism for theoretical positions to emerge.

Glaser (1978, p.23) warns against premature influence on category construction by talking with others and the need to be directed theoretically in both sample and question (1978, p.40). While Glaser and Strauss (1967) recognise the importance of the need to gain rapport with participants the direction of questions and emergent theory is the prime concern of the researcher. To this end, confirmation of accurate transcribing of data from participants is not directed at analysis (Glaser, personal communication 20/5/96). It is therefore considered to be unnecessary to return transcripts or data for participant reflection. It is however, consistent with the credibility of substantive theory that respondents should recognise and provide validation of the resultant theory.

5.10 Grounded theory, credibility and fit.

Glaser and Strauss (1967) are very clear about the credibility of grounded theory method. They suggest that theory generated by this method must have "fit", be "understandable", "general" and allow for user "control" (p.237). Fitness indicates the substantive theory's ability to correspond closely to the data (p.238). Glaser and Strauss further suggest that when a theory does not "fit" data are forced into categories and relevant data might be neglected. Grounded theory that is "understandable", is an indicator of the theory's workability, that is, the close correspondence to the realities of the field thus making the theory understandable to those people who work in the field. Obviously theory that is understandable is more likely to be utilised, explored and further developed. This utilisation of theory is also dependent on the theory's generality (Glaser & Strauss, 1967, p.242). Theory should consist of categories that should not be too abstract to the realities of the situation, but abstract enough to guide in many similar situations in an ever-changing context. Glaser and Strauss suggest that with grounded theory method the user has control (p.237) of research dissemination and is responsible for the adjustment of the theory in practice, thus the theory is part of a process, an "ever-developing entity" (p.242).

5.11 Grounded theory method: the study of concepts, and breastfeeding

There is a small but relevant body of literature that has combined grounded theory and the study of various aspects of breastfeeding. Further grounded theory method includes conceptual refinement and definition. In order to strengthen the position that grounded theory is a useful method for this study I argue the relevancy of the literature based on two strengths. Firstly, without exception the studies attended to the substance of the data and reflected the participants' experiences. Secondly, the findings reflect the dynamic and process aspects of the phenomenon of study.

Morse and Bottorff (1988) used a grounded theory method to study the experience of breast milk expression with 61 successfully lactating women. The findings indicated that the participants were located within two conceptual groups. Expressing breast milk held two distinct meanings for the two groups of women. For one group the practice was mechanical and messy, while the other group experienced embarrassment and awkwardness. This demonstrated both the dynamic of the situation allowing for diversity of experience and the dynamic of the experience. Keith (1997) considered how women make an infant feeding decision. In this work the author found six conceptual properties that reflected the decision-making process in infant feeding. The categories were; 'benefits to infants', 'mother's decision', 'procedural issues', 'body circumstances related to infant feeding', 'relationship factors and need for expertise'. These concepts reflect the experiential aspects of feeding choice.

A 1996 Portuguese grounded theory study reported that women decide about breastfeeding and weaning by 'weighing the risks and benefits'. The findings supported concepts that demonstrate "the interactive situations experienced by the breastfeeding woman" (Silva, 1996, p.170). Again the process and experiential aspects are demonstrated in the findings.

Breastfeeding as an empowerment process was the central concern for the Locklin and Naber (1993) grounded theory study. The authors considered this issue, as it was

experienced by a select group of low income, minority women of Hispanic ethnicity. The findings indicate that five themes emerged as descriptors of the experience of breastfeeding for these women. The themes were; 'against the odds', 'personal motivation', 'support', 'attachment', and 'telling the world'. They reflect the experience of the sample and indicate a process associated with factors that might enhance successful breastfeeding practices. Similar work reported by Locklin in a 1994 doctoral thesis, describe the breastfeeding experiences of a selected group of educated, low income, minority Hispanic women who were supported by a peer counselor. The findings were remarkably similar to the Lockin and Naber study (1993). Locklin reported five themes, 'making the discovery', 'seeking a connection', 'comforting each other', 'becoming empowered' and 'telling the world'.

Lothian's (1989) doctoral study was concerned with the process of breastfeeding over a one-year period with five couples. The central questions sought to describe what factor/s influence the choice to breastfeed and the continuation of breastfeeding. Lothian found that a complex network between the mother, the baby, and the support network could be demonstrated in a three stage model 'continuing to breastfeed'. This study also found valuable the importance of the baby's contribution to the patterns and duration of breastfeeding. This finding is significant given that I have argued in Chapter Four that the baby's contribution to the breastfeeding process has not been well demonstrated. The Wrigley and Hutchinson (1990) grounded theory study considered the experience, concerns, conflicts and relations of breastfeeding women who feed for longer than one year. The findings indicate two processes; the first, 'synchronization' in which the mother moves in pace with her child and the second, 'reorientation', in which the mother rearranges the focus of her lifestyle to the child. The authors note that as these processes evolve the mother develops a secret bond with the child that limits intrusion into the relationship. This work clearly represents a dynamic and process orientated experience of long term breastfeeding.

Gamble and Morse (1993) used grounded theory and examined husbands' experiences of having their wives breastfeed. They justified the use of grounded theory method in that it is "... designed to develop substantive theory. Such theory

results in the identification of salient concepts and variables..." (Gamble & Morse, 1993, p.368). The authors found that fathers postponed their relationship with the child as a result of breastfeeding. The authors represented the postponing fathering styles conceptually as a four-phase process.

Grounded theory method is most useful in illuminating concepts. Examples of this kind of work by nurse researchers include, Morrison (1990) on toughness, Wagnild and Young (1990) on resilience, Estabrooks and Morse (1992) on touch, Lutzen and Nordin (1993) on benevolence. Further, grounded theory has proved useful for illuminating the process involved in parenthood. Jordan (1990) described the experience of expectant and new fathers using grounded theory method resulting in a substantive theory on the phenomenon of new fathers. The method also had merit for the study of men during their partner's pregnancies (Donovan, 1995), as the method "...was seen to be suited...because of the limited nature of this phenomenon" (p.709). Thus complex concepts and constructs such as parenthood can also be studied using grounded theory method.

I have concluded, from my review of the grounded theory breastfeeding and concept literature that grounded theory method is well suited to understanding both process elements, and clarifying concepts. This is directly relevant as it supports the use of grounded theory method in the inquiry into breastfeeding mothers' experience of intimacy.

5.12 An introduction to the study design

In the following sections I elaborate on the design and process of the present study, considering the study management, ethical consent, sample characteristics, access to participants, and data collection methods. Throughout the explication adherence to the grounded theory method will be demonstrated. As previously mentioned, grounded theory studies are dependant on saturation of core categories by theoretical sampling in order to successfully develop a theory which has dense and stable integration of core properties (Glaser & Strauss, 1967, p. 70-71). It was to this end that this study was undertaken in two stages.

The study proposal was initially designed to meet requirements for a Master of Arts degree. As the theoretical complexity and scope became evident a case was made for the study to be transferred to the doctoral program. The justification for the transfer was to further refine the substantive theory by saturation of existing categories and to strengthen the theoretical framework. I sought to advance the theoretical density by further describing the process of emotional and physical intimacy as experienced by breastfeeding women. The transfer was accepted (Massey University Doctoral Committee, 1994); this enabled further theoretical sampling, data collection and analysis. Though data collection and analysis occurred in two time frames the sample is integrated and represents one theoretical sample.

Over the study period a number of presentations and publications (Dignam, 1995a, 1995b, 1998) have been produced. These in part have helped to shape and refine my theoretical thinking. The 1995 paper provided a mechanism for refining my initial thoughts, assumptions and understanding of the topic. My topic of interest was refined as a result of an extensive literature review in the topic areas of breastfeeding and intimacy, and a clinical working knowledge of the field. Publishing on the topic prior to the data collection and analysis made explicit my "pet" ideas and contemporary knowledge. According to Glaser (personal communication 20/5/96) this was an appropriate way of handling the literature and my own field or clinical practice knowledge. Reading extensively in the area of inquiry is not recommended by Glaser (1978, p.31). However, I would suggest that this edict relates to reading in the substantive field. As argued in chapter four, breastfeeding is not a discipline but rather a topic to which various perspectives are applied. It would be most difficult to arrive at a point of study without the information to argue a need for research. Grounded theory method texts do not provide any direction for the researcher who is expert in the topic area, but rather suggest that it is preferable to research outside of the topic one is familiar with. It is my contention that such a position is not always practically possible and discounts the value of expertise. Christensen (1988) noted that "a nurse researcher cannot pretend that there is no background of experience and knowledge, as well as some familiarity with the literature and the nursing setting, to influence the research conduct and outcomes" (p.59). Writing a position paper and illuminating assumptions and ideas before commencement of the present study, well before data collection and analysis, clarified the point of entry to the present study.

The 'prior publication' process as I have described provides an alternative for the researcher who comes 'informed' from the field.

Glaser has verified the 'prior publication' process by both acknowledging my personal communication and publishing my letter in his most recent work (1998). In the letter I outlined a number of steps I took to keep true to grounded theory method. The abridged letter and full response (cited in Glaser, 1998, p.121-122) are as follows,

> Dear Barney,...As I was unsure of the method I might use in this research, I undertook an extensive literature review in the area of social support and breast feeding...I then explored the idea of intimacy as a concept to see what dimensions might exist. I discovered that little was known or understood about breast feeding as a woman's experience of intimacy and was immediately drawn to this area of interest. As I had extensive clinical background counseling breast feeding women, I could see that this area would have implications for clinical practice.
>
> I thought at this early stage that the phenomenological method would best illuminate this experiential area, however having read extensively about the grounded theory method I became increasingly aware that I was interested in what was happening for breast feeding women in their experience of intimacy. Realizing that I was now well familiar with applicable literature and therefore far from naïve I wrote a position article based on the literature I had reviewed. This review highlighted my assumptions for this study area and also the possible clinical implication of a study in this area. I found this exercise cathartic and a way of being honest about my assumptions and premises prior to entering the field of study...
>
> In doing a grounded theory I was careful to only offer the area of interest in my interviews. I was anxious to allow women to both define and elaborate without constraint on the topic of intimacy as experienced by breastfeeding women, by not asking specific questions.
>
> Over the period of data collection I undertook to open code, memo and keep theoretical notes. I found as the categories emerged that the social support literature I had originally started with had very little if any relevance. Aware of my own experiences as a mother and clinician in the field, I wrote field notes on my own feelings and experiences...Ever the skeptic and keen to be true to the substantive nature of grounded theory I started to check myself in two ways. Firstly, I took a number of mentioned codes in the literature to see if these were hijacking my emergent theorizing. I was pleased to see that they were not influencing the importance of theoretical relevance of the emergent categories. Secondly, they were not influencing theoretical memos relating categories to each other.

Glaser comments directly after the letter thus,

So we see in this letter to me, that suspending one's knowledge of the literature by clarifying assumptions so they would not force the data and doing field notes on one's experience to correct these preconceptions also worked. She found that the problem based on the literature had little relevance and that interviews based on the literature would preconceive the interview. She came upon grounded theory after preparing herself to do study in the traditional way, so she took extraordinary measures to suspend her knowledge and stay open to the problem of the respondents. Her communication also points to the interesting pattern that many grounded theorists study an area of interest which includes studying life cycle interest through looking at many other people. The result is that they personally learn quite a bit about their life cycle interest in a transcending, general way which helps them in their personal handling of the problem. The grounded theory works for them, as well as for the people in the substantive area. For another example, my study of scientific recognition helped me personally in the design career in research-teaching. Sociology through grounded theory gives a useful perspective on one's own situation. The grounded theorist becomes his/her own consultant (Glaser, 1998, p.122).

This response affirms the measures I took to remain open to the data or as Glaser puts it, to remain theoretically sensitive.

5.13 Ethical considerations

Consent for this study involved a two-stage process. The first ethics approval was acquired through a Departmental Ethics Review Committee (Department of Nursing and Midwifery, Massey University) in October of 1993. In February 1995, the study was re-approved as a doctoral requirement by Massey University Human Ethics Committee. Ethical concerns addressed access to participants, informed consent (Appendix II), confidentiality, potential harm to participants, right to decline, arrangements for participants to receive information and the use of information.

Each participant was given an information sheet (Appendix III) and encouraged to consider carefully their involvement with the study. All data in the form of tape recordings, transcripts, computer disks, field notes and life space drawings were given a code. These data were stored in a secure file and access limited to the researcher and supervisors. Any transcribed material handled by a typist was protected by a typist confidentiality contract (Appendix IV).

Any writing, presentations or reference to the data in a public forum used only codes and all personal identifiers were obscured. These codes are subsequently used in the presentation of the transcript data in the data chapters. The letter indicates the participant, the next number indicates the interview followed by line numbers i.e. K1, 765-768. Often line numbers seem to indicate that a number of lines account for just a small sentence. This is due to the format of the coding transcripts and the lines correspond to the original transcripts in order to maintain the auditability of any substantive data.

Access to interview and observe was negotiated with each participant and enabled the participant to nominate venue and time. At all times it was the concern of the researcher to maintain confidentiality. Most interviews were undertaken in the participants' homes though three respondents chose an alternative venue. On each of these occasions, where an alternative venue was used, I was mindful to raise the issues of anonymity and confidentiality. For each of the participants, who met with me outside of the private home environment, the nominated venue remained the place of their choice.

As a nurse researcher, ethical concerns regarding professional involvement can arise. Swanson (1986, p.68) considers the two roles of nurse and researcher to be potentially problematic. This position essentially assumes conflict of interest and participant confusion about the researcher role. Participants in this study were informed of my own status as a nurse. I did not seek any recognition of my clinical expertise during the course of the research, however had a situation arisen where participant advocacy or intervention became imperative I would have acted in a professional manner. As a nurse the professional mandate to intervene becomes salient, when situations of life threatening severity present. During the course of this study no such cause for intervention presented. I was, however, asked on occasion for professional advice. These occasions usually presented outside of the interview or contact period. While I was more than able to offer appropriate advice the commitment to direct the participants to their usual health professionals had been outlined in the information sheet. The information sheet had also provided the participants with a list of appropriate agency contacts (Appendix III). This enabled me to refer the participants to those appropriate contacts over matters of clinical

advice. This in turn promoted my role as researcher and demonstrated faithfulness to the conditions of participant consent.

Participants were also offered the option of a summary of the findings and access to the final document. Not all participants indicated they wanted this option. All participants have had access to the preliminary theoretical model. Returning for a final interview with the participants I was able to share the model with them. This sharing promoted discussion about the categories and their relationships and enabled me to ascertain the degree of fit and relevance the model held for them. This process of showing the theory at the later stage of analysis is not addressed in the grounded theory texts, where concern for trustworthy theory is placed with the research consumer (Glaser & Strauss, 1967, p.98). It is however, an appropriate strategy for reassurance of the theory's substantive 'fit'. According to Glaser you "...do not show respondents data. Later the theory only" (Glaser, personal communication, 20/5/96).

5.14 Sampling

Grounded theory method requires the sample size and characteristics to be theoretically driven. That is, "Theoretical sampling is the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his [sic] data and decides what data to collect next and where to find them, in order to develop his [sic] theory as it emerges" (Glaser & Strauss, 1967, p.45). In this respect data collection via sample is dictated by the theoretical emergence. This is problematic at the initiation of a study, as theoretical direction is yet to be determined. Therefore the sample characteristics which determine the starting point of the study are based on informed guesswork, the best guess at an appropriate sample. Thus the sample for this study was initially directed at the population most likely to be experiencing the phenomenon of interest, breastfeeding women. What "type" of breastfeeding women at this stage was irrelevant in terms of theory generation as the method directs further sampling. A theoretical sample is not representative of a total population nor does it hold any statistical significance but rather is representative of the situation in which the phenomenon might exist. A range of situations is sought to ensure categories are saturated and further sampling is undertaken to develop these categories, and their relationships (Chenitz &

Swanson, 1986). The initial sample was directed by certain ethical concerns, such as the vulnerability of new mothers in the early postpartum period.

5.15 The sampling strategy

In recognition of the vulnerability of first time mothers and the experience in transition to parenthood (Hoffman Steffensmeier, 1982; Jordan, 1989; Miller & Sollie, 1980; Russell, 1974), I sought breastfeeding women with a healthy infant who was not a first child. I recognised the adjustment and energy required in the initial stage of parenting and considered it appropriate to interview women who had an infant between eight weeks and six months of age. Any woman who had an infant with significant health problems resulting in hospitalisation for lengths of time was excluded from the study. I considered that a mother who was experiencing the event of an infant with significant health problems would be an unusual context, and other processes might well impact on mother-baby dynamics altering the act of breastfeeding. These criteria were not directed by the assumption of theoretical appropriateness but rather concern for the least disruption to breastfeeding women's lives at a vulnerable time of early parenting. The final criterion concerned the participant's adequacy to understand the English language. I felt that the potentially sensitive nature of the topic precluded the use of an interpreter.

Gaining initial access to appropriate participants required identifying an appropriate venue for advertising the study to the widest potential population. I chose to advertise the study (for participant recruitment) through the health clinics of the Royal New Zealand Plunket Society Inc in the Manawatu Branch (local geographical area). This required approval, which involved a two stage consultative process. First I visited, on 20th January 1994, the Regional Nurse Manager to present the proposal and seek approval for advertising through the Royal New Zealand Plunket Society Inc. I specifically sought the Manager's approval and consent to display a recruitment poster in Plunket Rooms (health clinics). I also requested access to attend a staff meeting, to elaborate on the recruitment poster. This resulted in a one and a half-hour appointment and a further talk with staff. A follow-up call ascertained approval for the access to clinic venues for the poster display.

The second stage required contact with the volunteer (consumer) membership committee to gain access to a local branch meeting. The branch meeting (9/2/94) provided me with a ten minute speaking slot, at the start of the meeting. Representatives from each sub-branch were present and one nurse staff member. I was able to introduce myself, my research area of interest, and request permission to use the Plunket clinic walls to display my poster. At this forum I gave special attention to the detail of the research topic, as the consultative process for access involved speaking to women who could be potential participants or those who might influence potential participants. I was careful to present only the research topic and not elaborate on any of my research assumptions, yet also answer any questions to the group's satisfaction. I was explicit about my request extending to access only and that I could be contacted by any potential participants if further information was required. I stated clearly that I did not require any members of the Royal New Zealand Plunket Society to actively promote or advocate the study, rather any participants could be directed to me for further information. The sub-branch groups were interested in the time and commitment requirements of the study. The group was very supportive of the study topic.

Having gained consent for advertising, posters were displayed in the Palmerston North, Royal New Zealand Plunket Clinics. My first participant was recruited in response to this advertising at the Plunket clinic.

After a period of several weeks it became apparent that this method of recruiting participants would not be successful. The first participant was able to direct me to potential participants and thus the sample was contacted via the snowball sampling method. Snowball sampling, according to Woods and Catanzaro (1988, p.107), is a process where the participant is able to refer suitable friends or contacts to the study. As the sample size grew it became possible to request particular sample characteristics, consistent with theoretical sampling technique. The combination of snowball and theoretical sampling was successful and resulted in a total sample size of 20 women. The participants were assigned a code to identify their data, and protect their anonymity.

5.16 Sample characteristics

The 20 women participants in this study had experienced a wide variety of breastfeeding histories. All the women had older children and thus the baby, who was breastfed at the time of study, was not a 'first' child. The number of children of each participant ranged from two to five children including the baby. Not all the participants had breastfed all of their children. For example, one participant's first child was adopted and she had not breastfed this child. Another participant had weaned her baby at 5 months of age. In response to theoretical direction I sought to interview some women who were concurrently breastfeeding the baby and another child (tandem feeding). Three participants were tandem feeding. The participants' ages at time of first interview ranged from 27-47 years and the baby's ages ranged from eight weeks to eight months. The tandem breastfed children's ages ranged from three years to three years and three months.

At first interview, 19 women were breastfeeding, and one had weaned to artificial feeding. The breastfeeding babies and children were predominantly partially breastfed that is, were also taking solids and other fluids as defined by Labbok and Krasovec (1990). However, for most of the participants, breastfeeding was the baby's main source of nutrition. The breastfeeding history of the participants indicated a breastfeeding duration range of between two weeks to four years six months for the individual children of the participants.

Breastfeeding duration range does not necessarily represent cessation of breastfeeding between children. In one instance a participant had been breastfeeding her successive children, continuously for approximately seven years. This was not the experience of the other women in the study. In some instances where the siblings were considerably older than the breastfed baby, i.e. 24 years of age, an accurate description of past breastfeeding duration and practice was not obtainable. The participants expressed a range of breastfeeding experiences and a history of diverse breastfeeding practices and styles. This enabled the women participants to contribute from a wide range of memorable experiences and current practice.

Participants self-nominated their ethnicity and are predominantly identified as New Zealander, European. One participant nominated her ethnicity as Maori. Two participants nominated other western nationalities. The sample is therefore predominantly New Zealand European in ethnicity and does not represent any other ethnic groups. In respect to sample and ethnicity of the participants, I wish to make explicit my interpretation of the issues about research with Maori participants, the indigenous people of New Zealand.

The Maori population of New Zealand Aotearoa has previously been the subject of research which has sought to direct research 'at' Maori (Ellison-Loschmann, 1997), "with little actual active involvement and long term benefit as a result" (p.6). The recent popular academic stance on Maori research, is that research is undertaken by Maori researchers, for the Maori people and with Maori participants. This position has become known as Kaupapa Maori (Smith, 1996). Kaupapa Maori research is premised on a Maori worldview and is research that has been negotiated with participants and promotes aims, goals and processes, which are of benefit to Maori (Glover, 1997). If I were to have actively sought a sample of Maori participants the Maori research community would not have accepted the research as Maori research. According to Smith (1996), "…a pakeha [Western, white person] can be involved in Kaupapa Maori research but not on their own, and if they were involved in such research, they would have ways of positioning themselves as pakeha, or the more radical interpretation might say, by definition, no, Kaupapa Maori research is Maori exclusively" (p.15). Grounded theory studies have been reported on various topics that have participant samples of specific ethnic groups (Locklin & Naber, 1993). However, my topic of interest focused on breastfeeding and had not been determined by ethnic or cultural concerns.

In response to a question about their relationship status and breastfeeding support, participants nominated their partner or significant other. The participants' relationship status, ranged from married (n=17), partnered (n=1), or solo parent (n=2). Both solo parents indicated a stable relationship with a significant other. All respondents were able to nominate persons in their social network, who were supportive of breastfeeding. The sample is therefore representative of those women who feel some degree of support for their breastfeeding practices.

Specific demographic data regarding economic status and educational attainment were not collected. Participants did disclose their partner's employment and their own work status, either current or previous. At the time of first interview, only three participants were in part time paid employment; of these one was self-employed. Of those who were not in employment, their partner or husband was in employment. Of those partners or husbands who were in employment their jobs represented those found in educational institutions, management, the medical profession, as labourers and in self-employment. This range was also consistent with the type of positions held by those participants in part time employment and by the participants prior to giving up work. One participant was on maternity leave. The sample represented a wide range of social situations and economic status. The social situations and economic status were not considered as pivotal to the analysis of the data and therefore are descriptive characteristics of the sample.

5.17 Data collection

Grounded theory method directs data collection. Substantive coding and analysis start from the first interview and continue for the entire process. This study collected several data types, as is consistent with the grounded theory method. According to Glaser and Strauss (1967, p.65) no one type of data or data collection technique is necessarily appropriate as theoretical sampling for saturation, can accommodate multi-facet data collection techniques and types. In grounded theory various types of data are considered to be 'slices of data', the implication being that complementary material comes together to illuminate aspects of the topic. In this study data sources included informal interview, field notes, observational notes, a life space drawing (participants, self-projective psychometric procedure), memos and theoretically driven literature integration.

The prime source of data was the informal interview, using open-ended questions. The interviews were tape recorded and transcribed verbatim. I interviewed each participant twice during data collection and for a third time after data analysis was completed. During the first two interviews the topic was explored and discussed. Interviews were anything from one to two hours in duration. I asked only two 'set' questions at the beginning of the interviews. The first was, "tell me about yourself

and your family?" The second was "what did you think about the study topic, intimacy as experienced by breastfeeding women?" The first question was non-threatening and enabled the participants to speak on any aspects they felt were relevant about themselves or their families. This provided me with a great deal of breastfeeding history, personal context and demographic data. It also enabled me to develop rapport and a relaxed relationship with the participants. Often I would not ask the second question until some time into the first or even subsequent interview. The second question was designed to offer the most scope for the participant to define the topic. The question invited the participant to define the topic, as they perceived it (Bowers, 1988, p. 46). To facilitate optimum communication with the participants I used reflective and open-ended responses with 'encouragers' such as comments like 'tell me more'. The interview data were a rich source of information and the constant comparative coding techniques resulted in early theoretical direction. Thus, as the interviews progressed I was directed to ask questions derived from the early analysis. Some such questions were, "who owns your breast?" and "tell me about feeding in front of other people?" Theoretically driven questions act to probe for data in emergent categories grounding them for saturation and densification (Glaser, 1978).

The third interview was generally much shorter, about one half hour to an hour in duration. This interview involved elaboration on unfinished discussion, the life space drawing (Gills, 1989) and discussion around the theoretical model. Notes were taken during and after these interviews, as these were not tape-recorded interviews. During all interviews, I kept field notes on my observation of the participants. I recorded most of these notes directly after the interviews when I had left the participants, mindful not to clutter or subvert the interview process with note taking.

Participant observation is a common technique for data collection in grounded theory (Chenitz & Swanson, 1986) and nurses are considered competent users of this technique (Byerly, 1969; Pearsall, 1970). According to Byerly nurses, by the very nature of their clinical skills, are keen observers and participants. Observation skills result in a heightened awareness of the human condition (Jackson, 1975) providing rich data on behavioral aspects. There are various levels of researcher involvement and concealment in participant observation. Nursing literature has been concerned

with the ethical implications of concealed observation (Johnson, 1992; Wing, 1989). Mindful of these concerns during this study I was open about my observational role and took only minimal notes when with the participants. I observed many of the participants breastfeeding their infants or toddlers and recorded their interaction and interpretation of that interaction. In recording those breastfeeding exchanges, I engaged in a form of selective observation (Spradley, 1980, p.128). Initially I noted many aspects I observed during the interview, aspects like environment and participant demeanor. As theoretical analysis advanced I became increasingly focused on the breastfeeding dynamics observing the infant's hand movements, feet movements and gestures. I was not a participant in the breastfeeding exchange but present alongside the women at those moments during the interview. This type of observation is formally known as 'participant-as-observer' (Gold, 1969, p.35). This degree of observation involvement is less likely than the observer-as-participant to influence the participants or direct their behaviors (Brink & Wood, 1988, p.142). The influence on behavior is minimised because the researcher and informant are aware of the observational interest of the researcher and the researcher is not actively engaging in the activity observed. The collection of observational data was unstructured and provided a depth of material not associated with structured observation (Brink & Wood, 1988, p.144). Indeed Gold notes that,

> Although the field worker in the participant-as-observer role strives to bring his [sic] relationship with the informant to the point of friendship, to the point of intimate form, it behoves him [sic] to retain sufficient elements of "the stranger" to avoid actually reaching intimate form (Gold, 1969, p.35).

In this statement, Gold is indicating that while very personal and intimate disclosure may occur as a result of the researcher and participant relationship, an actual intimate relationship is not acquired.

I also recorded my own perceptions and thoughts, for "every field work role is at once a social interaction device for securing information for scientific purposes and a set of behaviors in which an observer's self is involved" (Gold, 1969, p.31). According to Glaser it is important to "do notes on your own experience" (personal communication, 20/5/96). Unstructured observation is most effective where the researcher has effective interpersonal skills and is able to reconceptualise the event

(Burns & Grove, 1987, p. 304). This is consistent with grounded theory where the researcher is required to be able to conceptualise the data (Glaser, 1992, p.12).

The life space drawing (Gills, 1989) also provided a source of data to further add information about the participants' experiences. This added another "slice" of data to enable refinement of analysis. This slice of data also provided some sense of closure to the interview process.

5.18 Life space drawing

This is a projective technique designed to determine perceptions of self in relation to significant others (Gills, 1989, p. 265). The advantage of projective techniques is the technique's facility to demonstrate aspects of personality beyond the use of language (Piotrowski & Keller, 1993). Some ethical concerns have been raised about projective tests where the assessment is not made explicit to the participants (Schweighofer & Coles, 1994). Schweighofer and Coles suggest that complementary participant explanation be used alongside the technique particularly for response scores. The life space drawings used in this study were not used as an assessment or test. In order to capture the intention of the participants the responses to the drawing were also recorded and included as data. Some use of drawings as a projective technique for both assessment and healing intervention has begun to be used in nursing practice (Salmon, 1993). The projective perceptions about closeness expressed in the drawings were most relevant to this study. Though projective techniques have declined in use (Watkins, 1994) they are able to provide self-descriptive data and can be used to illuminate a particular theoretical orientation (Semeonoff, 1976, p.2).

The life space drawing as used in the Gills' (1989) study provides a 'slice of data' that illuminates the participants' understanding of closeness. The projective technique required the participants to draw a circle entitled `me' in the centre of a sheet of provided paper. They were then requested to draw circles representing those they feel most close to, at the distance that best represents this. This was the format of the technique as used in the present study. The drawing was requested as a last exercise at the final interview. The rationale behind this data collection technique

was to determine the social network relationships in comparison to other interview and observation data. As 'closeness' is a construct of the concept intimacy (Timmerman, 1991), it seemed appropriate to include this data collection technique. When introduced as a final exercise it also provided closure to the interview. The life space drawing was introduced at the end of the interviews so as not to influence the participants' perception of the topic area. These drawings were completed by all but one participant who had moved away from the area at the time of the final interview and was subsequently interviewed over the telephone. The drawings were analysed and compared to the other data sources and have been included in the theoretical model as they provide pictorial representation of the connected nature of intimate contact. If the closeness had not emerged with analysis of the other data these drawings might not have contributed to the emergent theory. Indeed drawings would have been abandoned had the substantive codes and analysis not supported the construct.

Selected pictures are included in the elaboration of the findings. These pictures have been electronically reproduced and are therefore a likeness of the original drawings. They have also had any identifiable information erased.

5.19 Data analysis

In a grounded theory study, three major types of codes are derived from the collected data: substantive, selective and theoretical (Wilson, 1989, p. 483). Substantive codes are further elaborated by the use of memos, written notes that capture relationships and aspects of the codes. To undertake writing memos I took an interactive stance, actively engaging with the data. As analyst my concern at a substantive level was to consider the data for abstraction. I considered each line by line incident of the data in light of the questions: 'what is happening here?' and 'what is the incident/s that this represents and what category might this relate to?' Selective codes or categories emerged, that is, clusters or patterns emerged from the substantive codes. These represent abstractions from the substantive data and give rise to theoretical memos and notes regarding relational properties. Category generation required careful attention to comparative analysis and to best manage this I utilised the 'copy and paste' function on a word processor. This resulted in quick, clear comparison and

category refinement. It also promoted the generation of theoretical memos, in which I identified aspects of the category relationships to other categories. I also identified patterns or a family of codes (Glaser, 1978, p.74) and categories.

Initially as I began the constant comparative analysis and coding I was concerned that I might become blind to possibilities for codes and categories. A caution Glaser (1978) notes is that, codes and categories can appear to emerge quickly and the researcher may feel they know the 'real' problem. Glaser suggests taking time to pace the work and engage in reflection (p.20). In an attempt to remain true to theoretical sensitivity I also undertook a comparative content analysis and counted the frequency of the same substantive codes. I was concerned that number of codes, nominated under the same identification, might influence theory generation by weight or imposition of importance. I was quickly reassured that theoretical influence and the process of abstraction was consistent with grounded theory method's protocol. Numbers of substantive code mentions did not dominate in theoretical importance.

The next level of theoretical coding moves to a more abstracted level. This involves relationship dimensions and verification from the data (Wilson, 1989, p.485). The ultimate code is the analytical core category. This, according to Glaser (1978), must be central, must occur frequently and be stable or pervasive. The validation of the basic social process is in the sense it makes to those who are familiar with the study setting. The following chapters explicate this process as it contributes to the construction of a substantive theoretical model which represents 'linking as one' as the basic social psychological process for breastfeeding women who experience an intimate relationship with their baby.

5.20 Conclusion

Grounded theory method is an appropriate method for this study, as it adheres to a philosophical representation of social and symbolic meanings located at an individual, self-determined ontology. I concluded that the dynamic and interactive process of breastfeeding required a method that could accommodate the process of breastfeeding. The method also had to provide the means for the participants'

experience to be represented in substance, yet presented in an abstraction that would provide a framework for understanding the phenomenon. Grounded theory method met these entire requirements and thus I selected this method for the study of breastfeeding women's experience of intimacy.

I undertook to recruit a sample that might have experienced the phenomenon of concern. Sampling recruitment involved advertising and snowball method. The sample was theoretically driven, as is consistent with the grounded theory method of constant comparative analysis. Several data types were included over the data collection period and during analysis, these were transcribed interview data, observational field notes, theoretical memo's, life space drawing and literature. In keeping with grounded theory analysis, data were coded substantively, then as emergent categories and theoretical categories. The emergent theory is presented in the subsequent chapters, which present 'linking as one' as the basic social psychological process.

Chapter 6: Being with

6.1 Introduction

In the previous chapter, I presented the rationale for selecting grounded theory method to consider and illuminate breastfeeding women's experience of intimacy. I also presented the design and process of the research. In this chapter, I begin by introducing the emergent theory. My 'hunch' that intimacy as a concept might hold a key for elaborating and theorising on breastfeeding interactions was borne out by the findings of this grounded theory study. It is the thesis of this work that breastfeeding is an intimate activity. I present this thesis as a theoretical model representative of the basic social process which is a psychological process (BSPP) 'linking as one' (Figure 6-1). This basic process is central to the following breastfeeding theory that has been generated inductively from the substance of the women's reports on their breastfeeding experiences.

This chapter is the first of three data chapters, which build toward the model of breastfeeding interaction captured in the basic social psychological process (BSPP) 'linking as one'. 'Being with' is the first of the three core categories and will be further elaborated in this chapter. The other two core categories that contribute to the model are 'coming to know self' and 'coming to know baby'. Figure 6-1 indicates these three categories and the relationship between these and the core, basic social psychological process. The breastfeeding dyad, contribute to the breastfeeding relationship in a mutual and connected response. Each of the three core categories represents the dynamic that contributes to this process ultimately expressed as 'linking as one'. The theory will be reconstituted in a final data chapter where I revisit the model and elaborate on the social context, antecedents, consequences and environment.
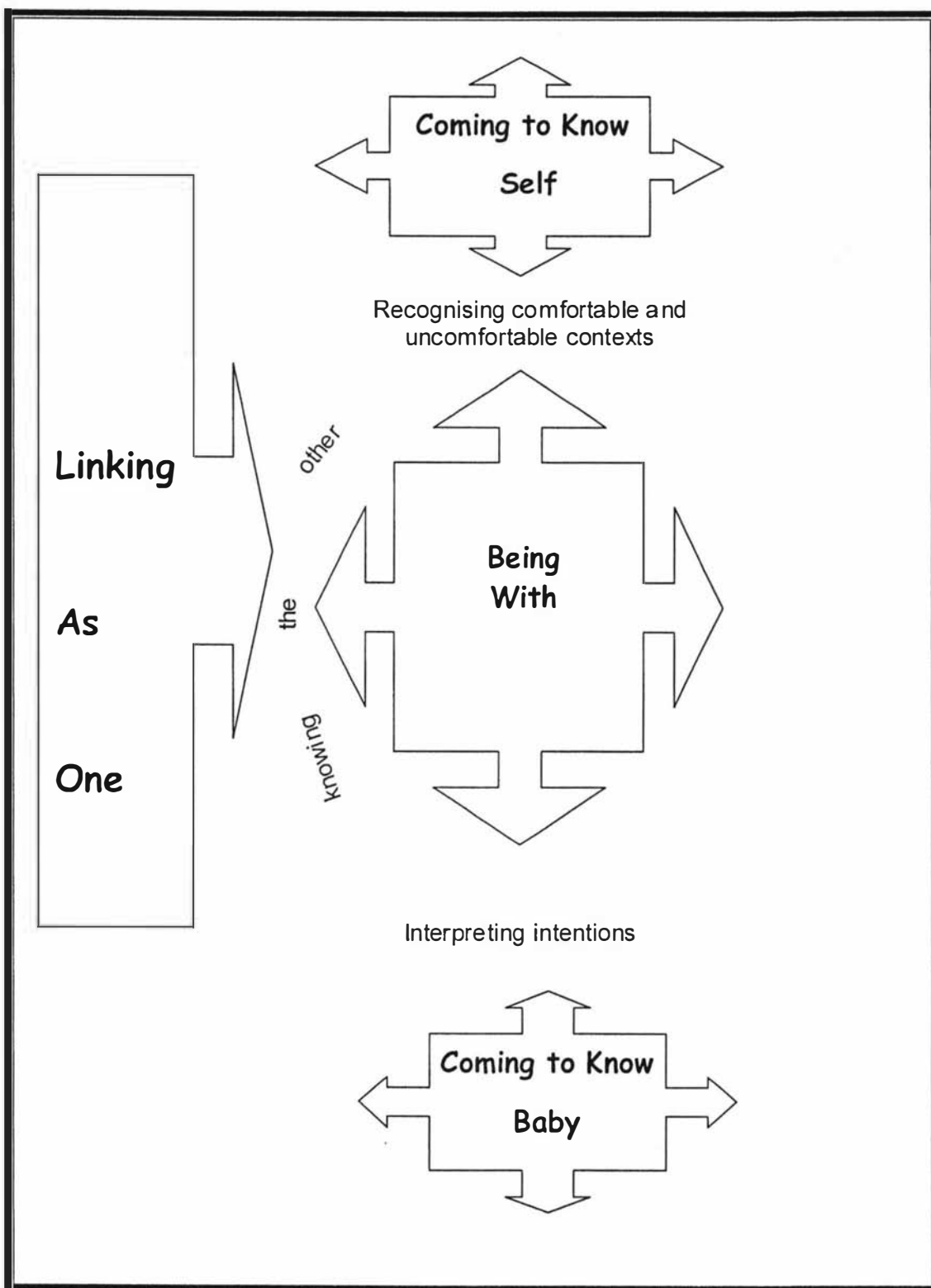
Figure 6-1 The Basic Social Psychological Process: Linking as One and the Core categories.

It is important at this point to declare the assumptions, that I hold, that underpin this work and are borne out by the following substantive data chapters. Several assumptions underpin this theory,

1. The act of feeding a baby or child from the breast is a beneficial activity for both recipient and breastfeeding woman.

2. Health professionals such as nurses can better understand feeding the baby or child from the breast, if breastfeeding women's experience and voice is accorded legitimacy.

3. Breastfeeding can (for some it may not) be an intimate act, between the woman and baby or child.

4. Women have the capacity to experience breastfeeding as an intimate act.

5. Women are able to comprehend intimacy between themselves and others, and this forms a point of reference for experiencing intimacy during breastfeeding.

These assumptions have been addressed in various aspects of this work. The first assumption is substantiated in Chapter Two where I have presented the literature evidence to support the benefits of breastfeeding. Further in that chapter I have argued the need for health professionals, such as nurses, to attend to the woman's perspective. The assumption that breastfeeding can be an intimate act is presented in Chapter Three where I consider the literature around the concept of intimacy and breastfeeding. The fourth assumption is based on the evidence that individuals have the capacity to engage in, and ability to seek, intimate relationships. The evidence to support this is presented in Chapter Three and indicates that intimate interactions are located between individuals and for women involves identity issues (Ernst & Maquire, 1987). The final assumption has been borne out by the following data chapters, as the participants have drawn on past intimate experiences as a point of reference for describing and understanding their breastfeeding interactions.

6.2   Breastfeeding an intimate activity

The basic social psychological process 'linking as one' is represented in the core category 'Being with' (Figure 6-2). Many of the women in this study reported that breastfeeding is an intimate activity and were able to describe an intimate breastfeeding moment. When the women participants were asked, what did you think

about the topic of this study, "Intimacy as experienced by breastfeeding women?" some typical responses were as follows.

K   I just sort of thought yes I can feel like that. I mean its something I know about. K1, 668-670

A   I sort of thought well that's really neat because that's how I feel it [breastfeeding my baby] is. A1, 317-318

S   No there are other times [of intimacy] but it's mostly when you're feeding,...S2, 288-292.

M   Just, that's what breastfeeding means, like it says, what did it say intimacy and breastfeeding mothers, that's just what breastfeeding means to me, me and my baby. That's what it means. M2, 35-42.

Q   For me intimacy has still got a lot to do with up here and in your mind...I mean for me it is a lot in my mind, so I suppose when I am feeling incredibly loving and close to him [breastfed baby], it's almost a mind thing in that I, yeah, and perhaps I'll feed [breastfeed] him, or just be really close to him.... it's very similar to the intimacy with my partner, I mean sometimes the physical, emotional, intellectual. Q2, 318-331.

This response was overwhelming, as the question did not suggest breastfeeding to be intimate and women were free to respond that they experienced intimate relationships with others. Only one participant did not express experiencing a feeling of intimacy with her breastfed baby.

E   I guess I have thought about it on and off the sort of thing you read about these wonderful loving little interactions with mothers and babies while they are feeding and I think I don't know what's wrong with me. E1, 1218-1224.
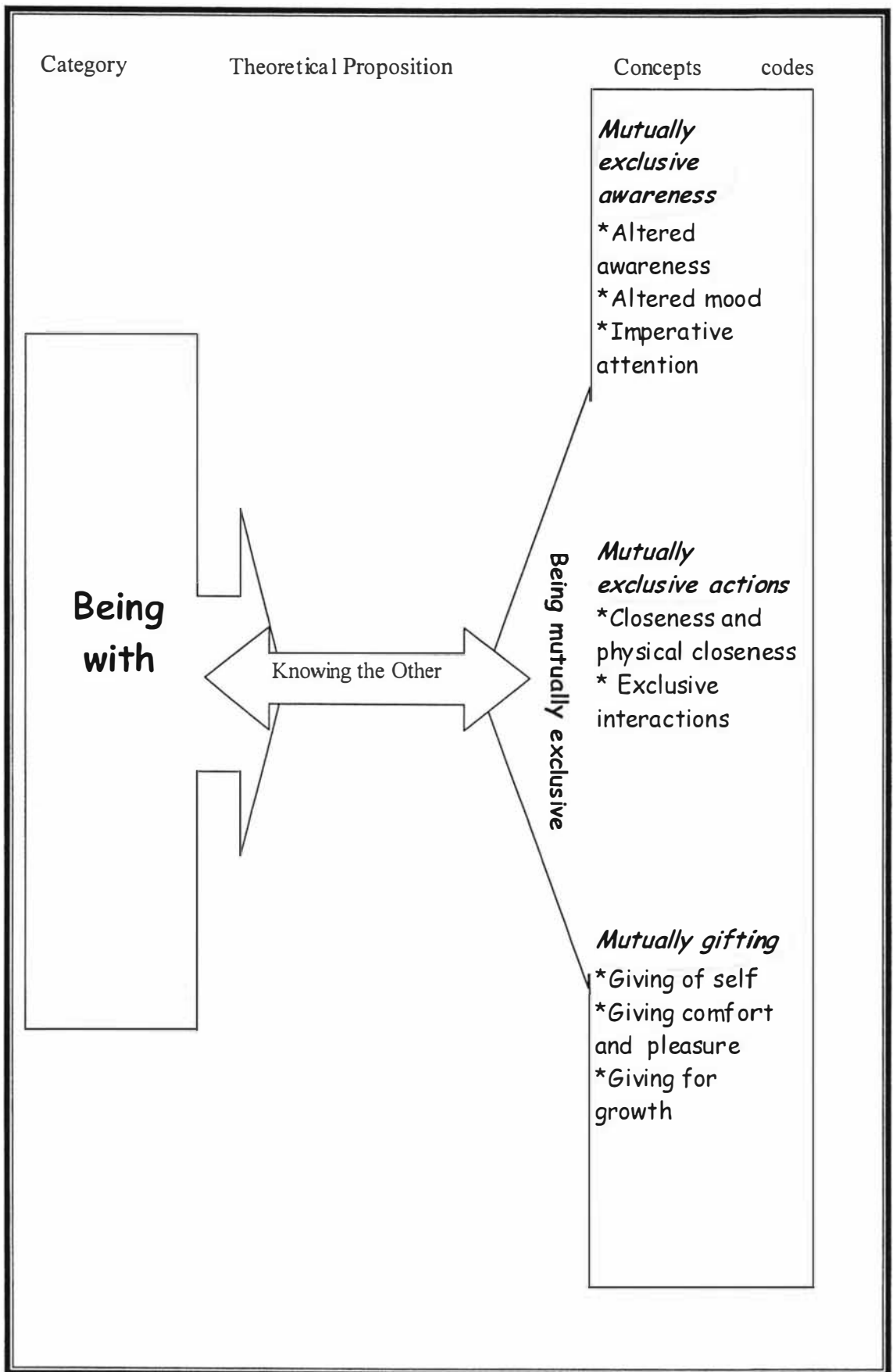
Figure 6-2   Core Category: Being with

This participant did express the recognition that breastfeeding could be an intimate experience and went on to articulate her perceptions of intimacy drawing on her experience with others. Most of the participants (n=19) in this study reported that at the time of the study, they felt their most intimate relationship was with their breastfeeding children, either toddlers or babies. This did not preclude them having intimate relationships with other children, their partner, close female friends or their own mothers.

It is worth noting that intimate breastfeeding moments are not usually associated with all breastfeeding encounters, but rather occur within certain enhancing contexts and I suggest, in part sustain the practice of breastfeeding. The context and influences effecting an intimate breastfeeding moment are further elaborated in Chapter Nine when I review the total model. The following category 'being with' reflects the interaction and experience of breastfeeding during an intimate moment. Three main concepts, 'mutually exclusive actions', 'mutually exclusive awareness' and 'mutually gifting' represent these intimate breastfeeding moments. An essential characteristic within the three main concepts is the mutual relationship and dual involvement of the breastfeeding participants. This mutuality is represented in the theoretical concept 'being mutually exclusive'. This indicates the absorbed and connected relationship between the breastfeeding participants. Drawing on the data I argue that a sense of 'knowing the other' is the underlying theoretical premise that enables the breastfeeding pair to experience a sense of 'being with' each other. This chapter elaborates on these concepts and the more substantive codes and in vivo codes within them.

6.3   Being with: Mutually exclusive awareness

The mutual nature of the breastfeeding encounter is consistent with the concept of intimacy. Synonyms for mutual include the following definition, "Joint: characterized by intimacy" (Websters New Collegiate Dictionary, 1976, p.760) indicating a connected and shared relationship that is associated with the concept of intimacy. Data indicate that during the breastfeeding encounter, the breastfeeding interaction becomes the primary focus. Women in the study reported experiencing a 'mutually exclusive awareness' during intimate breastfeeding encounters.

The concept 'mutually exclusive awareness' expresses the change in awareness and mood during an intimate breastfeeding moment. The substantive codes include 'altered awareness', 'altered mood' and 'imperative attention'. The women were expressing the idea that their awareness of the external environs was somewhat altered during the breastfeeding exchange.

O   You don't really see it. You don't…see what's going on, things could be happening around you and then all of a sudden you'll think. Oh, um, what's my other one [child] doing….Because you've forgotten, your brain has actually just totally tuned off, to your feeding…It must be…the way your body's made up that you just relax, to let the milk down. O2, 200-210

K   I am almost oblivious to lots of other things, it's sort of just the two of us in a way, often I'll have [pre-schooler] up there next to me. I'll be reading a book or whatever, but it is still sort of my time with [baby]. I forgot the dirty dishes in the sink and whatever I don't even think about the next bill to pay, it's all gone. K1, 449-459

M   Um, different times I think you are more aware of what's going on. But when it's all quiet and it's just you and the baby. I don't sort of, well I don't think of what I should be doing, sort of thing. M2, 237-244

A   It doesn't matter what's going on around us. A1, 386-387…then he'll get back into it [breastfeeding] and it's just like it doesn't matter who's in the room, it's just him and I. A1, 392-395

G   I'm more inclined to switch off, you know if [toddler] is being annoying or the dogs chewing up something or whatever [laugh]…I don't notice it as much… it sort of takes over you a wee bit. G2, 340-349

The environment and external context pales into insignificance as the women describe an altered awareness, a concentration, without recognised effort, on the baby or child. The primary focus, the breastfeeding interaction, diminishes any awareness of external stimuli. This was confirmed by one participant who responded to this code suggesting that she recognised the 'altered awareness' "absolutely, you

put wrong things in your tea" (Field Note 10/11/95). This affirmation captures that essence of being absorbed in the breastfeeding interaction. This 'altered awareness' is also reflected in reports of 'altered mood'. The women, during the intimate breastfeeding moments, often report a change in their mood or emotional state. In vivo codes such as 'regenerated', 'facilitates energy' and 'relaxation' all indicate the type of emotional changes the women reported.

K   I feel sort of calmer and I have all those nice warm fuzzies...I feel as it I've been topped up again for the day or next hour or whatever. K1, 739-746

I   It feels wonderful particularly if I am having a bad day or she's had a spell with wind, it helped keep me in control. I sort of thought at the end of it, when she's feeding it's worth being through what I've been through. Because she's beautiful and worth persevering [for] and keep going. I1, 448-456

H   I just find it nice and relaxing...it's just a nice time to sit and relax. H1, 204-207

G   See, she always relaxes me though, ...like when I go to feed [breastfeed] her, if I'm really wild with [pre-schooler] or whatever, I can tell right from the start I just change.... I guess it's that she mellows you a bit [laugh]. G2, 327-335

D   It is relaxing, it's good because it does make...me sit down, when I feed [breastfeed] her... it makes me sit down and take time to think. D1, 642-652

The women were able to relax, sit and feel rested or recharged. The breastfeeding exchanges affected their mood, they felt mellow, calm, relaxed, in control, and warm. I personally noted the mood and 'atmosphere' when interviewing one participant I recorded in the Field Notes 11/4/95 "Breastfed baby, relaxed and comfortable... Lovely interaction. The atmosphere is calm and relaxed". These descriptions are positive effects, associated with well being and satisfaction or fulfillment. The women felt they could persevere with breastfeeding, it made the breastfeeding effort worthwhile. The feeling of a relaxed, re-energised mood is frequently reported as a physiological response to the hormonal influences of lactation.

Baumslag and Michels (1995) recognise the impact of hormonal influences suggest, "The hormone oxytocin, secreted into the woman's body through the process of breastfeeding, helps a mother feel calm and nurturing. It is her body's way of helping her establish a warm loving relationship with her new baby. Her energies are focused on attending to the child and the home" (p.10). The extrapolation of this biological essentialism is that a maternal failure to feel calm and nurturing is a pathological state that might be due to a hormonal problem. This extrapolation is a classic example of socially constructed mothering based on affective responses to hormonal changes (Carter, 1995; Kitzinger, 1987, p.187).

The change in energy state and 'altered mood' have been reported in other accounts of women's breastfeeding experiences. It is also expressed in Maclean's 1990 study where women reported that breastfeeding is a welcome escape, to sit and relax. "I'll pick her up from her nap to breast feed her and I'll relax and be very comfortable doing it and I think a nice thing about still nursing is that I relax during those feeding times. It is an escape in some ways, a chance to sit and relax" (p.96). Indeed women in this grounded theory study do report a more focused encounter with their infant, though this is not reflective of increased attention to the home or mothering activities beyond the act of breastfeeding. Rather the 'altered mood' is one of the affective aspects of an intimate breastfeeding encounter. The other key characteristic of the concept 'mutually exclusive awareness' within 'altered mood' was, the substantive code, 'imperative attention', directed toward the breastfed baby or child.

Women reported experiencing attentiveness toward the breastfeeding baby or child, as 'priority focus' or 'priority awareness' a sense of 'individual attention' toward the breastfeeding recipient. These in vivo codes are embedded within the substantive concept 'imperative attention'.

L I can feed and it is time to sit and look at them and to concentrate on them and not anything else... usually you watch them...while you're feeding [breastfeeding], especially when they are little. L2, 308-319

D I think it's just a special time that you can say, it's just you and the baby, and especially initially when you are feeding so much too... I suppose it's quite nice too

when you are feeding them and you watch their toes and hands and just the way they respond to you. D1, 7715-1126

It is as though the attention is focused, like a magnet, the women are drawn to intense watching and observing of their infant during the breastfeeding encounter. The women scrutinise the baby or child yet there is no stress or *trying* to understand and read or know the baby. The looking at the baby or child is not contingent on the response of the infant in as much as the baby or child is perceived to be active in the interaction, but not actively seeking the attention. The key characteristic associated with 'altered awareness', 'altered mood' and 'imperative attention' is the *being* in the encounter rather than *doing*.

F   Well I mean you are looking down on them and you see every little tiny bit of her. F1, 400-402

O   One thing that you do when you're breastfeeding is that you check out all their bits and pieces, their fingers, their fingernails, their ears, their…hair. O2, 313-319

The constant attentiveness to the infant is imperative, women check, look and watch the baby. This 'imperative attention' is expressed in Rubin's (1984) study and is considered to be part of claiming the infant. Each detail and element of appearance is related to familiar characteristics and in this sense the infant is located within the sphere of the family. "The linking by association of each of the child's features or behaviours to persons the woman cares about, who belong to her, and to whom she in turn belongs and by whom she is cared for, is a claiming of the child as belonging in the composite and intimately significant sphere of the family" (Rubin, 1984, p.135).

The emotion generated by such attentive behaviour is similar to that expressed by the women in my study, "There is a surge of desire to nourish and cherish this child in its collective representation" (Rubin, 1984, p.135). The notion of belonging or identification of the infant is not paramount in the concept 'imperative attention'; it is rather identification with the infant that is being expressed. Identification with the infant is more consistent with the idea of 'being with' and experiencing a 'mutually

exclusive awareness'. This attentiveness to the baby does provide the breastfeeding woman the opportunity for 'reading the baby', a time to get to know the baby and this is further elaborated in Chapter Seven.

An intimate breastfeeding moment is facilitated by women feeling they know the baby and offers an opportunity to attend to the infant and thus more opportunity to understand and know the baby. Though mood and emotional state are affected during the breastfeeding encounter, the mutual relationship and the exclusiveness of the relationship between mother and breastfed baby or child is also affected by the actions between the two participants. These actions are expressed by the women as 'mutually exclusive actions'.

6.4 Mutually exclusive actions

'Mutually exclusive actions' occur between the breastfed and breastfeeder. These actions include processes represented in the concepts 'physical contact and closeness' and 'exclusive interactions'. The concept 'mutually exclusive actions' includes aspects of mutuality, activities that are shared, joint or reciprocated. The actions occur during an intimate breastfeeding moment and are exclusive to the breastfeeding pair. The first of these is represented in the substantive code, 'closeness and physical closeness'.

'Closeness and physical closeness' includes such expressions as those captured in the in vivo code 'mutual gaze'. The affective or emotional influence of the mutual gaze which is reported in the concept 'mutually exclusive actions' is another example of physical behaviours which in one context can be facilitative of communicative interchange, but in this instance are part of the substantive concept 'closeness'. 'Mutual gaze' is akin to the long look that lovers exchange. The lover's gaze, conveys emotional messages.

O   ...then sometimes they'll pull off and they'll just look at you lovingly O2, 130-132

B   I can remember particularly with my first one, we used to gaze at each other, in the middle of the night. B1, 404-406

T   ..., yes gazing at him, I'm quite gah, gah about it [laugh]...I don't think much actually goes through my mind, I just sort of feel an overwhelming, no not overwhelming, just a great surge of love for this little being, 95% of the time it's not like that...T1, 932-944

The gaze is an expression of sharing the moment and feeling the loving between both participants. This has been reported by other authors, particularly with reference to attachment, bonding and the sensitive moment theory (Klaus, et al., 1972; Klaus & Kennell, 1976; Rubin, 1977). Kitzinger (1989) captures the moment of gaze by stating "The mother and baby look into each other's eyes, engrossed in each other. The baby learns from her [sic] mother what it is to love and be loved" (p.76). Again the women were able to recognise that not all breastfeeding moments were like this, but that they do occur during breastfeeding and as part of intimate moments is of significance.

The 'closeness' reported by the women is another in vivo code that contributes to the substantive concept 'mutually exclusive actions'.

C   Oh, just when you latch them on [breastfeeding] and their little eyes look up and just the closeness, yeah the closeness. C1, 589-591

Closeness as a metaphor for breastfeeding is a feature of the literature and accounts for the experiential aspects of a breastfeeding encounter. The special closeness associated with breastfeeding is reported as one factor for long term breastfeeding women in a study by Hills-Bonczyl, et al. (1994). The women in the study reported they did not want to give up the close mother and child bond. Goldfarb (1995) acknowledges that the special closeness of prolonged breastfeeding may not be a recommending feature for some women who, "do not want such an exclusive relationship" (p.649). The exclusive notion associated with closeness and breastfeeding is found in the work by Baumslag and Michels (1995, p.xvii) which reports that breastfeeding achieves an "unmatched bond and sense of closeness". Kendall–Tackett and Sugarman (1995) and Bumgarner (1982) refer to the emotional bond and benefits of long term feeding.

Closeness is also associated with breastfeeding encounters outside of the long term feeding contact. Maclean (1990) shares the stories of breastfeeding women including excerpts from conversations during a study on the experience of breastfeeding. One of the comments from the women participants in her study acknowledges the physical closeness and emotional closeness. "I enjoy having my son close to me, knowing he's getting his greatest pleasure in life from my body, and I'm holding him so close and just watching him sucking and getting his nourishment. He's so close to me and so content. It's just unbelievable" (p.95). Other women in Maclean's study mentioned the closeness, associated with breastfeeding, the satisfaction derived from feeling close. This concept is supported in the work by Locklin (1995), and Tamminen and Salmelin (1991) in which women share about the closeness of breastfeeding.

The closeness expressed by the women is associated with the 'physical closeness' as well as the emotional feeling of closeness; often one is the example of the other. Physical contact is often mentioned as part of the substantive concept 'physical closeness'. Women reported, 'physical contact' as a substantive code in the 'coming to understand baby' category, further elaborated in Chapter Eight. This category involves the attention to the social communication between mother and breastfed baby or child. Physical closeness, as reported in this context, refers to the mutual relationship and not explicitly to the woman's need to read and understand the baby.

G   Yes, she's looking for my finger, like that [demonstrates baby grasps finger while breastfeeding]. It's nice, I think it's nice, it's a real closeness, I think…G1, 291-299

B   It's very close… and when it's little baby holding my finger and things like that when the baby fed [breastfed], and that's when they are very little and when they start to flash looks at you from their eyes, and then there's the hands come out and start to press your breasts, B1, 381-389…. Well I think it's very, um it makes you feel incredibly close,…B1, 395-396

The idea that the baby is 'holding on' and reaching out to the breastfeeding woman is a common report. However this is more often associated with the baby expressing

some intention toward the breastfeeding mother and is represented in the category 'coming to know baby'. This closeness expressed by close contact is also expressed by the description of the mother-baby position during breastfeeding. The mother describes holding the baby's hand while she is breastfeeding. The baby is in a cradle hold across the mother's front with the baby's head in the crook of her arm.

T   Sometimes he moves it [baby's hand] out and sometimes I can hold it, he's unconscious of it and it [baby's hand] sits there....[mother holds the baby's hand] I just like doing it, it just um, I don't know if it's sort of full contact from there right round the back, in, so it makes a circle... T1, 978-988

Rubin (1984) has reported on the complete circle position between mother and baby. Rubin suggests this as a reciprocal need, physical contact of both mother and infant, after birthing and calls the position, enfolding. "Maternal 'holding' is an enfolding of the infant within the largest and most sensitive surface of her arms and bringing the infant onto the surface of her chest, particularly her breasts, for a complete encirclement and containment of the infant in maximal body surface contact. The infant responds to maternal holding by curling his [sic] trunk, head, arms, and legs onto the maternal body surface for maximal contact" (Rubin, 1984, p.108).

I observed women breastfeeding while undertaking this grounded theory study and frequently noticed the encircled position as one of preference for breastfeeding. Encircling, provided the woman with an opportunity for physical contact and many of the interchanges described in 'coming to know baby'.

Rubin (1984) does not associate this type of encircled holding with breastfeeding though mentions that the breast is particularly accessible. I do not consider from either observation or women's reports that one position for breastfeeding is more likely than any other to be associated with intimate breastfeeding moments. The encircled position represents many of the characteristics so far demonstrated by this study. Characteristics expressed in this study which, represent breastfeeding as an intimate encounter include descriptions of completeness, connectedness and attentive awareness. An encircled, full contact position is representative of the connective nature of the breastfeeding experience.

Further substance is given to the importance of physical contact in work by Harris (1994) who suggests bathing with the baby is a remedial intervention for women who are experiencing breastfeeding difficulties. This work is distinctly different from the importance of early mother-infant contact, which was advanced by the early work of Sosa, Kennel, Klaus, and Urrutia (1976). The time factor is not as significant, it is the opportunity to touch and have physical contact, which is being advanced by Harris (1994). The significance of touch is further considered by Kaitz, Lapidot, Bronner, and Eidelman (1992) who assert that discriminate touch is learned without intention during infant caring routines. These authors do not mention the opportunity for touch provided by breastfeeding but rather focus on the woman's ability to know the baby by touch. For the purpose of understanding the concept of 'physical contact' in this study it is most closely associated with reading and 'coming to know baby'. However, during breastfeeding 'physical contact' maximises the potential for 'physical closeness', 'closeness' and 'being with' the baby.

In recognition of the demonstrated expectation of emotional closeness during breastfeeding (Matich & Sims, 1992) complementary data were sought from the women in the present study. The women participated in a life space drawing (Gills, 1989), this is a self-projective drawing technique (Chapter Five).

6.5   Life space drawing

The women were asked to draw a circle representing themselves and then other circles indicating those they feel close to in the position that represents the closeness in relation to themselves. Essentially three styles of drawing became apparent. These I have nominated as the encircled, the enmeshed and the spiraled representations of closeness. Notably in each drawing the participants presented the breastfed baby and or child in close proximity to the breastfeeding woman. The following are examples of the three styles and contribute to the code 'closeness'. One example of encircled closeness is evidenced in the following drawing.
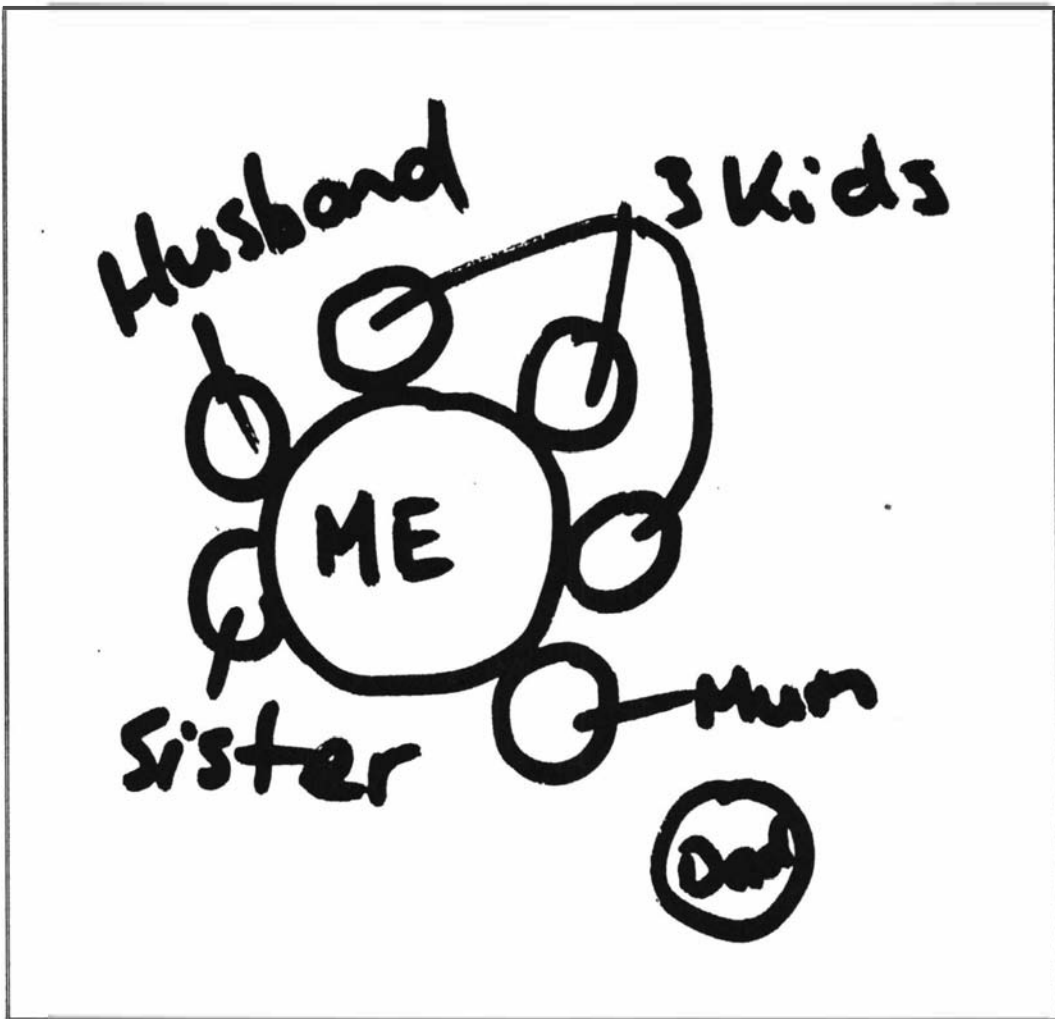
Figure 6-3   Resp J

In this drawing the respondent sought to locate each in equal distance, the lines coming out of the circles are just to link the names of individuals with a circle. When talking about this drawing the participant was anxious to stress "the equal status of the children" (Field Note, 4/5/94), yet noted that "partner and sister were most close" to her. When the drawing is closely observed the sister's circle wall can be seen as part of the participant's circle. The following example of encircled closeness is a little more complex.
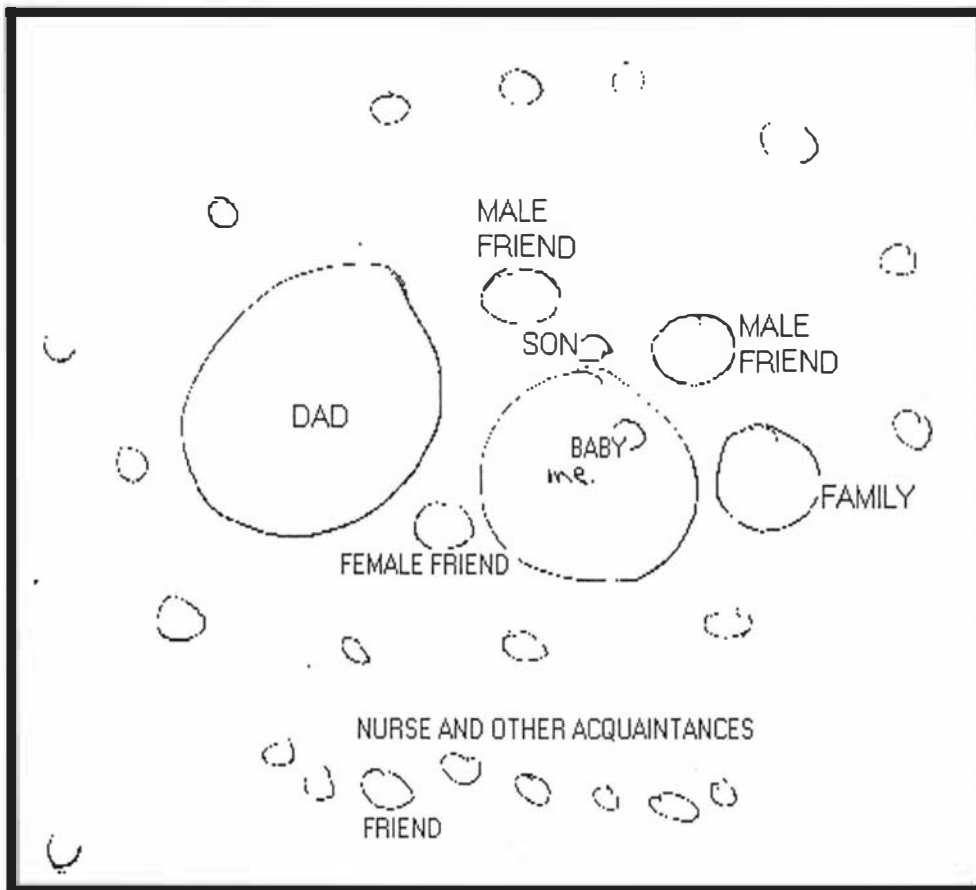
Figure 6-4   **Resp I**

The participant explained this drawing (Field Note, 23/4/94) in the following report on the conversation,

I   I actually put baby inside of me,

Res   Why is your partner's circle so big?

I   Cos I love him heaps,

Res   These circles have they got to do with how big a feeling they are?

I   that's right, yes…. The ones up here (close to self circle) surround my heart.

The closeness of others was not only represented in proximity to the participant's self circle but also in the size of the circles of various others. I also draw your attention to the small baby circle located inside the participant's self circle. This representation of other inside or overlapping the woman I have labeled the enmeshed drawings. A good example of this type of representation is in the following drawing,
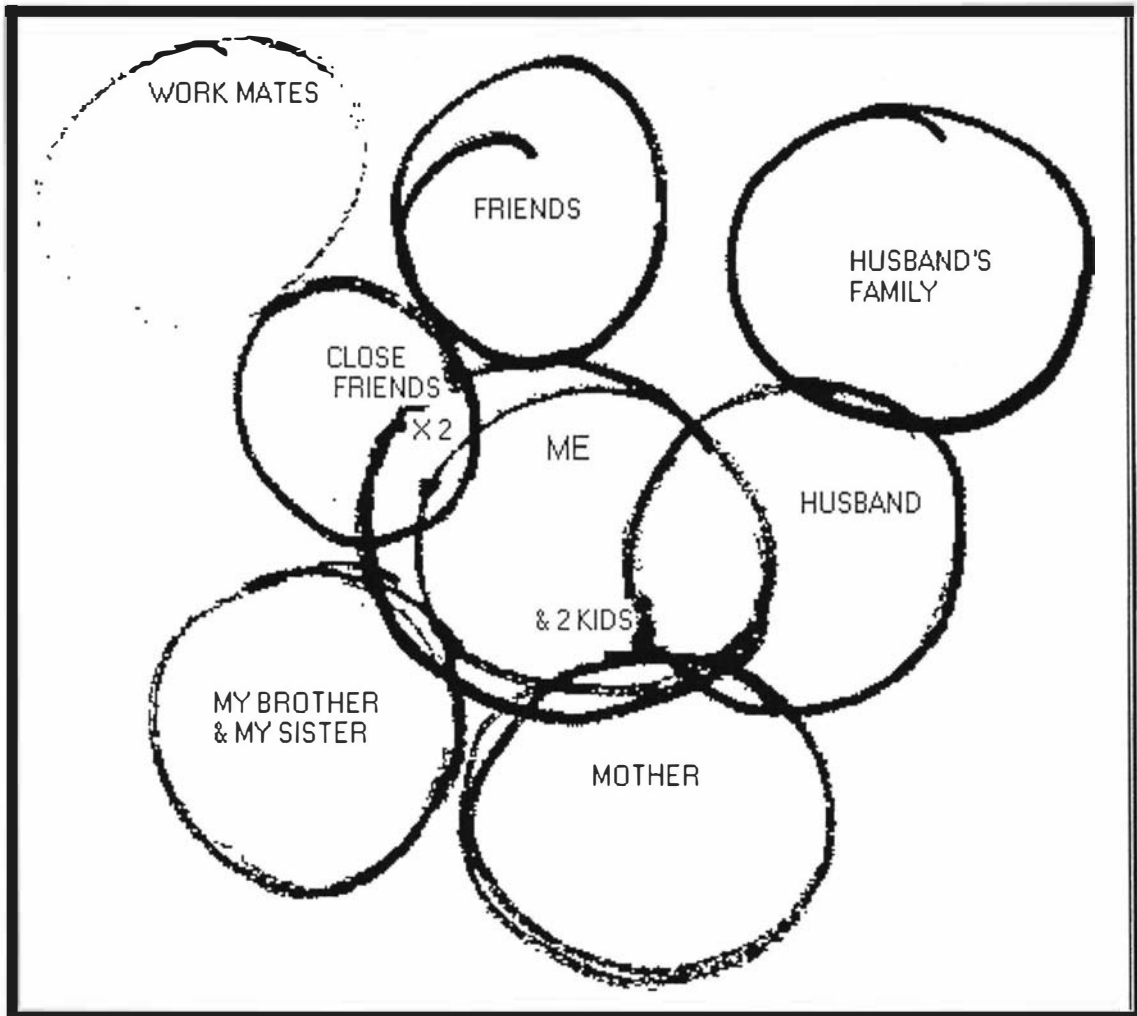
Figure 6-5   Resp C

In this drawing most of the other persons' circles are through the participant's self circle, with the exception of the children who are completely absorbed into the self circle. There are two ways of considering this drawing; either there is a perception of closeness that crosses personal boundaries between the self and others or conversely no self boundary exists in respect to the other's position of closeness. This is further repeated in the following drawing.
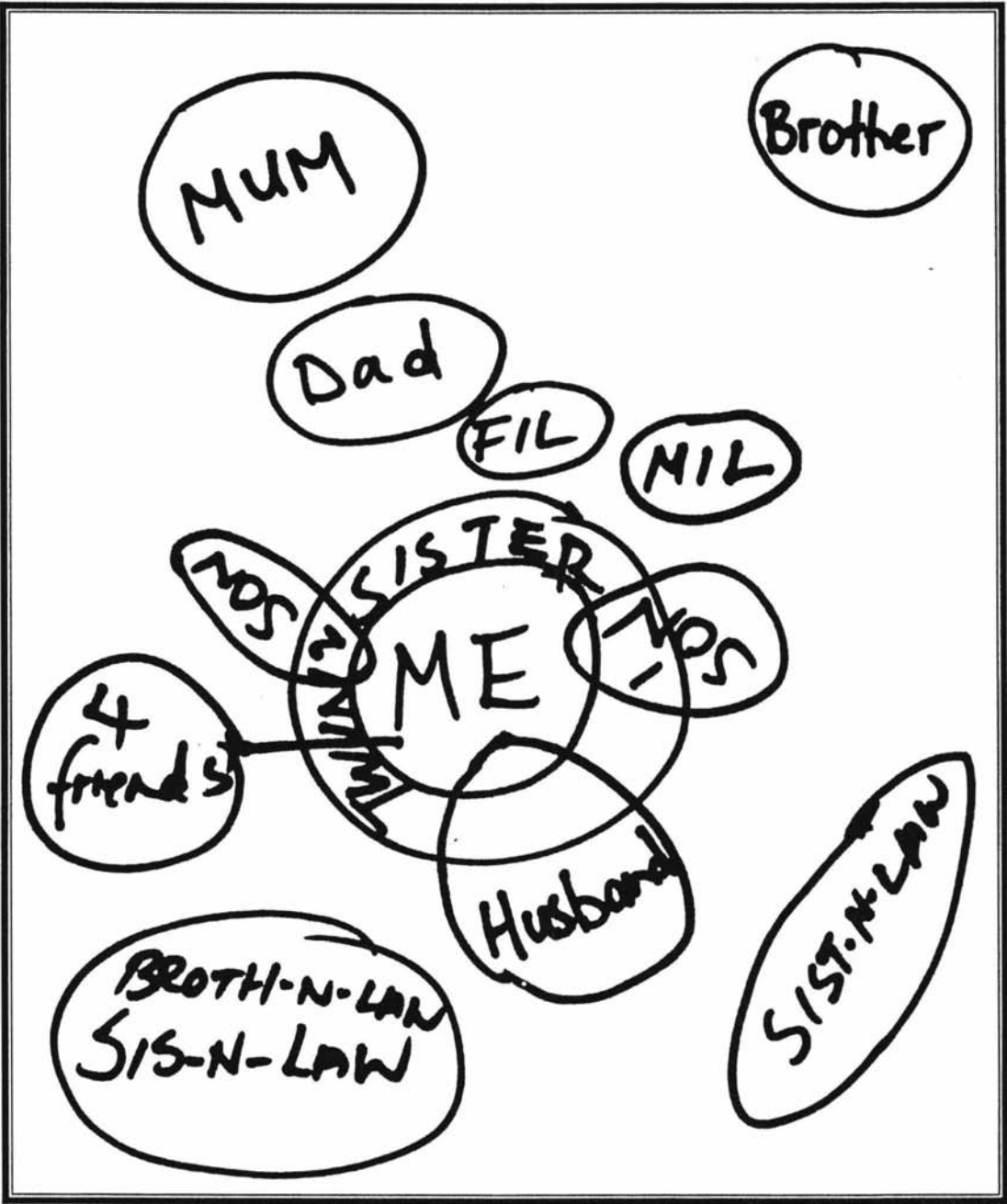
Figure 6-6   **Resp N**

Figure 6-6 represents closeness of others, with the children and husband passing through the self circle. However, the twin sister to this participant is an extended and encompassing circle around her self circle. Others who are close to this woman also pass through the sister's circle. The participant when talking about Figure 6-6 related that the "baby's circle was bigger, than the other son's" (Field Note, 7/11/95). The implication was that there was greater closeness with the baby. Often the idea of the most close person was represented diagrammatically as a spiral away from the self

circle. The spiraled drawings are a dominant theme in the participant's drawings and are in some ways most easy to understand. The following drawing indicates a spiral effect.
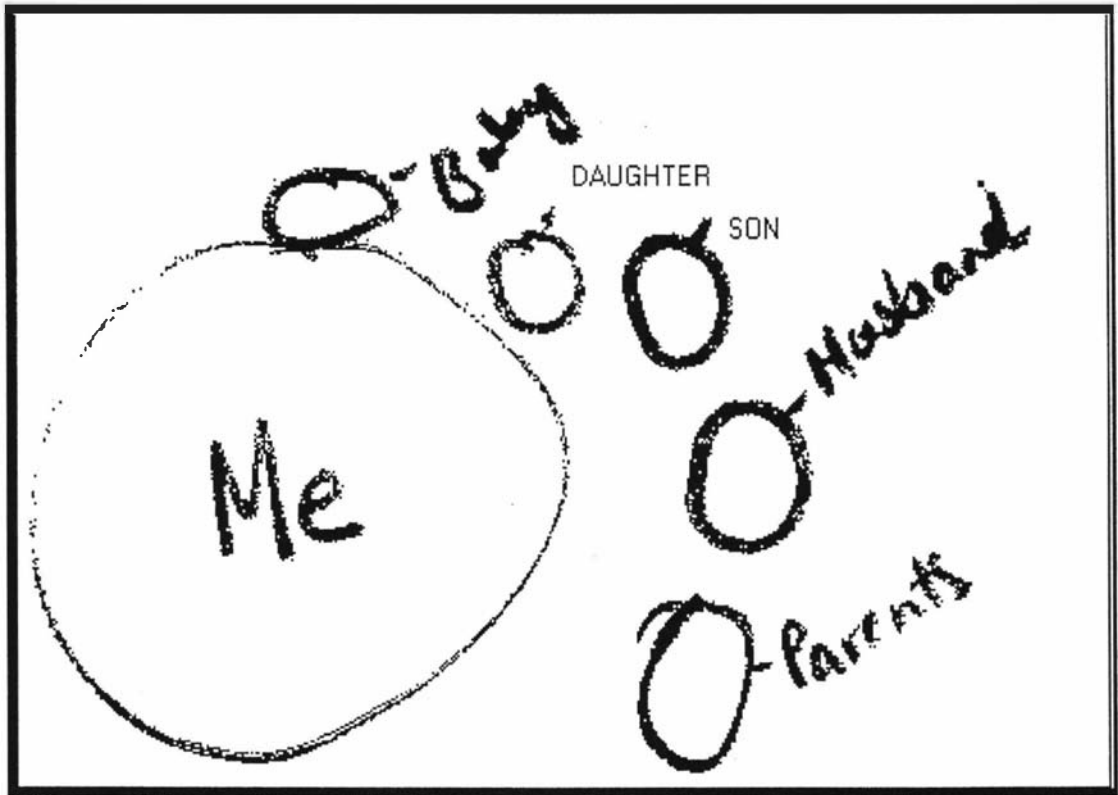
Figure 6-7   **Resp B**

In this drawing the participant indicates the baby as the person most close to her. Again as with the previous drawings the baby is touching the self circle. This representation is similar to several others. The following drawing is another example of spiraling away from the self circle.
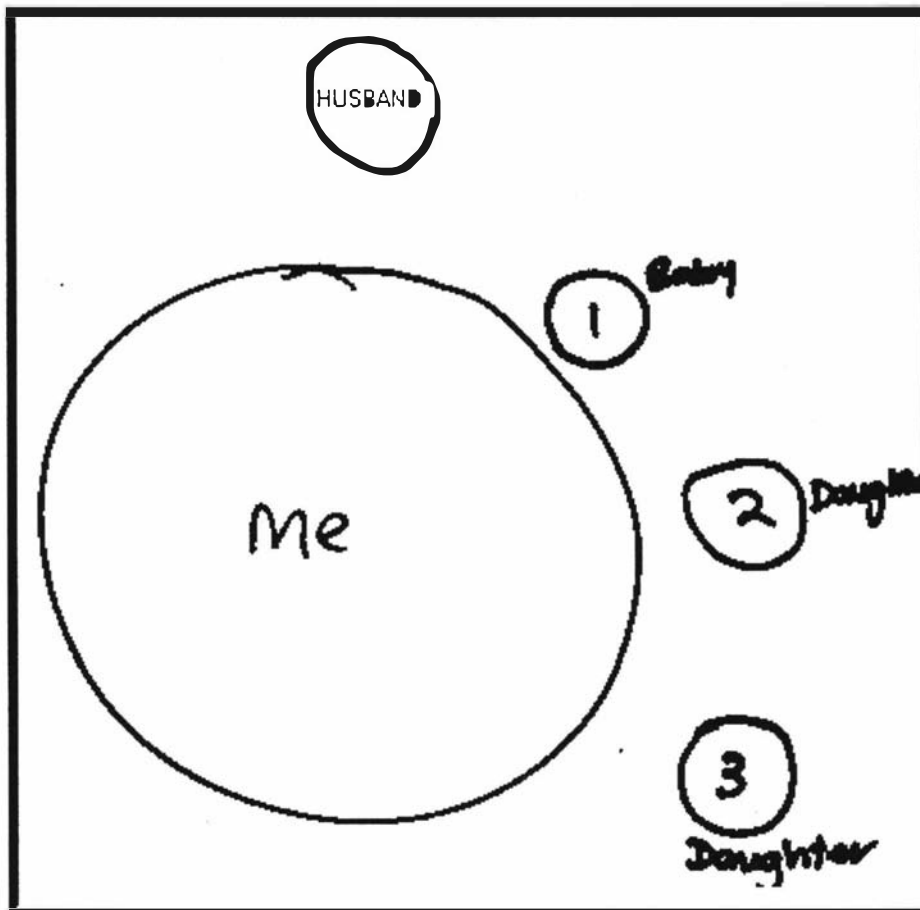
Figure 6-8   Resp S

When asked about the drawing the participant noted,

S   that one [child] seems just a little further away cos she's the oldest and she's leaving home, so I am trying to sort of distance from her

Res   Do you feel like you are closest to the baby?

S   Yeah

Res   who else are you close to?... That's your husband and you have put him about where the baby is?

S   No further out... I'm really close to her [baby] yeah cos she's dependent on me. (Field Note, 18/7/95).

These drawings are an alternative insight into the women's perceptions of closeness. It is not possible to extrapolate any interpretative position beyond that which they themselves discussed. The drawings do provide some evidence that the baby was perceived to be significantly closer than most other family members and that women often perceive the baby to be close enough to draw within their circle. This last

explanation of the drawing indicates that dependency is part of considering closeness. The following codes elaborate that perspective.

The concept 'mutually exclusive actions' hold an interesting paradox. The women reported that breastfeeding invoked a feeling of reciprocated dependence. That is dependence on the baby, and the baby being dependent on them. The paradox is that, this dependence, as reported during an intimate breastfeeding moment, was not considered negative or uncomfortable but rather an essential part of the intimate experience. One participant, when presented with the model, noted about dependency that "It's total dependency isn't it?" (Field Note, 10/11/95). The following substantive codes reflect 'oneness', 'exclusive dependence', and 'unique exclusive actions' as the key attributes of the concept. The idea of 'exclusive dependence' as an essential part of exclusive interaction of breastfeeding is demonstrated in the following quotes.

O   Oh you know that they depend on you entirely and... it's hard to describe really when you are breastfeeding, it's the bond that you've got. O1, 674-667

A   Yeah, it [breastfeeding] did, it felt great and I thought yeah, you still need me. A1, 1350-1352

M   Probably the feeling that the baby is really dependent on what you are doing [breastfeeding]. M1, 429-432

F   Well I think it is because there is a dependency there... sometimes you might see dependency as stressful, but at the same time, when everything is nice and calm there is a wonderful link between you and your child, and I think, I really love it...F1, 351-358

Women recognise that at times dependency can be stressful. This stress has been elaborated on in the category 'coming to know baby', 'recognising comfortable and uncomfortable contexts' and the code 'breast in demand' (Chapter Seven). It is the moments where the environment is right that this dependency becomes positive, a breastfeeding encouragement. I first considered the theoretical link between closeness and dependency after an interview. A theoretical note after the second visit

with a participant 20/4/95 states "need to check on closeness and the concept of dependency". As the grounded theory analysis progressed the idea of positive dependency was substantiated. Dependence between the two breastfeeding participants is described as a oneness,

C   I've always enjoyed just the oneness you feel, like, like you are one... when they look up at you and they are contented...C2, 172-178

The exclusive interactions are unique to the breastfeeding pair. The women reported feeling that they were the only one who could do this, breastfeed their baby.

A   It's something that only I can do for [baby]... I always think it comes back to, only I can do this for him, and I enjoy it. A1, 318-327. I sort of feel that as long as I'm breastfeeding him, he's my baby... A1, 372-378

K   ...it was important to me to have that special time [breastfeeding], that is just [baby] and I 'cos it's unique, nobody else could do that...K1, 431-435

The women are therefore experiencing a sense of interdependence that is not overwhelming or demanding nor stressful, but rather a positive dependence expressed by the concept of exclusivity between the two breastfeeding participants. Oakley (1986. p.154) includes in her study on mothering the women's responses to the question, "What do you like about looking after baby?" and reports this comment, "I particularly like breastfeeding her [sic]. I don't know whether I like the sensation, but I tell you what I do enjoy: I can be miles away from her [sic] and you suddenly think about her [sic] and you can feel it sort of beginning to come. And I enjoy the feeling that she's [sic] dependent on me..." (p.154). The baby dependency reported by this woman is clearly similar to the type reported by the women in this study. Dependency is perceived of as positive, affirming the women's sense of purpose and belonging. The need to be available, present and offering the breast during an intimate encounter is not demanding and uncomfortable.

Resta (1992) contributes to the explanation of dependency during breastfeeding, suggesting that the co-existence of reciprocal dependency and autonomy between

mother and child is part of developing psychological equilibrium. This is an interesting concept particularly when considered in light of the description of intimate breastfeeding by one woman in this study,

R   They [baby] are in a lovely vulnerable position and you can love them, and …it can sort of bring that balance back. R1, 718-724

Mutually exclusive actions may therefore present to the observer as any breastfeeding encounter. The breastfeeding pair may gaze lovingly at each other, position themselves in an encircled and enfolded position. It is however the woman's perception and emotional experience, the perception of completeness, closeness and mutuality that distinguishes the intimate breastfeeding moment which separates breastfeeding from intimate breastfeeding. The women do report some more conscious activity occurring between the breastfeeding pair. This is expressed in the concept 'mutually gifting'.

6.6   Mutually gifting

This concept includes the idea of giving; both breastfeeding mother and baby or child give to each other during the breastfeeding exchange. Three substantive codes are evidenced in the concept of 'mutually gifting'. These three codes are 'giving of self', 'giving comfort and pleasure' and 'giving for growth'. 'Giving of self' suggests that women are giving part of themselves in a way that is much more than an exchange of food.

F   I've had to think about it [intimate breastfeeding]. I think it's, I'm giving to this child….F1, 351-359… [giving to this child] part of me F1, 363 Probably more me being older, it's this need to be able to give her as much as I can… yes that's what keeps me going. F1, 430-437

C   …you're giving physically as well, … you are giving so much to them… C2, 145-149

The giving of self and intensity of giving seems to be associated with the age of the breastfeeding baby or child. As the child gets older and less reliant the emotional intensity is not so evident. One woman elaborated about breastfeeding her toddler,

Q   No [it's] not so intimate... It's probably my feelings towards her breastfeeding...well I'm not actually getting, I'm not getting the same from feeding her [toddler] as I get from [baby]. She's not giving back to me, and yet she is articulate...Q2, 549-567

The giving between mother and baby is expressed in Rubin's (1984) theory on maternal identity. Rubin asserts that the relationship between the mother and child locates the child as predominantly the recipient and the woman as maker and giver. Rubin's example of giving food to the infant is not specific to breastfeeding and indicates a more passive recipient role of the child.

No act of giving is completed unless and until it is received. So, even in the action and context of the act of giving, a receptive and responsive partner is necessary for completion of the act and the intent of giving. In giving food to an infant, for example, it is the infant as partner in the transitive act who must suck, swallow, and retain what is offered for the act of giving to be completed (Rubin, 1984, p.7).

In Rubin's work the child receives the gift of food. There is no sense of mutual reciprocity, which is expressed by the women in this study. Nor is there any sense of giving the self.

Kitzinger (1987) relates breastfeeding to other psychosexual acts such as birth and lovemaking. According to Kitzinger (1987) it is, "The sense of completeness of her own body, her satisfaction in giving, her closeness to and union with the baby as she breastfeeds, are some of these other aspects of sex... (p.14). Women in this study did not describe the intimate breastfeeding encounter as essentially sexual, however these descriptive phrases are significantly similar. The notion of breastfeeding as a gift is captured in the explication of breastfeeding by Raphael (1973) who entitled

her text, *The tender gift: Breastfeeding*. I would argue that the giving of self is an intimate act as is the perceived reciprocal nature of the interaction of breastfeeding. The 'giving of self' is expressed in breastfeeding; the act of physical closeness during breastfeeding enables the woman to experience giving to the baby or child.

H   I just like it because I feel it's virtually our time together… So I just find that it's really, it's our time and I just seem to be able to give him a big long cuddle. Whereas if you are bottle feeding it doesn't take as long and also I've had to share him. H1, 236-246.

The notion that sharing the baby and less contact time diminishes the opportunity of giving to the baby is not only located with bottle feeding as a feeding method but also for the weaning time when the breastfeeding opportunity diminishes or is stopped.

A   I sort of feel as long as I am breastfeeding him he's my baby and he's my last child and so I want, you know, to enjoy it as long as I can….A1, 370-379

It is the comfort and pleasure associated with 'mutually gifting' that becomes a mutual experience during the intimate breastfeeding moments. Giving comfort and pleasure is a further aspect of 'mutually gifting' during an intimate breastfeeding moment.

L   Well I suppose for me it's partly that you are giving him something that's really helping him. Like, cause you are feeding him you are giving him what he needs as food and the comfort…L1, 1047-1054

S   But it's nice that comfort, to think that I can satisfy her, And she can feed and drift off to sleep and that. S2, 205-207

L   I would suppose I would feel really intimate if he was upset and I was feeding him and it stopped him being upset, then I would feel like I was giving him some real comfort and that would make him better. L1, 1055-1061

The comfort of breastfeeding is tied up with satisfying needs and the instant nature of being able to feed the baby at a moment's notice. However comfort feeds were not necessarily intimate feeding moments rather they acted to relieve and calm or soothe. Palmer (1988, p.82) notes that the German word for breastfeeding is 'stillen', which means to quieten and soothe. The emphasis is on the effect, not the transfer of food between mother and baby or child.

R   Yeah it's more than just food it's…they know that they can come to you and things go wrong but you know it [breastfeeding] makes lots of things better… R2, 733-746

O   Yes there are comfort feeds…a lot of them are comfort feeds, they're not … like breakfast…or tea, a lot of them are sort of comfort feeds if you do it [breastfeed] in between….For him [baby] it's probably a comfort feed now, because that's what he wants. O2, 429-439

A   And then if he is a bit stressed out or anything I just feed him and you know, it just comforts him. A1, 457-459

Women expressed giving and receiving comfort during an intimate breastfeeding moment, though this was not the explicit intention of the encounter. Once again the notion of actively *doing* in the encounter is subsumed by the response of *being* in the breastfeeding encounter. Comfort feeding is feeding for the purpose of comfort and might offer an opportunity for intimate breastfeeding, but is not essentially intimate. The pleasure of breastfeeding is expressed in feelings of satisfaction with the encounter. "Certainly breastfeeding can be pleasurable for women. The intense, intimate bond that exists between a mother and her nursing child can be a source of great pleasure to the mother" (Dettwyler, 1995, p.167). The women in this study support this assertion and suggest that the pleasure of the breastfeeding experience is mutual.

P   Probably I'm feeling satisfied that he's getting satisfied just from me and nobody else. P1, 742-774

The exclusive and mutual activity between the two breastfeeding participants creates a sense of deep satisfaction. One woman recounts the wonder of a satisfying breastfeeding moment, acknowledging the impact of the environment on an intimate breastfeeding moment.

C   The way they look at you, well he needs me and I satisfy his needs, which is... Makes me feel good to be able to satisfy and it's amazing how when you feed they are satisfied, um, contented, as long as the outward environment is right, in that they are not tired, when you sit down to feed. C2, 163-169

As the women are giving comfort and pleasure so also they are receiving comfort and pleasure and conveying to the infant their own feelings. Dettwyler (1995, p.184) notes that breastfeeding is pleasurable because the physical sensations of breastfeeding evoke "warm fuzzies". Dettwyler presents the biophysical evidence of hormonal influence on mood and the learned associations of other pleasurable physical contacts to account for these feelings. No matter the cause, it is the perception of the women in the present study that suggests pleasure and the enjoyment associated with breastfeeding contributes to 'being with' the baby.

M   I think you are showing your love and affection in what you are doing [breastfeeding]...M2, 226-232

K   I guess that's one of the things I enjoy feeding because it feels so nice. That must be a motivating factor too. K1, 639-642

F   It's hard to explain, it just makes you have warm fuzzies is the way to explain it, F1, 384

The enjoyment of breastfeeding was identified in a recent New Zealand study (Basire, Pullon & McLeod, 1997). The authors noted that those women that enjoyed breastfeeding were most likely to continue. Breastfeeding, as reported by the women in this study is a very positive experience, an intimate moment where pleasure and comfort is a mutual gift between the breastfeeding participants. Tamminen and Salmelin (1991) explored the psychosomatic interaction between mother and infant during breastfeeding, in a qualitative study. These authors focused on a single

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breastfeeding situation and compared the findings between two groups of women, depressed and non-depressed women. They found five central themes, 'negotiation', 'hungry eating', 'talking', 'joint pleasure', and 'ending'. Several aspects of the Tamminen and Salmelin study are worth mention; specifically the authors describe the breastfeeding situation or interaction as a 'reciprocal commitment' or 'mutual task' (p.79), and these they relate to the theme 'joint pleasure'.

Firstly the terms, reciprocal and mutual reflect the mutuality previously explored in the present study. However, an essential difference is the more active component of the descriptive language, which suggests purpose, commitment and task. Both these terms focus the breastfeeding encounter as purposive, that is, for feeding. The exchange of milk is of course important to distinguish breastfeeding from activities to pacify a baby or child, but the intimate breastfeeding moment does not place emphasis on the exchange of breast milk. The theme 'joint pleasure' is similar to the characteristics, in the present study, of the substantive concept 'gifting comfort and pleasure'. An aspect of feeding which, according to Tamminen and Salmelin, was clearly distinguishable from other aspects, was the theme entitled 'joint pleasure'.

Joint pleasure is described as, "breast feeding now continued not in the context of hunger but simply for mutual pleasure and enjoyment. Interestingly, the mother often has special names for this stage of *being together*, indicating either the pleasurable aspects of breastfeeding or 'having a good dessert'" (Tamminen & Salmelin, 1991, p.81 italics added).

Locklin (1995) reported a qualitative study of low-income women and their experience of breastfeeding and found similar themes to Tamminen and Salmelin. The themes are considered to be primary descriptors of the breastfeeding experience. The themes are, 'making the discovery', 'seeking a connection', 'comforting each other', 'becoming empowered' and 'telling the world'. Seeking a connection concerned the support systems between women and social networks; it is not characterised as connecting with the infant. It is the theme *comforting each other* that closely resembles 'giving comfort and pleasure'. Comforting each other, is reported by the author as a theme which, "illustrates their awareness of a unique shared intimacy beginning to evolve between themselves and their babies…many women

gave poignant definitions of attachment, illustrating their deep satisfaction and emotional investment in their infants" (Locklin, 1995, p.288). Locklin shares several excerpts from the women's experiences and many of the concepts presented in this work are present in the transcripts. In this respect Locklin's work is a more gross representation of the concept 'giving comfort and pleasure'. It is noteworthy that Locklin's work does not account for the idea that breastfeeding is also giving for growth. The women in my study reported that they gave the infant food to grow.

'Giving for growth' as the final code within the 'mutual gifting' concept is unique to the participants' accounts. The women frequently reported the idea that the breastfeeding women give nutrition for physical growth to the baby and the baby demonstrates the evidence of that physical growth and in a way gives back to the mother by affirmation. This was a common theme in the in vivo code 'breastfeeding for food'. The substantive codes contributed to the concept 'giving for growth'.

O   It's a lot of giving [What are they giving back?] nothing much at this age apart from loving you in their own little way, you know you're giving a lot to them and they're growing...They're giving back the growing. O2, 758-768

J   You're giving her [baby] life to grow. J1, 678. You feel nice 'cos you are giving all the feed they need to grow and that's pretty amazing... J1, 641-644

B   I feel like I help sustain her, I was thinking the other day that I am amazed that I feed her, I actually feed her, I'm her whole sustenance... you see how big she is and you think, wow B1, 17-23

In turn the baby gives the breastfeeding mother a sense of self worth and 'gives self esteem'. The in vivo code 'gives self esteem' supports the substantive concept 'giving for growth'.

M   ...That she is enjoying it [baby breastfeeding], that sort of makes you feel really good, you know that you are, ...that you can make her happy. M1, 443-440

L   He reinforced that I was doing OK by being bonny and thriving and…it gave me back what I lost, confidence and feeling of not doing it right. L1, 493-497 So you know… it boosted me up wonderfully. L1, 499-502

One participant commented on the code of 'gifting for growth' when I returned with the model to present for her comment. She affirmed the theoretical importance by suggesting that " yeah, that's it, …before he [baby] starts solids I'm going to take all his clothes off and take a photo and say that's all me, it's one of those miraculous things" (Field Note, 10/11/95).

There is merit in considering the work on maternal identity by Rubin (1984) who presents the 'giving of oneself' as a maternal task associated with maternal identity. Particularly the aspect that giving is a means of communicating appreciated worth, one that charges the participants with self-esteem and self worth. Certainly the women in the present study located satisfaction and maternal self-esteem with giving in the intimate breastfeeding encounter. The satisfaction of giving for growth, both physical and emotional, is presented in other work about breastfeeding (Behague, 1993). Behague notes that physical growth can be recognised as a tangible expression of maternal success.

6.7   Conclusion

The category 'being with' is descriptive of an intimate breastfeeding moment. These moments are captured in the concepts, 'mutually exclusive awareness', and 'mutually exclusive actions' and 'mutually gifting'. These substantive concepts are in turn composite of in vivo codes, which express the many facets of the mutual and positive experiences associated with intimate breastfeeding moments. As breastfeeding women are engaged in an intimate breastfeeding moment they experience an altered awareness of the environs and an altered mood both relaxes and energises. These women are drawn to engage with the infant in such a way as to find it imperative to attend to the baby. The interaction of breastfeeding intimacy is reflected in emotional and physical closeness that affords gaze and attention, as the actions between the breastfeeding pair are mutually exclusive. The exclusive interactions that occur during intimate breastfeeding are considered to evoke a

positive sense of interdependence. During these breastfeeding moments an expression of mutual gifting occurs. Women expressed a sense of giving of themselves and giving and receiving affirmation, comfort and pleasure and growth.

'Being with' during a breastfeeding moment is reliant on some of the core concepts like 'coming to know self' and 'coming to know baby'. These core concepts involve processes such as 'recognising comfortable and uncomfortable contexts' as the women come to know themselves as breastfeeding women, and 'interpreting intentions' that occurs as women come to know the baby. These processes are enhanced during intimate moments and 'being with' during a breastfeeding encounter between mother and baby or child. Further these processes enable the women to experience 'linking as one' the basic social psychological process of an intimate breastfeeding experience. In order to argue this assertion in the following chapter I present the category 'Coming to know self'.

Chapter 7: Coming to Know Self

7.1 Introduction

In the last chapter I presented the category 'being with'. In this chapter I assert that just as the women engage in the breastfeeding moment that is an expression of 'being with' the baby or child they are also engaged in a process of 'coming to know self'. 'Coming to know self' (Figure 7-1) indicates the adaptation of women's behaviours in response to the experience of breastfeeding. This contributes to the breastfeeding woman's ability to engage in intimate breastfeeding moments and in turn the woman's perception of self is influenced by these same intimate moments. The data in this chapter support the assertion that women, through the experience of breastfeeding, are faced with moments that are uncomfortable. The context of breastfeeding, the physical changes associated with lactation and breastfeeding, and the need to maintain a sense of personal comfort, all contribute to the woman's response. The women 'reconceptualise the breast', or change their perception about their breasts, as a response to 'recognising comfortable and uncomfortable contexts'. As women 'reconceptualise the breast' they come to know themselves in a new and unique way. This process of 'coming to know self' contributes to the breastfeeding woman's ability to engage in intimate breastfeeding moments and impacts on the basic social psychological process, 'Linking as one'.

'Coming to know self' is supported by the three concepts 'contextually defined breast', 'physically defined breast' and 'adaptive breastfeeding'. These concepts are representative of experiences recognised by the breastfeeding woman as comfortable or uncomfortable contexts. The theoretical concept 're-conceptualising the breast' represents the overall process that contributes to breastfeeding women, 'Coming to know self'.

Category	Theoretical Proposition	Concepts	Codes

Coming to Know Self

Recognising comfortable and uncomfortable contexts

Re-conceptualising the breast

Contextually defined breast
*sexual breast
*functional breast
*breast ownership
*Sanctions for breastfeeding

Physically defined breast
*Physically altered breast
*Breast in demand

Adaptive breastfeeding
*Changed foreplay
*Altered access
*Isolate self
*Being discrete & keeping covered

Figure 7-1   Core category: Coming to Know Self

In order to share intimate breastfeeding moments with the baby, women expressed a need to feel comfortable with the breastfeeding experience. Data from the study support the proposition that as women come to know a new 'self' they react to uncomfortable experiences in order to maintain comfort. When women felt uncomfortable with aspects of their breastfeeding they sought to reconsider their perception of their breasts and their breastfeeding experience. Often this reconsideration altered certain breastfeeding behaviours. 'Re-conceptualising the breast' enables women to adapt their breastfeeding in order to maintain a feeling of comfort about their breastfeeding. On the basis of this analysis I would assert that, if breastfeeding is uncomfortable intimate breastfeeding moments might be compromised. The women's accounts of comfort and discomfort are located in the context of the experience of breastfeeding and are congruent with some of the more conceptual literature on comfort and discomfort such as that by Baumann (1996). Baumann looked at children in families with no home of their own, who were living in shelters. Baumann reported that the experience of feeling uncomfortable is a "disturbing uneasyness with the unsureness of aloneness" and this was "amidst longing for personal joyful moments" (p.152).

To be comfortable according to the Websters' New Collegiate Dictionary (1976) is to enjoy contentment and security, physical comfort and freedom from stress. A study by Brailey (1990) looked at stress experienced by mothers with young children and found that stress was due, amongst other things, to conflict between demands on the mother and child's needs and threats to the mother's image or self esteem. These are reasonable facets to consider when participants recount experiences of comfort and discomfort.

In order to maintain comfort with breastfeeding, women expressed distinct considerations about their breastfeeding. The first of these is the 'contextually defined breast' a concept that encompasses the substantive codes 'sexual breast', 'functional breast', 'breast ownership', and 'sanctions for breastfeeding'. The second concept is the 'physically defined breast', a concept that includes the two substantive codes 'breast in demand' and the 'physically altered breast'. The final concept is 'adaptive breastfeeding' and is representative of the substantive codes

'changed foreplay', 'altered access', 'isolate self', and 'being discreet and keeping covered'.

7.2 Contextually defined breast: Sexual breast and functional breast

Breastfeeding is a process that accents the culturally defined notion of the breast as a sexual physical attribute. As one woman noted,

D I mean when you look at all that pornography and things, breasts are just there as sex objects, and suddenly you have a baby and they take on a whole different meaning, D1, 468-472

This insight was passed down to one woman from her mother, perhaps as one way of coping with the discomfort of breastfeeding and sexuality.

A Mum said to me 'just remember that it's nothing to do with sex any more, it's a feeding tool and your baby needs it'. A1, 1702-1705

I first theorised about this in a theoretical memo 30/5/95 "women sharing create a sense of normal, one that men don't understand, is this based on experiential knowing? " The substance of this proposition is reflected in participants' responses and in the work of some feminist authors. The feminist literature exposes this duality of the breast as a fundamental example of conflict between biological essentialism and prescribed femininity or motherhood (Vares, 1992). "There are two kinds of breasts and they can't be on the same person at the same time" (INFACT, 1993, p.4). This quote captures the uniquely Western distinction between the sexual and the functioning (lactating) breast. The two are perceived to be incompatible, a perception perpetuated by the mass media, popular print and demonstrated in toy shops that endorse the notion that breasts are for sex and bottles are for babies (Agnew, 1996; Altshuler, 1995). The consequences of this assertion have been reflected in the public perception of breasts and breastfeeding, resulting in the ability of maternal nursing to inspire both awe and revulsion (Boostrom, 1995). Women are faced with a dilemma as they are pressured to be both good mothers and attractive sexual

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partners (Ruderman, 1992). The entire consideration of sexuality and breastfeeding as culturally constructed has been presented in work such as that of Rodriguez-Garcia and Frazier (1995). These authors call for further research into the relationship between sexuality and breastfeeding.

Some participants shared that their breasts were not sexual during the time of feeding, though they may have the capacity in certain circumstances to become sexual.

T   Well to me the value of a breast is what he's doing right now [breastfeeding] and, um, they do become sexual, but it's not a big issue while I'm breastfeeding with either of us [woman and partner], it's just a natural part of life. T2, 304-308

Q   ...he's never felt that good. It feels good, it feels fine [breastfeeding]... It's not a sexual thing. Q2, 346-352

Women in my study found that they thought about their breasts differently in different situations; this I consider to be the idea of contextual differentiation. Some women were able to maintain a feeling of comfort about breastfeeding when they could differentiate the contexts in which breastfeeding might comfortably occur. An association, by the women, of the breasts capacity to produce milk helped refine the sub concepts 'sexual breast' and 'functional breast'. The substantive code was called 'milk indicates non sexual'. Another code, which contributes to the definition of the substantive codes, is called 'sexual contexts'. Contexts such as the time of day and the setting, influenced how the participants thought about their breasts. If women were in situations that were normally associated with sexual relationships or activities then they might work to reconcile the discomfort of having a lactating breast.

J   Trying to separate it [the breast] from bedtime, you know sexual time, to daytime because you are still feeding at night. But you do have to change your way of thinking. Because you go to bed and still think, there's milk in there. I don't think sexual thoughts. J2, 6, 234-238.

J   ...we are using them during the day for something totally different from what they are used for at night. J2, 261-264

T   ...because they are full, they're not, to me they are not a sexual thing at the moment they are, ...well just the comfort of it... I don't think [husband] would feel comfortable about drinking milk. T2, 242-250.

Defining the breast as sexual or functional indicates a tension between normal and different. Normal might be associated with the lactating or functional breast or with a return to the non-lactation state.

L   You know like all those months your body is used as something to do something [i.e. to produce milk to feed your baby] and all of a sudden it has to turn around and be a sexual thing, where it's normally a functional thing...L1, 976-982.

L   Actually [my breasts] still [have] milk in them. I found out even though it was five years down the track...so yeah they went back to being like, like a sexual thing. L1, 929-935

Often the breast was reconsidered in response to the type of touch or contact, and who is responsible for that contact, an adult or baby. The type of contact, for example sensual contact or sexual contact was difficult to reconcile with the perception of the 'functional breast'.

E   ...I know this morning it passed through my mind like, I was ready to have my breasts to be dual function again... this is why I think they must be sexual is that [toddler] will sometimes bite and then he starts licking and I don't like it, it doesn't feel bad, it's just the idea of it. E2, 163-177.

Women were able to recognise moments when breastfeeding prompted a sexual response. Often the breastfeeding encounter involved more sensual aspects, such as the baby mouthing or licking the nipple. I first noted the distinction between sensuality and sexuality after an interview with one participant and wrote a theoretical memo 15/6/95 'sensuality and sexuality' to prompt my consideration of the distinction and what that distinction might mean. This enabled me to be sensitive to the idea as I engaged in data analysis. I was able to determine from substantive comparison that sensual types of experiences are often associated with sexual

experiences. Also the 'let down reflex' or involution of the uterus for some women felt, sexual. Thus the act of breastfeeding prompted a sexual response.

S   There are times, yes different to a sexual, especially when she [baby] was tiny and she would feed, and you could feel the uterus retracting and you could feel um, sexual. S2, 303-306

S   And the let down too is a really sexual feeling. S2, 314-315

As Carter (1995, p.150) has noted, attempts to explain breastfeeding sensations are an uncomfortable mix between feelings that belong to mothering and feelings that belong to sex. It is this uncomfortable tension which prompts women to reconceptualise their breasts, in order to maintain comfort.

F   I do remember when I was feeding my other two children I used to feel quite horny [sexually aroused] when the baby was sucking on my breast...Not all the time, but I have had flashes of it this time, and it's at a particular time of the day, more likely to be at night. It's more likely to be when my milks down.

Res   And baby is suckling a lot?

F   Yeah it must be when there's not a lot and she's playing around....Because it's a sensual feeling if you really think about it, cos it's then associated with sex isn't it, but really the feeling is sensuality, it is definitely sensuality. F2, 197-224

Recognition of the sensuality of touch and associating this type of touch with sexual experiences can create quite a sense of guilt or discomfort. It is as though some invisible boundary has been crossed. The interface between the 'sexual breast' and the 'functional breast' is difficult to reconcile without experiencing emotional discomfort. Women who were breastfeeding both the baby and toddler (tandem feeding), were able to provide an interesting example of the invisible boundary between sexuality and functionality. These women recall feeding infants and the discomfort with certain infant touch.

Q   I don't know whether she, um, when she puts her hand into my bra, I don't let her touch my nipple. I can't bear her... I don't think she would, she has tried once to sort of grab my nipple (laughs) but I hate that. I can't bear it.

Res   Tell me why you say that, what does it feel to you?

Q   Um, It's just too sensitive, absolutely too sensitive and oh, I am totally annoyed and it's just too invasive. Q1, 858-867.

R   That's feeding's one thing, but when someone's just playing with your breast, you know sort of,

Res   Does it feel, what does it feel?, it feels,

R   (Sighs) I just don't feel comfortable with, …No it just doesn't seem appropriate. R1, 633-64.

Inappropriate touch and uncomfortable touch are represented in these quotes. Other inappropriate touch, mentioned by the women included the stroking, squeezing and playing with the nipple by the breastfeeding baby or child. The tandem feeding women most often reported this type of touch. It was the breastfeeding toddlers or older infants who touched the free breast while breastfeeding.

The discomfort associated with increased touch and touch, which is not breastfeeding touch, prompts women to change their breastfeeding behaviours. This is elaborated in the concept 'adaptive breastfeeding'. The breast sensitivity also features in the reconceptualisation of the breast as functional or sexual. Some women reported that their breasts were very sensitive and thus did not respond well to touch by partners as part of sexual advance. For other women whose breasts were very sensitive prior to breastfeeding, breastfeeding desensitised the breast making sexual touch more acceptable and satisfying.

I   I probably feel a little bit better cos I've always had very sensitive breasts anyway. I2, 212-214

Res   So you don't mind your partner touching them [breasts]?

I   No, I find at the moment it's more pleasurable because I've got used to that pulling action from [baby]…I2, 230-236

I   I found now my partner can fondle my breasts a lot more now, whereas I used to cringe, cringe all the time. I2, 214-217

E   [Husband] asked me about that a lot, because [when] you stick your finger in the little one's mouth, and it's quite sensuous, but my breast mustn't be particularly sensitive, I mean,

Res   Did he ask you if it was sensual for you?

E   Yeah, he asks a lot, yeah … he goes, oh that must be lovely and it's like well no, and he can't quite believe it that I don't think it's lovely. E1, 1100-1115

The participants sought to accommodate the comfort and discomfort associated with perceptions of sexuality or functionality. The participants reported recognising the breast as both a sexual and functional breast; they controlled access and sexual demand according to context and their perceptions. This change in behaviour is further elaborated in the last concept 'adaptive breastfeeding' based on the premise that the reconceptualisation of the breast as a functional or sexual breast prompts behaviour change. It is important to note that breastfeeding did not occur in social isolation and a number of the previously mentioned quotes testify to the women's interpretation of the experience as a response to partners' and other influential adults' opinions and advice. The influence of others on the participant's growing understanding of self is further asserted by the concept 'breast ownership'.

7.3   Breast ownership

Part of the theoretical concept 're-conceptualisation of the breast' includes the breastfeeding women contending with the idea of 'breast ownership'. The code 'breast ownership' is located in the idea that before the breastfeeding relationship with the baby the mother's breasts belonged to the male partner. According to Maher (1992) the idea that a woman's breasts might belong to the male partner is evident in both historical and contemporary literature. Morse (1989b) highlights cultural biases associated with the perception of breasts as sexual and belonging to the husband, while McConville (1994) identifies breast ownership as a dominant theme for women. "In the street, at work, in the doctor's surgery, in breastfeeding children, women are made to feel that their breasts are somehow separate from themselves - and that their rightful owners are in fact men" (p.4). McConville notes that no published research into male psychosexual attitudes to breasts existed at the time of publishing her work.

Crawshaw (1996) explored the idea of ownership further when considering the issue of cross nursing (feeding); that is, breastfeeding a child/infant other than the woman's own. In Crawshaw's study the woman's child was considered the only legitimate feeder, the only person to be granted breastfeeding access and in some sense 'ownership' of the breast.

The women in my study were asked to consider how they felt about their breasts when breastfeeding and when they were not breastfeeding. It was these responses that prompted the substantive code 'breast ownership'.

F   Well... it's almost like they are not part of me... while I'm breastfeeding. F2, 259-267

S   At the moment they are [baby's]. Definitely. Before that they were mine. Yeah and you didn't go exposing them... It's always my body but, yeah it's hers too. S1, 1496-1531

A   I say they [breasts] are baby's now. I consider they are for him [baby], they used to be daughter's and he'd [husband] say, 'I hope we are not having any more kids. Will they ever be mine again?' A2, 233-240

The recurrent substantive code 'ownership' prompted me to ask the theoretical question "who owns your breast"? Considering issues around ownership was expressed as a very uncomfortable time for women. On an intellectual level women are well able to recognise that their breasts are a physical attribute of their 'body' and a representation of their 'self'. On an experiential level the idea of ownership provided a valuable key to exploring some of the emotions and discomforts associated with breastfeeding. The question about ownership was often greeted with a knowing smile or giggle and then a torrent of emotions and ideas about both the ideas of ownership and physical access to the breast. Some responses to the question, "who owns your breast?" are as follows,

I   I like to see that my partner belongs to them rather than myself.

Res   Now while you're feeding?

I   Yes I still feel that, now while I'm feeding. I2 220-224

Q   Oh I do. [own the breast]

Res   Are there times when you feel like you don't?

Q   Yeah there probably are. Yeah. When I um, probably in bed at night…. When I'm feeding him [baby]. Q1 933-940

G   Well they belong to me, but they don't really, they are my baby's. G1 402-405

K   To me definitely or though at the moment I still feel as if they are out on loan a bit, K1, 15

C   …you know they felt like mine before I had the children, yeah now they are sort of like public property, especially with demand feeding. C2, 87-92

The idea of ownership of the breast has been historically reinforced in western society. One text suggests, "If a woman gets pleasure from having her baby stimulate, play with and feed from her breasts, her husband may well not enjoy the baby's relationship with his wife. Until now, his wife's breasts have belonged to him and he may resent the little intruder" (Stanway & Stanway, 1978, p.183) This text was written by a husband and wife medical team and offers the following hints on how to combine a good sex life with a happy breastfeeding baby,

1. Make sure your husband doesn't feel left out- physically or emotionally.

2. If feeding makes you feel sexy or even pleasantly relaxed, tell him so as to encourage him to make the most of it.

3. Wear a good nursing bra and remind him that you're doing it for his own benefit so that he'll have your breasts looking good years from now.

4. Respect his wishes not to feed in public or in front of certain people if you know it upsets him.

5. Plan the odd trip out together once your let-down is well established. Express some breast-milk and leave it for the baby sitter to give. You can't expect your husband to look favourably on breastfeeding if he thinks he's going to be tied to the house for the next six months.

6. Keep up your previous mistress image as much as possible" (Stanway, 1978, p.186).

This excerpt represents a set of historical and patriarchal values so foreign to the woman's own perspective and is supported by the data of this study. This advice most certainly acts to maintain male privilege. It does, however, at least recognise that breast ownership is not necessarily perceived of as the domain of women. McConville (1994) recognises the issue of ownership suggesting that women recognise that in regard to the breast, they are "literally, physically and emotionally attached to them" (McConville, 1994, p.4). Yet women are subject to viewing breasts as a personal battleground.

> On one level we know that they are of course, *our* breasts. We have our own feelings about them, ranging from pride and pleasure to dislike and shame. They are part of our identity, affecting our health, self-esteem and sexuality. Yet on another level, our breasts have been subject to a massive male takeover bid. They are no longer unique, integral aspects of ourselves. We see breasts daily as free-floating parts that can be pictured and parodied in all sorts of ways, from porn to breast kitsch (McConville, 1994, p.5).

Identity perceptions are modified as a result of women considering the breast as an object. For those women who felt assured of the breast as their own, the breast was not reported as an object. A few women within the study sample had never considered the idea of ownership of the breast.

T   Um, I've never thought about it, they are mine (laugh) totally mine...so by not thinking about it they have always been mine. T2, 160-166.

Often when breasts are objectified the breast is reconceptualised and women related their breasts to other feeding related similes,

O   ...drink bottles is what mine get called. O1, 352-358

I   Sometimes I feel a bit like a milking machine. I2, 339-340

A   I think these are (baby's) food. A1, 1707-1712

Res   How do you think of your breasts?
E   (Laughs) Milk supply. E1, 1012-1014.

In the instance of feeding older children such as toddlers and older infants the women would relate their breasts to the names these breastfeeding children gave them. In this way the toddlers asserted their ownership, this idea of 'toddler ownership' contributing to the code 'breast ownership'.

O   That's juice, mine are juice, that's what she calls them, my juice for [toddler]. I mean she's not quite so bad now, but when she was little, you know Mummy's giving juice, that's what she calls them. O1 352-358.

Q   She [toddler] knows that they're called breasts, um, but she at home calls them drinks....It's like when she was sitting on my mother-in-law's knee a couple of months ago and my mother-in-law's lovely, ... she [toddler]said, she was stroking her breasts, but up here [top of the breast], and she said' [Nana] you've got lovely drinks'. Q1, 676-681

R   She, like it's 'my besty', she calls it besty...My besty and books, part of going to bed, very important. And I say 'just a little bit', 'All of it', 'All of it' she'll say, she wants it all. R2, 85-91

The breast is thus named and owned by those with access to the breast and one such access is clearly that of breastfeeding. The endearing terms convey many positive

messages to the breastfeeding women and this is elaborated further in the category 'being with' as it contributes to an intimate breastfeeding moment. I particularly like the name "besty", the idea that breast is best, and best for the young feeder, while also conveying the individual idea of ownership "my besty". The women who were tandem feeding had noticed that the toddlers and older children who breastfeed also felt the right to ownership of the breast beyond the breastfeeding experience.

E   ...as he has got a bit older, just, it must have been towards the end of the pregnancy and since I've had her [baby], he and I had, it got almost into fights... to get him to just cool it because he would just be all over me... I felt like it wasn't just my breasts E1, 994-1003

E   You know he comes up and reaches underneath my [clothes], he still does, actually when he was almost weaning himself he did that a lot instead of nursing, was just fondle my [breast], you know reach up and hold... so he does think they are his. (laugh). E1, 1040-1047.

Thus the breast is 'owned' by those who have access, while of course belonging to the breastfeeding woman in a rational and obvious way. The discomfort of recognising this ownership of self by others is reconciled by considering the breast as an object and somewhat dislocated from self, or considering the breast as a breastfeeding breast and thus reconceptualising the breast in a new way.

7.4   Sanctions for breastfeeding

As the women come to experience breastfeeding in a variety of social settings, opportunity for other discomforts present. Many of the women recounted being acutely aware of what other people might be thinking of them when they were breastfeeding. During a breastfeeding experience women reported an awareness of the breastfeeding audience, those who might observe breastfeeding, particularly as the women increased their breastfeeding exposure in a variety of social settings. Often the breastfeeding audience would respond to that experience by a gesture or

particular look, it is these data that contribute to the code 'sanctions for breastfeeding'.

Often women reported noticing looks, from those with whom they came in contact, when they were breastfeeding. These looks or disapproving glances were interpreted in particular ways by the women and for many contributed to discomfort with the breastfeeding experience. The breastfeeding experience became one that was sanctioned by the looks of others, women checked for people's expressions and responses. The women reported interpreting these looks and these data are represented in the following quotes from the women.

K   There has been times when people have given me a look that suggested that maybe what I was doing [was unacceptable], I felt uncomfortable. K1, 578-582

A   ...you know [baby made sucking noises] and I used to feel really uncomfortable about that because that drew people to look and, then you would be talking to people and I would feel myself going red. A1, 734-740

Women would carefully attend to the looks and reactions of others while they breastfed, closely monitoring others for approval or disapproval of the breastfeeding act.

K   ...occasionally nobody has actually said anything but I've had the looks, occasionally I've felt uncomfortable with the looks. K1, 553-556

D   I have found odd people will give you a glance but when you are bottle feeding it doesn't matter where you do it no-one blinks an eye lid really. D1, 203-207

Frequently women reported asking outright if breastfeeding was acceptable. The responses given to the women's questions directed the subsequent breastfeeding behaviours. This more overt sanction of breastfeeding indicates a social expectation that breastfeeding is not a normal or expected and acceptable practice. One woman shared her experience of visiting with a male manager in a business setting and seeking permission when she needed to breastfeed her baby,

F   I thought, Oh God here goes and I said to him 'would you mind if I feed the baby there's just no settling her if I don't' and he said 'no go ahead' and it was fine. F1, 282-287

While many of the women acknowledged that breastfeeding in public was uncomfortable this was associated with exposing a part of the body normally kept away from public gaze or only on public gaze in the most sexual of contexts. Breastfeeding in public as an embarrassing activity has been previously mentioned in the literature (Benson, 1996; Caplan, 1998; Ruderman, 1992) confirming the practice as one of concern and discomfort for breastfeeding women.

Obvious physical characteristics such as leaking, sucking noises, or baby noises only helped to compound the embarrassment, the discomfort of the moment. It is important to note that conceptual work in embarrassment (Goffman, 1967) attributes the emotional response to unfulfilled expectations, that is, others do not respond as we hope they would. These very physical and obvious breastfeeding responses contributed to the in vivo code of 'being exposed'

C   …if I'm squirting... I've got to take him off…I can do it nice and discreetly…but often I can't… so actually it's a waste of time trying to feed anywhere in public. C1, 286-293

A   I sort of felt like it was the same sort of thing with [my toddler] I used to feel embarrassed, cos she was such a really noisy sucker, and I could be on the phone and people could hear. A1, 729-734

So noise, leaking and physical exposure made these women feel uncomfortable. Morse and Bottorff (1989) have studied the issue of leaking breasts, they found that leaking is expressed as a negative feeling. "... mothers were embarrassed when the amount of milk leaked was sufficient to show through clothing, becoming obvious to others" (Morse & Bottorff, 1989, p.18). These authors go on to describe what women did to manage and control leaking, though they fail to address the underlying cause for the need to disguise the lactating breast. Rather the authors suggest several

strategies for controlling leaking. Maclean (1990, p.40) also mentions the problem of leaking and the embarrassment women felt as a result. Drawing on Kitzinger's earlier work (1979) Maclean suggests that leaking is associated with other body fluids, which are discharged involuntarily, and represents something of the shame associated with exposing the sexual body. In the literature I find no mention of noise other than the physiologically correct sound for suckling (Renfew, Fisher & Arms, 1990, p.62). One might speculate that noise as an exposing factor has the same connotation as leaking. Whatever the root of the embarrassment it was the reactions of the other or the interpretation by breastfeeding women of others' reactions that sealed the embarrassment.

Women in the study, who consistently mentioned being exposed and uncomfortable with others viewing the breast or breastfeeding interaction, also demonstrate the idea that breasts are sexual and private.

L   I don't want my boobs [breasts] hanging out in public...L1, 582-583

T   I wouldn't like them to see me, I suppose I wouldn't like to feel exposed. T1, 332

H   ...you are exposing parts of the body you wouldn't normally expose. H2, 239-241

A   I had visitors coming in...while you are trying to do this [breastfeed]... and you're fully exposed. A1, 1692-1695

H   Yeah it was more so they couldn't actually see me, I wasn't ashamed of actually feeding my child, it's just that I didn't want them to see my body (laugh). H2, 221-215

Exposure was compounded, as was the discomfort of the women, if the nipple could be seen. A good example of this is the following quote by one participant, who said:

E   ...some people are thinking that I am letting the breast out. Although, I guess you could see the nipple. E2, 145-149.

Women felt that the exposure of the breast during breastfeeding was associated with showing the breast in an overt and sexual way and might be regarded as lewd. Their concern was that if others saw the breast they might fail to see the breastfeeding. In other words the breastfeeding act might be made invisible. This is demonstrated by this woman's account:

A   I just sort of felt really uncomfortable. Like I sort of thought I wouldn't sit here with my top off, and I sort of felt like it was the same thing. A1, 725-729

However when it came to interpreting the response of the audience as acceptable or unacceptable it was predominantly men, or older people who gave a 'look' or looked away, both gestures indicating a discomfort with breastfeeding. This discomfort was transmitted to the breastfeeding woman. Men were identified as an unacceptable breastfeeding audience, as demonstrated by these three participants:

D   ...but if you are with males or out in public you are aware that they are not seeing it in the same light. D1, 500-503

N   Well you have got a lot of old men and young boys sitting out there, perving at you. N1, 307-309

I   He came in here I think he felt so awkward he made me feel awkward. You know I was sitting there... he didn't know where to put himself. I1, 538-546

It has been reported that men might disapprove of breastfeeding as a public activity (Freed, Fraley, & Schanller, 1992). The ability to communicate this disapproval by look or gesture contributed to discomforts expressed by many of the women. Men might not actually be 'perving' i.e. looking for sexual pleasure, or indeed perceive breastfeeding and breast exposure as sexual, but the women felt that they did. Justified or not, women became adept at attending to markers of social disapproval and reacted accordingly. Piper and Parks (1996) suggest that support should be aimed at creating cultural norms. This is a rather optimistic aim when one considers the pervasive notion of breasts as sexual objects, a position commonly held by western males (McConville, 1994). Women in the present study were ready to

acknowledge that the sexual connotations associated with breasts were expressions from the breastfeeding audience and this caused discomfort. The following quotes indicate the inherent discomfort associated with any perception of sexuality,

N   Oh well, you just feel as though [males] they are undressing you and staring right at your breasts. N1, 319-321

E   Well obviously there is something sexual when a man makes me feel self-conscious. E2, 158-161

The idea that older folk or the older generation was not a very accepting breastfeeding audience was also expressed. These folk represent a sub group of people considered to be an unacceptable breastfeeding audience. The following three participants clearly articulate their concern for offending an older generation of breastfeeding observers,

B   There are people that I am going to offend particularly older people. B1, 608-610

L   My man's quite a few years older than me, he's a lot more conservative; that could be a generational thing. L1, 561-568

P   We had a big party at my mother-in-law's when I was breastfeeding my second one [child] and because there was [sic] a lot of people I sat in the next room, the light wasn't on but the door was open so that I could see… I sat there feeding him [baby] so that I didn't embarrass anyone and myself, and an older guy walked through and he looked down at the baby, as it was half-dark. Then he realised that I was feeding [breastfeeding] and got all embarrassed and said 'oh we didn't used to do that sort of thing in my time'. I didn't like to say but I thought to myself, well I did; go out of the room into another room…P2, 557-572

It was difficult to determine from the data the exact age groups of those that the breastfeeding women perceived to be accepting or un-accepting of open breastfeeding. There was some indication that the generation that would have

predominantly experienced bottle-feeding as the dominant feeding method of their time, were perceived to consider the practice of breastfeeding in public unacceptable.

I   It doesn't worry me…We [woman and her mother] went to a coffee place... and I think because I didn't know anyone, I don't know what, but I thought, oh who cares. I was quite happy, I thought, well I'm a very open person anyway... I don't get embarrassed easily, so it never bothered me [breastfeeding in public], but I had my shirt open…it wasn't revealing a lot, my mother said 'oh do it up quick, oh they are coming past' I said 'Mum, people are doing it all the time, and I don't think about it'. I think a lot of it comes down to generation perhaps, as well and there are some people that do prefer to be a bit more private. I1, 515-535

Some women mentioned that other cultural norms might be violated by breastfeeding in a more public way. Women reported breastfeeding to be an uncomfortable activity when feeding in front of friends who were of another culture. In these instances the age of the audience did not seem to be the identifiable discomfort. The participants identified these acquaintances to be from the Maori, and Chinese ethnic groups.

D   No, no, I'm always quite careful in mixed company, cos some of our Maori friends they are not, well I know one in particular if I breastfeed he'll leave the room. And his wife does, but he's quite sensitive about it and I'm aware of that, yeah D1, 513-519.

D   Well I was around there [visiting Chinese friends] one day I hadn't, I mean they came round a lot and that and often I do feed with them here but I was around. I was in their house one day and I was going to feed her and she said "would you go up to the bedroom to feed her here please", and it suddenly dawned on me that, they never said anything but possibly, in my house cos that's what I do I just fed her but in their home obviously I respected it and did, went up to the front room and fed her, which was fine but obviously they didn't feel comfortable in their home to have me in their lounge feeding her. D2, 279-298.

Several cultural factors are evidenced by these remarks, the obvious cultural norms that encourage private and unexposed breastfeeding. The effect of cultural norms,

gender distinctions and age considerations on the breastfeeding experience are all congruent with the literature about breastfeeding in public. Riordan and Auerbach (1993) devote a section in their text to the cultural context of breastfeeding and suggest that "breastfeeding in a public place or in the presence of friends is an activity that is extremely sensitive to cultural norms" (p.33). Maclean (1990) found that "the cultural heritage of the family influenced the acceptability of breastfeeding in front of family members" (p.84); as did age and gender (p.84-85). Though cultural norms and values are strong influences on the participants' comfort, they underpin many of the other issues surrounding breastfeeding both in public and private.

The other acceptable audiences were surprisingly associated with the very elderly in society. Women recounted that it is the older folk, in their late years who were better able to relate to breastfeeding as an acceptable practice. One woman demonstrated this in the following quote,

F   But I am really amazed at the attitude, I'm dealing with 90 year old men... they came to visit me [in the hospital after baby was born]

Res   ...they wanted to know if you were breastfeeding?

F   Mmm, yes, one man did, and I said well of course look I am, and he said yes but is there anything in them (laugh)...F1, 613-629

Other women friends or individuals that had either experienced breastfeeding or had some exposure to the practice were often reported by the participants as an acceptable breastfeeding audience. The following quotes indicate the type of people who might be most accepting of the practice of breastfeeding and therefore most likely to maintain the breastfeeding woman's comfort with the experience of breastfeeding in public.

D   Mainly women friends you don't worry, although I have got some best friends whose husbands wouldn't notice a thing because their wives have sort of had three or four babies too. D1, 519-524

A   Plunket, play group not a problem, around women that have fed [breastfed] you know, or mothers, that doesn't bother me. A1, 701-704

Women also reported that breastfeeding previous children and coming experienced to the idea of breastfeeding in front of others enabled them to feel more confident about the experience and thus maintain a stance of acceptability and comfort when feeding in front of an audience. I personally noted this comfort when observing one participant breastfeed, the breast was not hidden or covered during the feed and the woman appeared very relaxed feeding in my presence. I noted (Field Note 7/6/95) "query [this woman] felt safe for her breast to be exposed".

M   Last time I wouldn't of, [breastfed in public] I would have thought oh I'll feed her at home before I go somewhere, whereas this time you don't really worry about where you feed her …M1, 304-324

A   I am just more comfortable now- I just sort of think well it's a natural process, they've seen it done before and if they want to leave the room for a while, well then fine. A1, 757-761

Certain situations were more comfortable such as being with strangers or a situation where there was some distance between the breastfeeder and the observer. In other words, not in being in close proximity to those who might observe the breastfeeding interaction or not being likely to know the person doing the observing. These two subgroups of breastfeeding audience were also considered to be an acceptable breastfeeding audience.

H   It doesn't really worry me, it's probably a whole lot of strangers…H2, 221

J   I got stuck at K Mart [large retail store], one time when I actually went to the toilets in there... and two other people walked in that I don't know and I felt quite comfortable. J1, 443-447

Further the women noted that the proximity of the observer to the breastfeeding pair could be 'too close' for comfort. The context of this encounter, either in a public or private setting was not as important as the proximity of the person observing the breastfeeding. Participants reported recognising a comfortable distance between

them and the observer. The idea of proximity was a contributing factor to the comfort of the breastfeeding experience.

E   I don't mind if it's in a shopping center or something, it's only when you are in close proximity to them in like a sort of, where you would interact. E2, 117-121

I   I felt quite conscious in a coffee shop but I'd be quite happy in a park. I1, 509-512

Often times the baby's need to breastfeed outweighs the embarrassment of the moment and the discomfort of the environment. The audience and the characteristics of the environment are put aside in order to breastfeed.

F   But do you know what I did when she was two weeks old? I went to the super market with her, I had to grab some stuff. I put her in one of those big trolley things with the proper thing, never thinking that she would wake up. Well at the check out, and it was ten times harder trying to bend down and pick the stuff up out of the trolley, because I picked her up, because she was crying, so I actually put her on the tit [breast] right there, while I was heaving my groceries. F1, 296-309

These situations do not represent comfortable or intimate feeding moments but instead are testimony to the environmental influence women battle on a daily basis to maintain breastfeeding. This has not gone unnoticed in the literature and the call for environmentally friendly, breastfeeding workplaces and public places has been mentioned in the literature as a most urgent need to promote, protect and support breastfeeding (Auerbach, 1990, p.45).

Similar reports of unpleasant (uncomfortable) environments for feeding have been mentioned by Leonard (1991); Maclean (1990); and McConville (1994). Leonard captures the position of these aforementioned authors, as she describes and asserts the situation for breastfeeding women.

So having battled our way through the checkout and finally rewarded ourselves with a sit down and a cuppa, while we feed our hungry babies, the last thing we need is anyone inferring we are odd that the

toilet is the only place we should be 'carrying out such an act'! If we

are not ordered to leave, we are probably so embarrassed that we pack

up and go anyway (Leonard, 1991, p.116).

Leonard further asserts that breastfeeding should 'come out of the closet' and become recognised by law as a legitimate human right, in any context. McConville (1994) cites a 1989 study by the National Childbirth Trust (London) in which a survey of restaurants that claimed to have facilities that would accommodate a breastfeeding mother, showed that in fact 70% provided no more than a toilet.

While women are faced with these constraints, they have to recognise that which is comfortable or uncomfortable as a breastfeeding place, and in doing so act to maintain comfort and thus promote that intimate breastfeeding moment. For some women the comfort or discomfort depended on a perception of societal norms. One woman mentioned how this impacted on her perception of breastfeeding in front of others.

E   I don't know I guess I thought a couple of times with [first baby] maybe I am being a bit brazen, if that's the word, or something. It didn't occur to me that it would be a problem but since I have had [second baby] and as I have talked to more people and know more people that are breastfeeding I realise that it might be a problem and it's almost I think it's almost something that might be acquired…. I have talked to more people and realise what they are thinking. E2, 131-144

P   My husband used to say that, before we had kids, he used to be embarrassed when someone was breastfeeding and he was in the room, so that's probably why I'm sort of, just a bit uncomfortable in case other people did feel uncomfortable. P2, 91-96

F   I think its socially acceptable now, people expect it. F1, 482-483

Women attended to the gaze of others, interpreted looks and experienced being exposed, and they came to recognise acceptable breastfeeding audiences and unacceptable breastfeeding audiences. Women recognised if the observer was an anonymous person or if the proximity was too close; both these things affected their comfort. The women also found acceptable those audiences who held congruent

norms while those with dissimilar norms promoted discomfort and were considered an unacceptable breastfeeding audience.

The participants in this study reflect similar feelings and experiences when exposed to the sanctioning looks and proximity of others as those cited in Maclean's (1990) study. Maclean mentions that in reacting to others' comments or disapproval results in the woman feeling uncomfortable. "The decision to breast feed in public appeared, in large measure, to be based on a woman's perception of its appropriateness and on the opinions or reactions of others when she did it" (Maclean, 1990, p.83). Maclean goes on to say, "Women who were uncomfortable breast feeding in front of others frequently used the word exposed" (p.86).

Part of 're-conceptualising the breast' in order that breastfeeding women can feel comfortable about and understand 'self' involves reconciling the 'contextually defined breast' and working toward comfort with breastfeeding. To engage in this process women have to consider the breast in respect to access or 'ownership' and perceptions of the breast as the 'functional breast' and/or the 'sexual breast'. Breastfeeding women have to come to understand the social 'sanctions for breastfeeding'. As women noticed the looks and indications by others they modified their breastfeeding practices to maintain comfort for themselves.

Physical changes also impact on breastfeeding women's perception of their breasts. Physical discomforts according to Evans et al. (1969) occur more for unsuccessful breastfeeding mothers. Women reconceptualised the breast in response to the experience of lactation and altered physical sensation of the breast. This response consistently reflected the motivation to move toward comfort in the breastfeeding experience. The breast is 'physically defined' as it undergoes physical alteration. Physical contacts, such as breastfeeding and the partner's touch, shape breastfeeding experiences and the 'breasted' identity of the women.

7.5 Physically defined breast: Physically altered breast

The change in body image associated with changes in the shape, size and physical comfort of the lactating breast was a constant reminder of the breast and breastfeeding. The women frequently reported reconciling the change in breast size and developing a new sense of 'self'.

H   When you're breastfeeding you look so huge [breasts], you think that this isn't my body. H2, 272-279

Women reported an uncertainty about their breast changes, a sense that things might never be as they once were. This uncertainty resulted in a degree of anxiety and emotional discomfort.

F   ...They become part of my body, ...part of my image, part of how I look sort of style...my friend said aren't you proud of your big boobs, you always wanted big boobs, but I think, oh my God what are they going to be like after I've finished feeding, they are going to look disgusting. F2, 70-86

T   They [breasts] get big blue veins through them, I can remember being really shocked... and suddenly there were a whole lot of stretch marks on them, I hadn't done anything to prepare myself... T2, 201-209

Some women found that alterations in the breast as a result of lactation were not a positive experience. Others felt that a bigger bust was a positive attribute. Either position resulted in a reconsideration of the perception of 'self'.

O   ...you feel fat and flabby enough with your big boobs full of milk. O1, 512-514

F   I actually didn't develop a bust until after I breastfed and I was getting older, you know. I was just so pleased about these big boobs that I have. F2, 251-258

A breast that feels messy, uncomfortable and sore, is a constant reminder of a body change. This change evokes an adjustment both in self-perception and behaviours. The physical discomfort and size alteration of the breast contribute to the code 'physical alteration'.

K   I know there are times especially in the morning when they are full of milk; sometimes they are too tender, that's had to be an adjustment that has had to be made. K1, 607-661

Whatever the perception associated with breast size, a change in body image was described by many of the women. The very management of a lactating breast and breastfeeding necessitated a change in behaviour.

N   Oh you go around all day with your shirt hung out, you never feel properly dressed…you go to bed with your bra on… it's messy, isn't it, leaking everywhere? N1, 222-230

As the women reconceptualised the breast and breast changes from a non-lactating breast to a lactating breastfeeding breast they came to know and understand their themselves as breastfeeding women. For many of the women this process enabled them to feel comfortable about their breastfeeding. For others breastfeeding was not comfortable either physically or emotionally. The physical demand placed on many women when they are breastfeeding can become an emotional demand.

7.6   Breast in demand

Q   That feeling that I've been touched and stroked and everything by my kids all day and then my husband you know, starts being gentle and stroking and loving, I can't bear it. Q1, 942-947

A sense of excessive demand on the breast was a commonly reported position, particularly when the women felt unable to control access. This is expressed in the following excerpt,

N   [Breastfeeding] Certainly can tie you down, but just for someone else to be able to feed him, especially at that 5 o'clock and 9 o'clock at night,

Res That demanding time?

N   Oh they're forever hanging off your nipple... Well it is, it's frustrating. N1, 141-146

It was in part the constant contact with the breast, which prompted women to share this about the discomfort of constant demand.

D   Do you not like that contact, while you are feeding?

O   No I feel as though I have had enough of that, hanging off me all day long without somebody else trying to take over again. Like a lot of women feel. O1, 386-389

R   I've told him this time a lot that I feel really touched out, really... very tired. R1, 857-865

The demand is both frustrating and tiring. Women can feel over exposed and drained from the experience of 'breast in demand'. The experience of tiredness is often reported and has been demonstrated as one aspect that improves with the cessation of breastfeeding (Forster, Abraham, Taylor & Llewellyn-Jones, 1994) However, many participants in this grounded theory study recount that breastfeeding re-energises them and relaxes them (see Chapter Six, 'altered mood'). It is therefore likely that tiredness is linked with other aspects such as the demand on self and the constant touched out feeling. The women also reported the need for space and privacy. It may be that 'demand feeding' represents a lack of maternal control and a leap into possible subservience and domination. "Women who demand fed found, as the schedule feeders predicted, that they were controlled by their babies" (Maclean, 1990, p.61).

Women in this study controlled the access to their breasts in order to confine the demand and maintain breastfeeding comfort. I noted on the 2/6/95 in a theoretical memo that "control is a mechanism for demand." This premise was substantiated in further analysis.

Auerbach (1994) makes a similar assertion in an editorial about women who wean, suggesting that it is not the physical problems or their perception about breastfeeding but rather a loss of mastery (p.223). The mastery alluded to by Auerbach is about being in control and feeling confident to manage an uncomfortable situation. Though control of access to the breast might be learned with breastfeeding experience, it also contributes to how one objectifies the breast. One woman, reported that,

P I just feed him when I need to…I feel like I still own [the breast] because it's up to me, 'cause I decide when I feed him… P2, 325-331.

The code 'physically altered breast' reflects the process of coming to recognise the breast as a physically altered, lactating breast. The women in the study reported having to reconsider their body, their breasts. The very physical manifestations associated with breastfeeding, such as leaking and squirting also contribute to 'feeling exposed' while the act of breastfeeding for many might be an uncomfortable demand on their body. 'Breast in demand' is characterised by the accessibility of the breast to others such as the breastfed baby or child, the partner or husband. As women recognise the discomfort and seek to maintain comfort they reconsider their perception of 'self' and seek to change their breastfeeding practices. This modified behaviour is presented as the concept 'adaptive breastfeeding'. Breastfeeding behaviours are altered as women 'isolate self' from others in order to maintain breastfeeding comfort. As they breastfeed they are 'being discreet' and 'keeping covered'. Some breastfeeding women reconceptualised the breast as they altered access and changed foreplay.

7.7 Adaptive breastfeeding

In 'coming to know self' by re-conceptualising the breast certain changes to the practice of breastfeeding are wrought. Often as an attempt to maintain a comfortable feeling about breastfeeding the women in this study altered both how they thought about their breast and the way they breastfed. 'Being discreet and keeping covered' while breastfeeding were common strategies and are presented as codes within the 'adaptive breastfeeding' concept. Women also remove themselves from social

circles, often to socially isolating environments in order to feel comfortable with their breastfeeding. In this way the interpretation of unacceptability, by the breastfeeding audience is countered by adapting breastfeeding to maintain comfort.

In many instances women would isolate themselves from the gaze of the person/s who made them feel uncomfortable. This experience is represented in the substantive code 'isolate self' and an example of this is when some women were asked to leave the room to breastfeed. Some breastfeeding women found it the most appropriate way to maintain a comfortable feeling with their breastfeeding. The following excerpts demonstrate this,

S   My father-in-law, my mother-in-law asked me to leave the room to feed, which I did. S1, 1056-1057

A   …a lot of people thought I was stupid to go to a bedroom to feed… He [husband] would say you've got to respect her privacy, and she's still learning…you know how to feed in public and feel comfortable. A1, 636-644

Adapting to the discomfort of breastfeeding by altering behaviours is consistent with the popular notion of adaptation, modifying to fit a condition or the environs. Kaye (1982) supports the idea that mutual adaptation occurs between breastfeeding mother and baby. Kaye further asserts that if infants suckled continuously mothers would take "a far more passive role in the feeding" (p.40). Adjustment of breastfeeding behaviours results in a new way of knowing about 'self' as a breastfeeding woman. Miller and Sollie (1980) suggest that parental adaptation to the stresses of parenthood is a coping strategy. In the breastfeeding encounter coping with discomfort is the stress that influences breastfeeding behaviours. This adjustment for many of the particpants' had been made with a previous breastfeeding experience and women spoke of learning from past breastfeeding situations.

'Being discreet and keeping covered' were adaptations to the breastfeeding interaction which helped maintain comfort. This substantive code includes in vivo codes, such as 'covering modified', 'minimal exposure' ' covered self' and 'discreet in public'. These were most often reported as ways of adapting the breastfeeding

experience while maintaining breastfeeding in public situations as a comfortable and acceptable practice.

J   I think as long as I always pull my top up rather than unbutton the shirt and put it over, I mean you can be discreet about these things in public. J1, 456-460

K   Some time in public places I mean I actually feel quite comfortable and I think I am quite modest in my feeding. K1, 538-541

H   …but I just sort of tried to cover myself up as much as possible (laugh) yeah. H2, 207-209

O   Keep covered so that you're not hanging… which can be offensive to anybody even your husband walking past sometimes,.. [husband says] put it away or cover it up. O1, 229-234

Neither Morse and Bottorff (1989) nor Maclean (1990) suggests that disguising breastfeeding (by being discreet to hide the 'tell tale' sign of leaking) is for the purpose of maintaining comfort. The whole business of discreet feeding and maintaining covering has been considered by numerous authors (Kitzinger, 1989; McConville, 1994; Maclean, 1990; Minchin, 1985; Renfew, Fisher, & Arms, 1990; Riordan & Auerbach, 1993); in fact most breastfeeding books discuss breastfeeding positions and clothing that might hide the exposed breast from public view. When literal attention is given to the necessity of this practice (covering and hiding) social norms and values are implicit, the immediate consideration of comfort seems incidental to these more encompassing rationales. There is some evidence (Tyler, 1973) that keeping the body from uncomfortable exposure enhances the sensual and pleasurable contact between individuals. Certainly the participants of this study indicate that covering the breast while feeding maintains comfort and enables the breastfeeding encounter to occur.

7.8   Changed foreplay and altered access

The very physical change in breasts during lactation also altered the women's consideration of breasts as sexually available objects. Further elaboration on the physical changes was considered in the concept 'physically altered breast'. As a result of the change in breast function and associated discomfort, breastfeeding adaptations such as 'changed foreplay' and 'altered access' were behaviours that some women used to maintain comfort. The women reported the process of reserving access and at times coming to a point where the breasts were unavailable to anyone other than the baby. 'Changed foreplay' and 'altered access' were practical demonstrations of the woman's re-conceptualisation of the breast. These adaptive behaviours represent the women seeking to reconcile the emotional discomfort of combining breastfeeding and sexual relationships.

E   Soon after [first baby] was born we were sort of getting intimate [sexually] in bed and I got quite, a big milk let down and I didn't like it at all. (laugh). It really turned me off. E1, 1140-1149

J   I didn't want [husband] at them [breasts] and I still wear my bra because I'm fairly biggish anyway, and I need them [bras] for comfort and he thinks I shouldn't wear it [bra] to bed. There is always that, but I don't let it bother me. J2, 151-157

J   He says when are you going to loose the bra, (laugh). J1, 542-544

C   Oh yeah, well sometimes he probably does feel a bit out of it but he's very understanding with that, because I wear my feeding bras to bed, I mean you know I have them on 24hrs a day, still 8 months later I leak something dreadful so I have flannels in at night. C2, 111-118

I   The thing I found very hard particularly in an intimate situation, that I have to wear my bra, that's really what gets me down I find that very, very hard for me to come to terms with that. I2, 248-253

O   You're always padded up at night time so you don't leak everywhere.. yeah, its so unromantic. O1, 489-491

It is this dual breast conceptualisation of body in function and body as sexual which contributes to the issue of ownership. Clearly these women felt a certain pressure to return to 'normal' and as one partner requested, "loose the bra". McConville (p.89) suggests that the male who cannot cope with the combined maternal and sexual breast has long hampered the success of breastfeeding. In an interview on breastfeeding and the male perspective, Michel Odent (1992) the doctor who pioneered underwater birth, "...argues that in the polygamous arrangement, where sex during the suckling years is usually taboo, a young mother is free to concentrate on her baby" (Davies, 1992, p.64). This Odent contends is one way of dealing with breastfeeding and male sexual needs. His argument is not explicitly concerned with male sexual privilege but rather acknowledges that such an arrangement is for the good of the infant and mother. Polygamy would benefit breastfeeding, as the breastfeeding relationship would be free to continue outside of sexual pressure. This position is asserting that women should recognise male sexual privilege as more legitimate than the baby's needs.

Keeping control by 'altering access' in a breastfeeding situation was also a strategy for keeping the demand on the breast to a comfortable level. In considering this aspect of the model I was driven to theoretically sample women who were tandem feeding their infants. My assumption was that these women would have increased demands on the self and might modify and adapt their breastfeeding behaviours in more overt ways. Some women who were tandem feeding the baby and another child demonstrated ways to control access to the breast and thus maintain a sense of comfort. Interestingly they did not recount any more discomfort with their breast demands than the other women who were breastfeeding only one infant. Work by Berke (1989) suggests that tandem breastfeeders experience some emotional discomfort but not in association with extra demand. The tandem breastfeeding participants indicated two significant strategies for controlling and altering access to the breast. These two strategies are the denial of a breastfeed to the child and rules for breastfeeding and are illustrated in the following quote,

Q   I say, no you're not having a feed now and we have certain rules that she doesn't feed outside or in church, because she will do that she will ask in church, … and she'll ask in a lot of places, and I just say, No, you're not feeding in public. You feed at home. Q1, 712-19.

In order to maintain comfort women exercised this right and controlled and altered access, not only to the breastfeeding child or baby, but also to partners.

A   …If he [partner] sometimes he'll come up behind me and he'll be being cheeky or just joking around and he'll grab me there (demonstrates cupping breasts with her hands) and I'll think yuk don't do that… and now I say don't do that. A2 5-6, 224-233.

'Breast ownership' is a useful concept for women to reconcile access to the breast. As a concept it allows women to objectify the 'self'. The self as object is a way of understanding a breastfeeding identity, a way of 're-conceptualising the breast'. The social response to breastfeeding is also shaped by the ideas held in the concept of 'breast ownership', essentially, partners and breastfeeding children have legitimate access to the breast, others and the more public gaze is a less comfortable breastfeeding audience.

7.9   Re-conceptualising the breast

Maintaining both physical and emotional comfort while breastfeeding is important to sustain the practice of breastfeeding and enable intimate breastfeeding moments. The theoretical question about breast ownership contributed to an elaboration on breasts as functional and sexual. This in turn led to the exploration of issues about self-perception, maternal satisfaction, attitude toward breastfeeding, and the development of a breastfeeding identity. As previously noted, according to Blum (1993, p.291), "Breastfeeding provides a wonderful lens magnifying the cracks and fractures in our construction of late-twentieth-century mother". While this illumination is academically enlightening, it does little to enable women to reconcile the conflict between their experience and social attitudes and little to promote an untroubled breastfeeding attitude, or to achieve a state of harmony (Leff, et al., 1994).

It is the development of a new sense of identity, which changes with social experience that is reflected in the theoretical concept 're-conceptualising the breast'. It is important that the idea of self and breast remain distinguished as these distinctions hold currency with women's perceptions of the importance of the breast during breastfeeding. I was interested to note that in an early work by Ayalah and Weinstock (1979) women recounted their identity and talked about self in relation to their breasts, in a text where the only picture to identify each contributor was a picture of their breasts. Locating the breast as focus for understanding self has clearly been considered before. The concept 're-conceptualising the breast' represents implicitly a reconsideration of a former identity or previously held concept of the self. The change of conceptualised self is from that of a non-breastfeeding woman to that of a breastfeeding woman.

Much has been written about the theory of 'self' (Kippenburg, Kuiper & Sanders, 1990; McAdams, 1991; Morgan & Schwalbe, 1990). One particular aspect is the transition of identity and self-definition during transition to motherhood (Deutsch, Fleming, Brooks-Gunn, Ruble & Stangor, 1988). Sampson (1988) has considered the extent to which the self is considered as an individual or collective. Most recent work has embraced the notion of 'self' as an evolving and socially constructed concept (Hermans, Kemper & Van Loon, 1992).

Arvay, Banister, Hoskins, and Snell (1999) embraced a constructionist perspective in a report on a recent qualitative study drawing on the lived experiences of women to understand the theories of 'self'. Four themes were identified in the study: struggling for authenticity, inner knowing, changing over time and the contextual self. Some interesting similarities emerged between the findings of the Arvay et al. study and the responses of the women in the present study. In struggling to locate self, as a concept, women in the Arvay, et al. study spoke of 'soul' as the most adequate descriptor. The participants of the present study, reported the idea that engaging in intimate moments was a 'soul thing'.

The spiritual aspects of relationships have been explained in other work as connections to the self (Walton, 1996). From the narratives of women in the Arvay,

et al. (1999) study the self continued to change over time and was contextually determined by social relations. This finding is also congruent with the social and contextual influences on women as they experience breastfeeding. Beeber (1989) asserts that the need to protect the 'self' from anxiety is associated with the need for tenderness. While the Beeber study was undertaken with mentally depressed clients it was the association with anxiety or discomfort that illuminates the drive for individuals to seek intimate and tender relationships. This aspect certainly supports the premise that breastfeeding women in 'coming to know self', recognise and seek to address uncomfortable breastfeeding experiences.

7.10 Conclusion

This chapter has argued, on the basis of the data, that women have a variety of breastfeeding experiences that cause them to feel comfort or discomfort. These experiences may be located socially or as personal and physical experiences. As a result of recognising comfort or discomfort women alter and modify the perception of them selves and change their behaviours in order to maintain comfort. In this way they come to re-consider the breast and ultimately to know themselves in a unique way. It is the maintenance of comfort that enables these women to engage in intimate breastfeeding moments with their baby. In turn, as they come to experience these intimate breastfeeding moments, they further build self-esteem and self worth. In the following chapter I consider the women's experiences of coming to know the baby in the breastfeeding encounter.

Chapter 8: Coming To Know Baby

8.1   Introduction

The following chapter is the last of three data chapters, which elaborates the supporting data for the category 'coming to know baby'. 'Coming to know baby' along with the categories 'being with' and 'coming to know self', contributes to the basic social psychological process 'linking as one'. Data that support the category 'coming to know baby' indicate that through the breastfeeding experience and during intimate breastfeeding moments the participants were able to interpret the baby's engagement with them and develop an affirmed sense of knowing the baby. 'Coming to know baby' is both a process and outcome and is subject to constant refinement and development by both breastfeeding mother and baby. The process of 'coming to know baby' contributes to the experience of intimate breastfeeding moments. Further as an outcome of these intimate moments, 'coming to know baby' is an essential aspect of affirmation and belonging for both mother and baby.

> Breastfeeding is not only a method of physical nurturing, it is a way of communicating with another human being and a way of loving (Entwistle, 1991, p.24).

The process of coming to know the baby occurs as women come to read, or develop an understanding of, the infant through the experience of breastfeeding. The data support positive maternal breastfeeding perceptions when a woman feels that she knows the baby and the baby knows her. The extent to which such knowing of the baby impacts on maternal identity has been theorised by Rubin (1984). Rubin suggests that as the infant increases their behaviour cues and behavioural repertoire, women seek an identification and image of mother, which is advanced by "a 'knowing' of the newborn" (p.141). I can neither substantiate nor refute Rubin's theorising as to the impact of 'knowing' the baby on maternal identity. It is my assertion that 'coming to know baby' is a process that occurs during breastfeeding
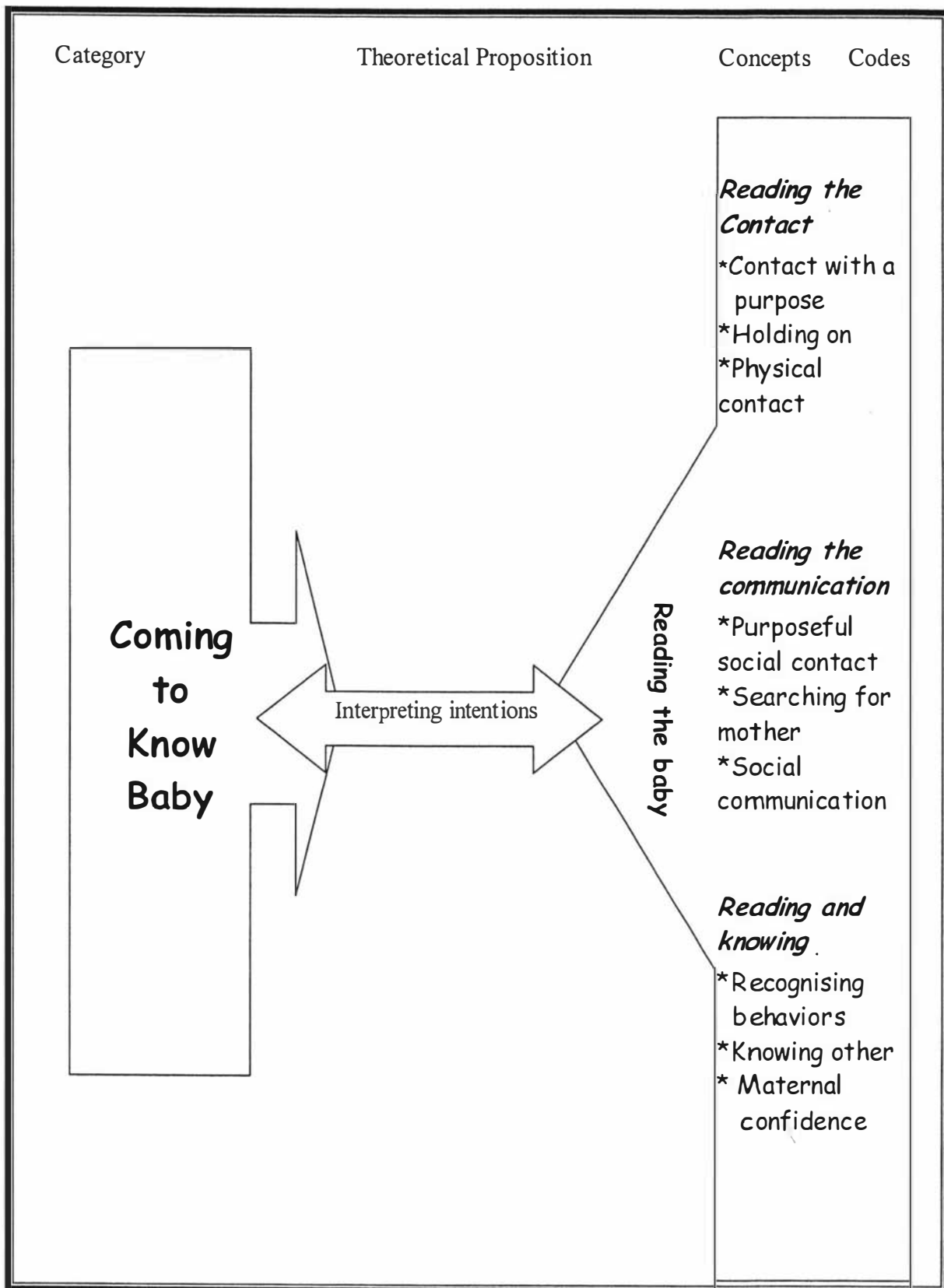
Figure 8-1   **Core Category: Coming to Know Baby**

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and is part of an intimate breastfeeding moment. During the process of breastfeeding the dyad is engaged in an active social exchange, yet the breastfeeding woman appears relaxed and oblivious of any emotional effort. The women are engaged in 'reading the contact' and 'reading the communication' and this is an expression of 'reading and knowing' the baby. The women also suggest that baby knows the breastfeeding woman. Each of these concepts is a pivotal part of the social psychological work of 'interpreting intentions'. The theoretical proposition, 'interpreting intentions', captures the overall dynamic, that is, the interpretations of the baby's needs, wants and expressions in order to feel that the breastfeeding woman is 'reading the baby'. In essence, I will argue from the data, that 'reading the baby' is a result of the interactive breastfeeding dynamic that is advanced by breastfeeding mothers interpreting the intentions conveyed to them by their infant's behaviours and cues. The interpretation of intentions within the breastfeeding dyad facilitates the perception by the breastfeeding woman that she is coming to know the baby. 'Coming to know baby' is diagrammatically represented in Figure 8-1.

8.2 Reading the baby

As women breastfeed their babies or children, they are spending time getting to know them. While this seems a self-evident statement many of the activities, which enable this process, are not explicit or recognised by breastfeeding women or health professionals. In many instances 'reading the baby' is associated with the experience of breastfeeding, though this may not be exclusive to the breastfeeding experience. Throughout the breastfeeding interaction the intention to read and understand the baby is an imperative. To read, is to peruse, understand, comprehend, and interpret (Websters New Collegiate Dictionary, 1976, p.961). When one is reading then one is in the act of perusal, scrutiny, and inspection (Collins Pocket Thesaurus, 1992, p.363). This is the essence of the construct 'reading the baby'.

'Reading the baby' involves elements of physical touch, social communication and verbal or non-verbal expressions of familiarity and belonging. Each of the concepts that support the category are linked by certain characteristics or associated threads. These include the physical contact or touch between the breastfeeding pair. This touch might not be just breast to mouth contact but hand, feet, and face touch by the

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breastfeeding mother, or face, hand, or breast touch by the breastfeeding infant. Another characteristic common to these concepts is the communication between the breastfeeding dyad. This includes the more usual social communication behaviours, eye contact, vocalisations, smiles and searching that creates social exchange between the breastfeeding pair. Finally, a common characteristic of the concepts is the recognition of the baby that is perceived by the woman as she observes the infant's behaviours and engages with the infant. The breastfeeding woman comes to know the baby in a unique and privileged way. This 'coming to know baby' is fundamental to the theoretical proposition that the central activity of the breastfeeding woman is evidenced in the interpretation of the intentions of their baby. Ultimately, these data support the category 'coming to know baby'.

8.3   Reading the contact

'Reading the contact' is a concept that encompasses the substantive codes 'contact with a purpose' and 'holding on'. These substantive codes represent the touch or physical contact within the breastfeeding encounter. The first substantive code 'contact with a purpose' includes the substantive codes 'purposeful touch', and 'purposeful contact'. It is both the physical touch and the intention of the touch that remain common to the substantive code 'contact with a purpose'. One mother described the contact,

L   I suppose his hands would be expressive, when I think about it. Like he um, sometimes when I'm holding (the baby), he'll actually try and grab my finger and hold on to my finger.

Res   OK and how does that make you feel, when he grabs hold of you?

L   Oh, lovely because I think he wants, he knows I'm there and he wants to see that I am still there. L1, 1342-1359

With each of these moments the mother is reading the intention of the baby, projecting her interpretation of the physical contact by verbalising that the baby is conveying that it both knows and wants her. The touch of the infant results in an interpretation by the breastfeeding woman that the baby knows her. This is demonstrated in the example shared by one woman where she recounts her interpretation of the baby's small hand as it grabs or grasps and touches his mother.

N   Oh he's into touching faces and collars... he's communicating with me. N2, 766-774

Further, the woman interprets that physical contact holds the purpose of communication. The body language of the baby conveys meaning as with this report,

D   ...A friend of mine, one day was around and I don't think she had ever seen her [baby] feed before and she said 'oh look at her toes'. She just sat and watched her toes... I thought this is quite neat to share toes with her, it sounds silly but it's a little thing...her hands sort of stay put but her toes are doing all the talking I guess. D1, 760-784

The women focused on the feet as the baby's expressions of physical communication. When the infant was breastfeeding the body language expressed in the wriggle of the baby's toes conveyed messages of satisfaction and pleasure. Often the women touched the toes while breastfeeding their infant (Figure 8-2). This gesture is an indication of the woman's awareness of the baby's body movement as a form of communication.
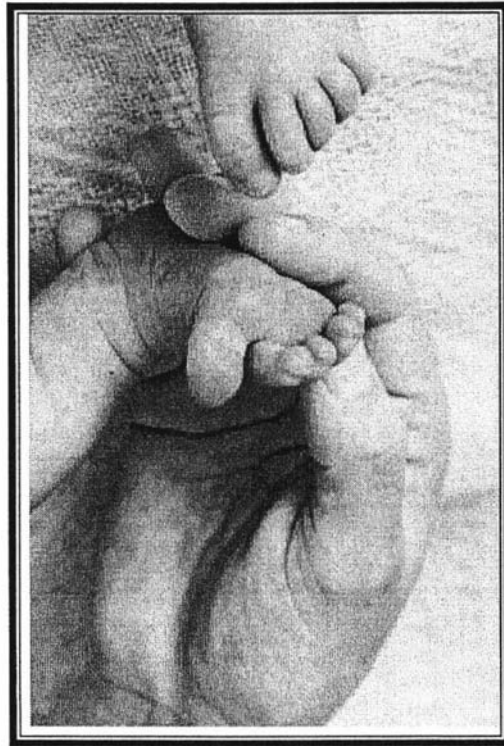
Figure 8-2   Baby's Foot[1]

The idea that body language is an essential means of communication is also well presented in the in vivo code 'holding on'. This code again demonstrates the breastfeeding woman interpreting an intention from the baby's physical touch. In the following instances the infant, according to the breastfeeding woman, is checking and gaining comfort from 'holding on'. The physical contact is reported by the woman to be a personally positive experience. Many of the women reported that the baby touched with the intention of 'holding on'.

O   Yeah, he has always done it. It's almost like a comfort to him,… almost like he is checking to make sure that we're [here]… he always just holds on. O2, 303-308

S   Yes, I just love her little hands, when I'm feeding her and this hand is often holding on, she's really only just started doing it and she will hold on either to my bra or my thumb or my finger. S2, 133-141

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[1] The photographs were given with permission. I wish to acknowledge the professional work of Rosie O'Neill (Auckland) as photographer.

S It's just, these little hands. Sometimes I feel holding on, I sort of question to myself, is she holding on to be secure. Is she frightened I'm going to drop her or something. But I think it's part of learning, grasping reflex. S2, 191-197

That women in this present study consistently reported an intention in the baby's 'holding on' leads me to consider the importance of the grasp reflex. I will never again under-estimate the influence and effect that the baby's grasp reflex, to hold on, conveys to the breastfeeding woman. I observed this behaviour in the participants in the present study and found that they were immediately drawn to the baby, immediately engaged and actively responded to the infant. The following picture (Figure 8-3) is a visual reminder of the powerful and emotive response that babies' hands invoke.

Figure 8-3 Baby's Hand

The touch of the infant whether 'holding on' or just a touch by the hand on the top of the breast conveys an intention to the woman. The baby is reaching out toward the woman, expressing a move toward, a recognition and acknowledgement of the other

person. This movement and touch is read and given meaning. This is well expressed by the following quotes,

J   Touch... yeah sometimes she does or sometimes she touches your clothes, that's nice, ...I suppose you are feeling wanted and needed. J1, 665-674

K   They usually come out [hands] and pat my skin sometimes...his hands, [at the top of the breast]... It touches them [breasts] and makes me feel like he's wanting to communicate with me...that I'm important to him, and his legs and often you see him sort of squirming and he's squirming with pleasure. That he's sort of coming on, or coming off or whatever and he opens his mouth, just makes me feel like I'm important to him. K1, 481-498

It is difficult not to conjure up the image of a small lamb with tail wagging as it drinks. The physical response and contact by the baby induces a sense of maternal affirmation. The woman conveys to the baby affirming messages, touching them and reassuring them that they understand and can 'read the contact' with their baby. The women reciprocated the touch by allowing the infant to grasp their hand or by reaching to stroke and touch their infant.

Eidelman, Hovars, and Kaitz (1994) demonstrated the difference between mothers' and fathers' tactile behaviours with their newborn infants. Women characteristically touch and stroke the baby more than pat or shake them. The male touch style included more patting or shaking in physical contact. This finding is consistent with the observations and reports of women from the present study. The women in the Eidelman, Hovars, and Kaitz study preferentially targeted the infant's hand and face more than the body. The authors in that study did not include feeding styles but filmed men and women holding their infant. This is an important omission as the holding position of breastfeeding offers the maximum opportunity for women to attend to the infant's touch and return touch to the infant.

A preference in touch styles is also associated with intimate relationships. "The type of touch employed in intimate relationships is also different from that used in more superficial relationships; it generally includes more stroking and caressing than

patting" (Knapp & Vangelisti, 1996, p.287). I have noted in a Field Note (3/5/95) the physical interactions that occurred between mother and baby while I was present, "Lovely mother baby contact, gentle touching on the face by baby, hand holding, baby content, cooing, talking, smiles and interactive, mostly directed at mother". In a Field Note (7/6/95) I record "Observed feeding, lots of breast showing, mother baby eye contact, touched baby on cheek -endearing, baby smiles and coos".

I have found no literature to support the assertion that touch enables a knowing of the baby. The impact of touch and physical contact has been recognised in the literature on bonding (Eyer, 1992). Though the distinction between bottle feeding practices and breastfeeding has been poorly recognised in the bonding and attachment literature it is important to note the more recent comments by Kennell & Klaus (1994). These authors assert that the building of close affectionate ties between mother and infant occurs with contact, "This is most likely to proceed successfully with breastfeeding, in which close contact and interaction occur repeatedly..." (cited in Lawrence, 1994 p.ix). Physical communication is only one aspect of the mother-baby breastfeeding dynamic. The social aspects of communication, such as smiles feature in the concept 'reading the communication'.

8.4   Reading the communication

This concept includes the more usual social aspects of communication. Several substantive concepts are encompassed in the concept 'reading the communication', they are 'social communication', 'searching for mother' and 'purposeful social contact'. The women notice interactions such as smiles and vocalisations and attend to these social communication indicators. Thus, contact is considered to be 'purposeful social contact',

B   Just like flashing, like she'll [baby] stop now and flash me a grin, a smile, get half off [the breast] and flash me a grin and then nuzzle back in as quickly as she can, when she realises she's had her bit of contact. B1, 398-406

A	He [baby] looks up at me while he's feeding and he might close his eyes and then open his mouth, sticks his little tongue out and he'll smile and it's just, you know, just you and me mate, that's sort of how I feel. A1, 399-405

Eyer (1992) notes that the emotional response to physical breast contact occurs after birth and specifically mentions the contact with breast and baby's touching the mother with its hand as prompts to evoke a peaceful, sense of achievement. As previously mentioned the physiological hormone response to breastfeeding includes the release of oxytocin and prolactin, which can induce calming and peaceful emotional responses in breastfeeding women. The emotionally positive attributes of interpreting physical touch include not only communication and the physical expression of the baby's intention but also the affective aspects.

Q	cause you actually feel as though the baby, you know you sort of, you know in a way that he's really enjoying the milk, he needs the milk, it's his nourishment, it's an instinctive thing. It somehow seems different when that hand comes up, …is it some way of actually saying, I want to actually touch you, it's you, this milk is coming from you and I'll touch you. Q2, 490-499

Women express the thrill of knowing what the baby is trying to convey by the touch, particularly when they interpret the touch intention as an expression of the infant's want and desire. It has been argued that touch provides a bridge between biological and psychological processes and enables development of early mental representations (Hofer, 1994). If this position holds merit then breastfeeding as a type of reciprocal touch provides a rich opportunity for child development. The breastfed infant/toddler conveys approval and affirmation to the mother not only by smile but also by gaze and eye contact.

K	It's certainly communication [breastfeeding] I can't avoid to have things like eye contact, with him…K1, 441-444

Q   …then she'll say, 'other side, I'll have the other side now' and she has this little ritual where at the end of the feed [breastfeed] she keeps the milk in her mouth [laughs] and looks at me and sort of cheeky silly little thing that she does. Q1, 669-680

The smile conveys positive messages to the mother. These are 'read' as affirmation, as loving messages. The look is interpreted to mean reciprocated love.

Q   But sometimes they will pull off [the breast] and they'll just look at you lovingly. O2, 129-132

The action is fleeting not sustained, this is different from the lover's gaze which is presented in the 'being with' category in Chapter Six. The gaze from the baby is directed toward the breastfeeding woman and interpreted as the intention of communication. One woman described this type of communication, inclusive of reciprocity and inter-change of meanings and of emotions:

T   I think he, I feel he has sort of relaxed into me. The other night was just really interesting….he started to get quite chatty and it was sort of like having first course [breastfeeding], and when he's stopped and then he'd sort of look up and chat away and then he would sort of go back to it…and stopped and looked up at me and sort of chat, chat, chat and we'd have a chat and it was a really interesting experience, that one, because he was certainly interacting with me as a person. T1, 1019-1042

In this instance, the woman recognised the characteristics of communication in the breastfeeding interchange, such as the reciprocity and interaction aspects associated with adult communication. Work by Schmidt (1996) on the impact of women's gestures and speech on the development of infants' speech suggests that women play a significant role in the development of formal communication.

The importance of touch in breastfeeding has been commented on by Lawrence (1994, p.185). Drawing on anthropological studies Lawrence reports that the opportunity for increased skin-to-skin contact by virtue of culture or climate facilitates the practice of breastfeeding. The opportunity for contact and the impact

on breastfeeding is not particularly useful in determining the impact of breastfeeding contact on the mother-infant relationship. Contact becomes more meaningful if the woman is able to express a sense of understanding about the breastfeeding contact.

Often times, the women interpret their baby's communication to be particularly seeking their attention and their breast. As with gaze and eye contact, the intention of this behaviour is perceived by the breastfeeding woman to be the baby's way of actively directing attention toward them. In these instances the breastfed baby is perceived to be 'searching for mother'.

J   when she stops she looks up at me and I say 'yep I'm still here' and she carries on…just saying 'hello'… J1, 726-730

G   She wants to see that I'm still paying attention to her, I feel. That she wants to see that I'm looking at her that's how I figured it. Are you still watching me, are you still, you know, because quite often I could be talking to someone else while I'm feeding and she gets, you know, keeps coming off [the breast] and you know, 'concentrate on me please' sort of look. G2, 216-219

She likes holding my hand…the uppermost hand and when she'll turn away, she'll often, she'll keep looking up at me…I am looking at her, she wants me to look at her, I have to be looking at her. G1, 282-288

So the looks and gaze convey messages which the women read in order to know their baby. The very vocal coos and baby noises along with actual verbalisation by toddlers and older breastfed children all contribute to the woman's understanding of the baby (or child), through the experience of breastfeeding. This verbal communication is 'social communication', and involves turn taking. The whole idea of interchange of vocalised messages is conveyed in this concept. The breastfeeding woman reads the baby noises and interprets the meanings as those that the baby intends to convey.

M   Yeah, she goes [baby noises] you know what I'm doing, she gets what she wants and she's happy. M2, 197-200

The women reply based on their perception of the baby's needs or interpretation of the meanings of vocalisations and cues.

Q   Probably more the cooing type things, I'd say when he [baby] does things like that, …I'd probably say 'oh what a good boy, are you having a nice drink, are you enjoying it'. Q2, 471-476

D   And you have to feed them and talk to them in the middle of the feed…you are almost interacting the whole time. D1, 565-568

The feeding and talking is recognised in work by Tamminen and Salmelin (1991) who reported on women's experience during a breastfeeding encounter and developed five themes; talking was the third phase after negotiation and hungry eating. The authors describe the talking phase as "Sucking is interrupted for several shorter or one or two longer periods…during this intensive phase of 'talking together'. This psychosocial interaction is cyclic by nature and involves mutual imitation" (p.81).

As previously indicated in this study the baby offers a vocalisation, the mother responds by a reply based on a premise that some need or emotion had been expressed by the baby, the baby vocalises or expresses in some way and so it goes on. It is the projecting of intention and fostering understanding, which dominates the recounting of these breastfeeding interactions. These are demonstrated in the reciprocal development of the conversation. The baby noises are interpreted or the explicit communication is interpreted, this in turn, contributes to the perception of the breastfeeding experience as the women come to 'read' the baby's intentions and 'come to know baby'.

Older breastfeeding children and toddlers can actually articulate intelligibly their pleasure, needs and intentions. Their contribution offers a unique perception of breastfeeding. This was not an aspect I had considered at the beginning of my study.

The precious verbalisation of older breastfed children reported by their mothers included the following,

Q   She says it's yummy and it's lovely and she often talks about the taste...for a while she said it tasted like mayonnaise (laughs). Q1, 787-797

In this quote the child is indicating that the breast is best and desirable. This is an ultimate affirmation for the breastfeeding woman. The social communication is far more explicit and the interpretation of the mother can be validated. The sense of knowing the baby becomes affirmed as that baby confirms, as a toddler, the desirability of the mother's breast and breast milk. This affirmation is further endorsed by a number of other concepts, such as 'recognisable behaviours' and 'maternal confidence'; these are found in the 'reading and knowing' of the baby.

8.5   Reading and knowing

The concept 'reading and knowing' refers to the woman perceiving that she knows the breastfeeder (baby or toddler). It encompasses the in vivo codes such as 'knowing other' 'not a stranger', 'understood and accepted' 'learning of other', 'recognisable behaviours' and 'maternal confidence'. It is the interpretation of knowing that underpins the central characteristics of the concept 'reading and knowing'. The first most obvious indicator of this is that the infant displays to the breastfeeding woman 'recognisable behaviors'.

Women became adept at recognising cues for various behaviours. Cues are the physical expression of the baby that indicates opportunity for the woman to act toward the infant in a predetermined manner. These cues extended beyond feeding cues. The recognisable behaviors or mannerisms are only a small part of this concept; it is the interpretation of the behaviors that promote recognition. This in turn reinforces that breastfeeding women know their baby or child.

R   That's a special sort of thing, cause you feel like the others don't know what he [baby] wants, you know, I sort of feel like they don't read him, whereas I can...yes

you know and he knows, when he looks at me I know what he is saying. R2, 615-626

A   I know his personality. I know what he [baby] likes and what he doesn't like. When he cries I know what he is crying for. If I don't then I panic. But I know if it's a tired cry or I'm hurt or I want a cuddle…A1, 448-453

K   It seems quite hard to get to know each other, … I can tell what he [baby] wants now, like I can tell when he's pooing and [husband] doesn't know, and it's not the smell. There's a lot of body language there and I sort of know, I mean I hadn't thought about it, it's not something you think today I am going to learn about. K1, 499-518

The concept 'recognisable behaviours' includes the women's expression of recognition and understanding their baby's wants and needs. The women feel as though they know the baby in a way that only they can engage with the infant, a knowing of the other. The substantive code 'knowing other' is an amalgam of the in vivo codes, 'mutual knowing', and 'unconscious knowing'. The key characteristics include action or interaction in response to the perception of knowing the baby and understanding or 'reading' the baby. The activity is perceived to be mutual, that is, the baby knows the mother as well as the mother knowing the baby. The women commonly reported being 'directed by interpretations' during the experience of breastfeeding, or when in close attentive contact with the infant.

P   Well I know what he likes, I know what to do to make him happy, make him smile. P1, 994-996

The need to respond to the cues offered by the baby is paramount for many of these women, as is the feedback from the baby as they respond to maternal cues. Thus each is directed by their interpretations,

K   I think he [baby] knows, there is a lot of cues that I give him now, as soon as I get the highchair...I think he is getting to know those kind of things. K1, 520-526

J   I sort of, [if] she's [baby] getting wriggley getting ready for a feed, you can talk to them and they instantly stop....I'm sure she is awake more often when I have a stressful day, and that's what makes it stressful, because she is awake more often. J1, 695-708

S   I guess that in the touch for her [baby] it's the bonding, me touching her and it's the same way [for baby], she's saying, I love you Mum, and that's my Mum and she just wants to touch too. S2, 159-163

It is a rather 'unconscious knowing' that the women express. There is not an active determination to get to know the baby but rather as behaviors present and are interpreted the women perceive they know the baby. In most examples women were not actively seeking to test if the baby knew them, but rather sensed that the baby did know them.

S   There's that sense of us needing each other or not even needing perhaps that's not the word. A sense of knowing each other. S2, 241-244

Women were able to demonstrate to themselves that the baby knew them. One woman recounted the weaning of her baby (to a bottle) and leaving the baby while going on holiday. As if to re-establish the relationship the mother reported,

N   Just, um, just for my own curiosity I tried [baby] on the breast when I got home, just to see whether he did remember [breastfeeding] (laughs). He remembered alright. N1, 51-55

This baby responded to the mother's voice and touch, reassuring the mother that he knew her. This same participant reported in the following quote,

N   [Nana] had not long put him to bed, (laugh) I sort of thought I don't care (laughing). I thought I want to see this baby, and as soon as he heard [my] voice he woke up startled and shaking his head in disbelief, that it's actually Mummy home. Didn't you? [directing conversation to baby in her arms] you put your hand up to my face, wanted to touch me….wanted to touch my face and I let him….To feel Mum. N2, 513-527

As women come to know baby they express confidence in being able to recognise and read the infant. There is an expression of the substantive code 'maternal confidence'.

The women demonstrate confidence in their ability to understand and know their baby. In turn, the baby fosters this confidence by providing sufficient feedback for the women to feel that they are recognised as the baby's mother.

M   That makes me feel like she knows that I am her mother and, she knows who I am, she recognises you know, who I am and whereas in the beginning they don't … well they know that you're their mother but they don't show they know. M1, 463-473 Like you feed the baby, she cries and you feed again and you don't, you are not concerned should I be feeding her, shouldn't I be feeding her, you know .M1, 92-96

It has been demonstrated that women can know their baby by touch (Kaitz, et al., 1992), even during routine infant-mother interactions women are able to recognise the infant by touch. It is plausible that the extensive touch associated with breastfeeding would enable this 'knowing the baby'.

Women are assured they know their babies by the way that they come to interpret their baby's intentions. The women are 'reading the baby' and in doing so 'come to know baby'. This work may occur as a result of intimate breastfeeding moments, during other breastfeeding times and during any contact with the baby. Women did, however, mention this activity when they considered their breastfeeding experiences and it might be argued that breastfeeding affords the opportunity to attend to the baby and 'come to know baby'. Kirkland (1991) used the term affordances to

indicate the environmental offering available to the infant or adult as stimulus for an interactive response by the participants in an encounter.

According to Kirkland, " These are actions and activities which, when picked up, are usually perceived directly and without any mediating mechanisms" (p.100). The importance of 'knowing' the baby is stressed as part of recognising maternal identity and baby distinctiveness (Rubin, 1984). It is difficult to ascertain if maternal identity is supported from these data; certainly maternal confidence and personal affirmation is advanced.

The sample in this grounded theory study did not include infants younger than six weeks of age. Thus, it is difficult to determine if the concepts 'reading the contact' and 'reading the communication' have merit for infants under the age of six weeks. Kitzinger (1987, p.164) suggests that it is not until about six weeks of age that the baby initiates non-verbal conversation, by way of gaze, social interactions and behavioural cues. Drawing on my clinical experience it is my considered opinion that even from birth a breastfeeding woman seeks to understand by interpreting intentions from the infant's behaviours. This results in a perceived ability to 'read the baby' and contributes to the woman's 'coming to know baby'.

This position is supported by literature associated with attachment theory and maternal identity formation (Klaus & Kennell, 1976; Hofer, 1994; Mercer, 1985; Rubin, 1984). I do not however support this assertion with the data, but acknowledge the possibility of further refining the concept. This would require the inclusion of a suitable sample of younger babies and their breastfeeding mothers.

8.6   Conclusion

Women 'come to know baby' in part through the interactions associated with breastfeeding. Women read the baby as they seek to interpret the baby's intentions. Three specific aspects of interaction prompt the perception of 'coming to know baby'. As the women read the contact with their infant and interpret physical contact as having a purpose, they interpret the infant's grasp as holding on to them, as

expressing the baby's way of recognising and knowing them. The women interpret social contact and the baby's searching and looking for them as a purposeful expression of knowing them. The communication of social cues is interpreted as an exchange of meaning, an exchange that is affirming and reinforces the woman's perception of knowing the infant.

The women read these communications as reinforcing a sense that the baby knows them and they know the baby. In the recognition of baby's behaviors the women express that they have confidence to know the baby. 'Coming to know baby' is one of three categories that contribute to, and is part of 'linking as one' in an intimate breastfeeding moment. The other categories, 'coming to know self' and 'being with' have now been presented. The following chapter revisits and reconstitutes the theoretical model representative of 'linking as one'.

Chapter 9: Linking as one

"The view of breastfeeding as a process forces the investigator to consider the human quality, the interaction that sustains production and renders its transmittal from producer to user such an intimate experience..." (Auerbach, 1991, p.116).

9.1 Introduction

This chapter reconstitutes and elaborates on the model generated by grounded theory analysis and partially explicated in each of the preceding three data chapters. The model represents the processes that contribute to and are implicit in an intimate breastfeeding moment, described by the basic social psychological process 'linking as one' (Figure 9-1). I have introduced the model briefly in Chapter Six in order to locate the three main categories. In that chapter I presented the category 'being with', elaborating on the theoretical proposition that 'knowing the other' in a breastfeeding encounter directs the experience of being 'mutually exclusive' in an intimate breastfeeding moment. Then in Chapter Seven I presented the second category, 'coming to know self', and argued from the data the theoretical proposition that breastfeeding women come to recognise comfortable and uncomfortable contexts and reconcile this by re-conceptualising the breast in order to maintain personal comfort with breastfeeding. In reconsidering the breast women alter their self-perception and/or adapt their breastfeeding behaviors. This change in personal perception and behavior enables women to maintain comfort and ultimately engage in intimate and sustaining moments of breastfeeding. The third category is explicated in Chapter Eight and I present the theoretical proposition that woman seek to interpret their breastfed baby or child's intentions, that is, to read the baby. This ability to interpret the baby or child's intentions is expressed as a mutual understanding between the breastfeeding pair. In this way breastfeeding women are 'coming to know baby'. 'Coming to know baby' is a category that enables women to engage in the experience of intimate breastfeeding moments and is influenced by that same engagement.

In this chapter I present and argue on the basis of grounded theory analysis of the study data the basic social psychological process 'linking as one'. In order to explicate the basic process I firstly introduce the model and explore the theoretical components drawing on Stevens-Barnum's (1990) theoretical commonplaces as a framework. The contextual influences and characteristics of intimate relationships are introduced. I also provide evidence of the women's understandings of intimate relationships in order to locate their experiential reference point. Finally, I elaborate on the basic social psychological process, 'linking as one' (Figure 9-1).

9.2   A breastfeeding theory

In response to the data analysis, I was theoretically directed to focus on breastfeeding and the women's descriptions of an intimate breastfeeding moment. I have developed a process-orientated theory that is a substantive theoretical description of breastfeeding interactions as they relate or describe an intimate breastfeeding moment. The substantive theory I have generated is not a nursing theory but rather theory about a phenomenon, which has implications for nursing practice.

It is not a nursing theory as nursing acts and interactions or problems are not the subject of study. It is possible to argue that breastfeeding may present a problem for nursing practice and had I embraced this position I could have chosen to present this work for consideration as a nursing theory. This is a reasonable position, but one I resist, as this position rests on the premise that the practice of breastfeeding is problematic. That is, breastfeeding requires nursing intervention in order for women to be successful. I have argued elsewhere that where nurses have sought to consider the practice of breastfeeding as a set of problems to be addressed, a certain discourse, which marginalises breastfeeding women's experience, is perpetuated.

Antecedents

- Lactating
- Breastfeeding
- Undisturbed
- Social exposure

Social Environment

Coming to Know Self

Linking As One

Being With

Coming to Know Baby

Consequences
- Satisfaction
- Success
- Growth
- Comfort
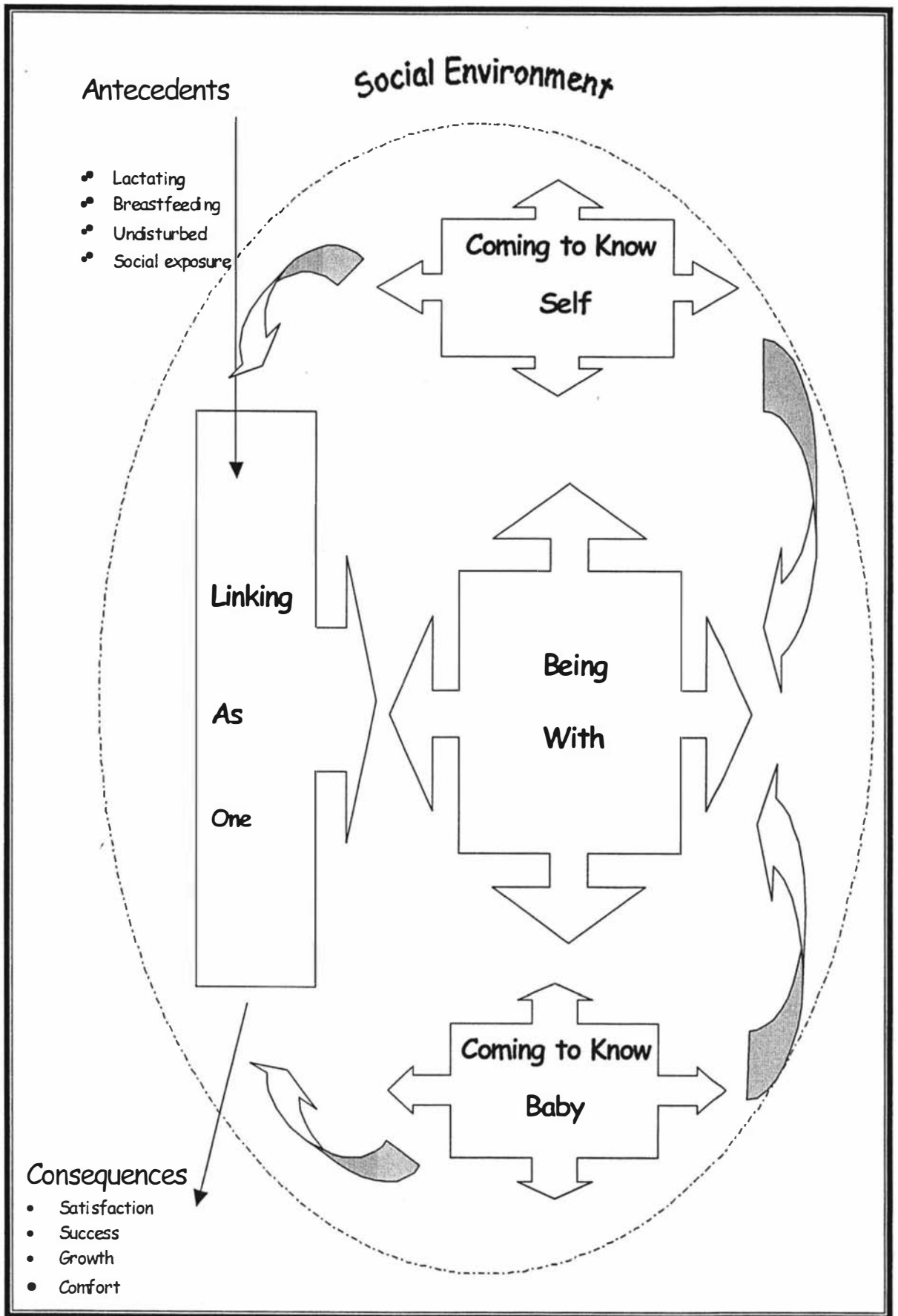
Figure 9-1   Linking as One

9.3 Assumptions

The assumptions about this study have been elaborated earlier in this work but in order to promote clarity the following assumptions underpin the theory 'linking as one' (Figure 9-1).

- The act of feeding a baby or child from the breast is a beneficial activity for both recipient and breastfeeding woman.
- Health professionals such as nurses can better understand feeding the baby or child from the breast, if breastfeeding women's experience and voice is accorded legitimacy.
- Breastfeeding can be an intimate act, between the woman and baby or child.
- All women have the capacity to experience breastfeeding as an intimate act.
- Women are able to comprehend intimacy between themselves and others, and this forms a point of reference for experiencing intimacy during breastfeeding.

The first assumption is substantiated in Chapter Two where I have presented the literature evidence to support the benefits of breastfeeding. Further in that chapter I have argued the need for health professionals, such as nurses, to attend to the woman's perspective. The assumption that breastfeeding can be an intimate act is presented in Chapter Three where I consider the literature around the concept of intimacy and the indications from this literature that breastfeeding may be an intimate activity. The fourth assumption is based on the evidence that individuals have the capacity to engage in, and ability to seek intimate relationships. The evidence to support this is presented in Chapter Three and indicates that intimate interactions are located between individuals and for women involves identity issues (Ernst & Maquire, 1987). The final assumption has been borne out by the preceding data chapters, as the participants have draw on past intimate experiences as a point of reference for describing and understanding their breastfeeding interactions.

The following antecedents are conditions for women engaging in intimate breastfeeding moments. It is important to note that the following aspects of the theory relate to breastfeeding as defined by the basic social psychological process

'linking as one'. Not every breastfeeding experience is a moment of intimate engagement.

9.4 Antecedents

In order to breastfeed the woman must have the physiological manifestation of lactation. The recipient of breastfeeding must be physiologically able to latch and suckle on the breast for exchange of breast milk and or comfort. Breastfeeding is contingent on the social exposure of the breastfeeding woman. This exposure to social interactions may occur with a variety of family and social networks, as well as with strangers. The breastfeeding woman also requires opportunity for undisturbed and exclusive breastfeeding interactions. These antecedents are implicit in the more functional components of the theory.

At this point it is useful to introduce the functional components of the theory, these according to Meleis (1991, p.219) include the act, interactions, and finally the environmental aspects of the theory. These functional components can be considered as 'commonplaces' (Stevens-Barnum, 1990).

9.5 Commonplaces: person, other, act, environment

Drawing on an adapted framework (Stevens-Barnum, 1990, p.22) the commonplaces of this work will be presented. The structure of the following section of this chapter uses Stevens-Barnum's commonplaces and includes person, other, act, and environment. To determine these commonplaces enables the author/theorist to introduce the structures of the theory and the reader or analyst to determine the structures for evaluating a theory (Stevens-Barnum, 1990, p.12). The first of Stevens-Barnum's commonplaces for consideration is the 'person'.

The 'person' of concern for this theory is the breastfeeding woman. The biologically essential nature of the phenomenon of the study, breastfeeding, precludes males as the focus of this theory. The person of concern is most commonly referred to as the participant in this study or the breastfeeding woman. I have avoided using the term mother, as this term implies more than a biological relationship and represents more meanings and interpretations than a woman who is breastfeeding. This assertion has

been argued by Bundrock (1995) who suggests that the discourse of motherhood interfered with breastfeeding. Bundrock further asserts that breastfeeding is a metaphor for women as passive biologically essential mothers. I support this assertion and in order to distinguish motherhood from breastfeeding have avoided the term 'mother'.

The 'other' in this theory is the breastfeeding recipient. The recipient is usually a baby or child who is given access to the breast and partakes in the consumption and benefits of breast milk as a result of the breast contact. While others may have access to the breast and may have influence on the breastfeeding pair, the contingent breast milk exchange is not usually the primary concern in these contacts. 'Other' may be more than one individual baby or child, at either simultaneous or periodically singular events. It is usual, though not imperative, for this baby or child to be the biological offspring of the woman. The other is usually referred to as the breastfed baby, though this term does not preclude a child and is thus not age determined.

The act is breastfeeding. Breastfeeding is the intimate act of gifting, for comfort, pleasure and growth, human milk and human contact to a dependent baby or child. The act is mutually exclusive and mutually satisfying to both participants. Breastfeeding as thus defined is represented in the social psychological process 'linking as one'. Breastfeeding as an intimate act, is the most advantageous breastfeeding experience, but it is not all women's experience nor is it associated with every breastfeeding encounter. Breastfeeding as an intimate act is sustaining of the practice of infant feeding from the breast. Breastfeeding is described by a composite word 'breastfeeding', which is reflective of the process of the act, unlike the description breast feeding which indicates two separate distinguishable acts. It is usual for the breastfeeding event to include in the interaction, a dyad. The dyad is typically a breastfeeding woman and one breastfed baby or child. The breastfeeding act as defined provides opportunity for and is contingent on:

- the breastfeeding woman re-conceptualising the breast according to recognition of comfortable and uncomfortable breastfeeding contexts and experiences.

- the breastfeeding woman interpreting the intentions of the other by reading the baby or child during the breastfeeding act.

- the woman and breastfed baby or child engaged in breastfeeding, coming to know each other.

- the breastfeeding woman adapting her breastfeeding behaviors as she seeks to maintain comfort.

'Linking as one' in a breastfeeding intimate moment, occurs in a quiet and uninterrupted environment in which the woman and breastfed baby or child feels comfortable. A breastfeeding woman who has a relaxed and undisturbed psychological state may be better able to facilitate an intimate breastfeeding moment.

The contextual environs may have little impact on/or significance to the breastfeeding dyad when they are mutually engaged in the breastfeeding encounter. In order to fully experience breastfeeding as defined, experience of feeding the baby or child from the breast must have occurred in social settings, that is, must not be isolated from social influence. This assertion has been supported in the evidence from the participants, regarding their awareness of others' perceptions and interactions with them as they engage in breastfeeding.

As a result of these environmental aspects of the theory an intimate breastfeeding moment may be advanced. Breastfeeding that is characterised as the process of 'linking as one' may foster certain outcomes or consequences

9.6 Consequences

Breastfeeding is shaped by social sanctions and as a result is often modified and controlled by the breastfeeding pair. Breastfeeding promotes maternal and infant satisfaction and has been described, by the participants as 'successful'. Breastfeeding promotes growth, physical and psychological, for those who participate in the act. Breastfeeding behaviors are altered or adapted in order to maintain comfort with the breastfeeding experience and this in turn optimises the opportunity for breastfeeding as an intimate act. These consequences are posed as theoretical statements on the basis of the data analysis presented in Chapters Six to Eight. Further elaboration of

the consequences and theoretical statements, and the implications for practice are presented in the following chapter.

9.7 The social environment: women's experience of intimacy

The practice of breastfeeding does not occur in isolation from the social environment in which the participants live. The participants who affirmed breastfeeding as an intimate activity also described aspects of adult intimate relationships and intimacy with children. These reports locate the women's reference point and understanding of intimacy, providing data that indicates the participants' perceptions of the topic. The women recalled their intimate experiences. This reflection on experience, in order to construct understanding of new experiences, is essentially located within the constructionist approach, that is meanings are located, defined and redefined according to the social interaction. The following data also support the approach of symbolic interactionism that symbols and language hold meaning derived from interpersonal and social experiences. In order to clarify this assertion it is necessary to reiterate that breastfeeding was considered an intimate activity by most of the participants (n=19) of the total sample (n=20).

As previously substantiated in Chapter Six, the women expressed an immediate identification with the idea of intimacy as a description for their breastfeeding relationship. When asked about my study topic, intimacy as experienced by breastfeeding women, responses were similar, the women considered breastfeeding an intimate, special, and close time.

9.7 .1 Levels of intimacy

The following responses represent some of the attributes of intimate experiences, particularly intimate relationships with other adults and children. These examples are useful reminders that for breastfeeding women the experience of intimacy is not exclusive to the baby and intimate relationships with others have contributed a range of experiences and emotions that they might now associate with breastfeeding. The women in this study responded to this initial question by suggesting that intimacy is

different between adults and children; occurs on different levels; and has different depths. The following three quotes illuminate this idea of levels,

K   I can have a situation where there are levels of intimacy to me, with bonding. K2, 246-248.

G   Yes, it's more equal with your husband somehow, I feel that you know, you give and take a lot, whereas I think the baby still takes a lot more than gives back. G2, 259-263.

E   I wasn't entirely sure I mean I thought to some extent body sort of, sort of the issues of how a sort of intimacy in a sexual versus other level...E1, 182-1185.

Identification of intimacy as qualitatively different when compared to a range of individual relationships and the idea of levels is also consistent with work by Traynowicz (1986) in a position paper on conceptual intimacy.

9.7.2 Intimacy is sexual

It is in the reporting of the various interpretations of intimacy that women indicate some of the popular understanding of intimacy as sexual.

A   It's a funny word really because intimate, you think sex [laugh] but um, everything but really, isn't it. A2, 198-201.

G   I've been thinking about it since and when I think of intimacy I think you get very confused with other emotions, so I'm not really sure what I think intimacy is. I mean it's not just sexual, because that's for my husband. G2, 134-140.

The women reported that male partners reminded them that intimacy holds a sexual connotation. The implication is that women initially thought of intimacy as reflective of the relationship with their baby. This is evidenced in the following quotes,

H   Well I told [husband] that you wanted to know about intimacy and he said "Well you'll have nothing to say". I thought there is nothing of intimacy between us at the

moment that will be a short sweet subject. He never thought about me and the baby.
H2, 68-4.

B   I initially all I thought about was that you were interested in the intimacy between me and my baby, and my husband enlightened me as to another sort of intimacy and other relationships. It just never occurred to me. B1, 234-238.

It is not surprising that the partners enlightened the women as to other types of intimacy. Timmerman (1991), in a pivotal work on the concept of intimacy, demonstrated that intimacy is gender defined and that women and men experience intimacy as functionally different. This idea has been explicated earlier in this work (Chapter Three) and explored in relation to the conceptual understanding of intimacy.

Commentary and review by Gooch (1991) asserts that states of excitement and ecstasy occur in the mother-infant nursing dyad and suggests these are similar to the states of excitement and ecstasy between adults during sexual intercourse. Gooch postulates that infant breast experience affects the adult's integration of body sensation and impacts on the core of self. This assertion represents a very androcentric approach to understanding breastfeeding as something synonymous with sexual encounters.

Significant evidence exists that women consider intimacy differently from men. In pivotal work Bakan (1966) asserts that women value connective and relationship intimacy. In this conceptual review Bakan makes a case for relationship differences based on biological determinants. He asserts that female sexuality is more bound with relationships than male sexuality. Bakan suggests that agency and communion are two characteristics that can be located to specific gender preferences. According to Bakan, agency is characterised by separation assertion and mastery (male traits), while communion is surrendering, expressing, self-effacing, connecting and merging (female traits). The terms agency and communion are described as existing in dialectic tension in healthy lives (McAdams, 1988). Other authors such as Orbach and Eichenblaum (1987) suggest that the need to be connected is for women a point of reference from which they formulate thoughts and feelings. Certainly women in

this study demonstrate a drawing on other intimate relationships in order to elaborate on the concept. Intimacy was however, mentioned by the participants as associated with the concept of bonding.

9.7.3 Bonding and family intimacy

The women suggested intimacy is distinctly different from bonding in that intimacy promotes bonding.

M   First I thought um, well I thought it was about the bond between mother and baby but [husband] read it [study topic] and he thought it was about what happens between husband and wife with a breastfeeding mother, so he obviously, we sort of got different [ideas], M1, 571-580.

C   [The topic] I took it as bonding between, that's the first thing that struck me, that word intimacy brought bonding between the baby and mother. C1, 149-153

L   …the intimacy that you feel is mainly for your satisfaction, for your [self], making you feel good, whereas the bonding is what the baby needs to make it feel good. So I feel the intimacy is more for me really. L1, 1226-1237.

K   I have thought about that, um, for me bonding needs intimacy to occur, I couldn't have bonding without intimacy, but I could possibly have intimacy without bonding. K2, 221-226.

Bonding as a theory is very pervasive in Western thinking. I have argued earlier that it has influenced and dominated the breastfeeding literature as a potential benefit of breastfeeding. I do not wish to further argue the merits of bonding theory but rather assert that it is not surprising that women make an association between intimate moments with their baby and the facilitation of bonding. Wihelm and Parker (1988) developed an instrument for measuring intimate bonds in order to assess adult intimate relationships. Their validated questionnaire identifies sensitivity to mood states and enables health practitioners to assess the relevance of intimate relationships. Of most interest to me is these authors' identification of intimate

relationships as 'intimate bonds'; another demonstration of the popular association between intimacy and bonding.

Overwhelmingly, the participants regarded intimacy as relevant to the mother-baby breastfeeding relationship. I was thus theoretically directed to ask whom they were most intimate with and the women responded with a range of family, partners, children and most notably the breastfed infant. It was analysis of this dominantly intimate relationship reflected in their reports about breastfeeding that resulted in the development of the model 'linking as one'. Social structures and normative societal values are contextual influences on this theoretical work, however a basic social structural process did not emerge. Rather the basic social process emerged as a social psychological process; 'linking as one' (Figure 9-1).

Contextual social influences were primarily located within the social experiences of intimacy, other intimate relationships and the environmental context of breastfeeding mothers. It is worth noting here that the family as a context for intimacy did not emerge from this theoretical analysis. At first thought this seems rather unusual, given the women's reports about intimate relationships with various family members.

L   I do have an intimate relationship with all the children at times. L1, 1415-1417.

T   I have a very intimate relationship with my husband. I have a very intimate relationship with my baby, um, I have an intimate relationship with my daughter. T1, 795-802.

C   ...it would be my husband. I'm very close to my mother. C1, 445-448

While these quotes indicate a range of family intimacy it is worth noting that the last quote subtly distinguishes intimacy and closeness. The woman indicates her intimacy with her husband, and closeness with her mother. While for many women the distinction is not obvious there is some literature to suggest that closeness is applied to a greater number of relationships and friendships, while intimacy may be reserved as a description for more sexual relationships (Parks & Floyd, 1996).

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Family intimacy has been heralded as a important area of study (Perlmutter & Hatfield, 1980) and one that has contributed to the understanding of interpersonal dynamics within a family (Scarf, 1995; Weingarten, 1994). However, the women's reports focused on the interpersonal dynamics between them and their breastfeeding baby or child. The emphasis of their account was not on family relationships, but rather their breastfeeding relationships. This would in part explain why a basic social structural process did not emerge from the analysis.

9.7.4 The context for intimacy

The following data are evidence of the context in which women were able to recognise intimate exchanges with their breastfed baby or child. The context for intimate moments includes a social environment (Figure 9-1) where interactions are uninterrupted or undisturbed. During the breastfeeding encounter time is put side during which the woman and baby give close attention to each other. The women expressed the need to be uninterrupted and have a quiet environment.

S   The night feeds are the most precious really. They're the times, because it's just her and I and I can sing to her and no one else can hear and well…. they're the times when there's only her and I to goo and gah together S2, 110,120....
        And she hasn't got anyone else distracting her. S2, 125-126.

R   It [breastfeeding] makes you stop and give time to them…It makes you sit down and you focus on them and you know that for those few moments they can feel loved and cuddled, (but otherwise you don't sit down and cuddle them) and they're quiet and you're quiet. R2, 709-717.

The need for uninterrupted privacy and quiet in order to restore relationship intimacy has been commented on by Hosman and Siltanen (1995). Drawing on the findings from their study these authors assert that where privacy was violated restoration strategies were likely to be applied. The seeking of appropriate moments to facilitate intimacy is implicit in the participants' accounts. Further the participants reported needing to feel relaxed or be in a relaxed state, (not exhausted or tired), to fully enter into the breastfeeding encounter.

O Sometimes you can be sitting there, and your brains just ticking over and over and over now I must go and do this. I must go and do that. I'll hurry up and get this feed out of the way, and then you have to think "Oh no, that can wait, just sit back and relax and let it happen." Because you do, it doesn't come naturally, …not all the time, sometimes you've got to learn to relax O2, 648-673

T I'm trying to create um an intimate or a relaxed atmosphere so that he can actually relax into it. Where he's feeding well it's just a very much together…T1, 867-879.

It is difficult to ascertain from these accounts if relaxation was an antecedent or consequence of the feeding interaction; I suggest that both apply. Morse and Bottorff (1988) found that during milk expression women who were easily able to express breast milk had a relaxed attitude toward the process. The inability to relax, due to stress or trauma, may inhibit the letdown reflex associated with oxytocin release (Ebrahim, 1991, p.14; Riordan, 1993, p.90). Stuart-Macadam (1995a, p.10-11) notes that during breastfeeding the hormonal levels of prolactin and oxytocin may have a soothing and calming effect on the breastfeeding woman. Other authors have noted that an environment which induces relaxation, facilitates the letdown reflex, a particularly important aspect for women who are attempting to express breast milk (Feher, Berger, Johnson & Wilde, 1989; Kitzinger, 1987).

Renfrew, Fisher, and Arms (1990) provide women with advice and explanation about relaxing to breastfeed and facilitate the letdown reflex. They acknowledge the difficulty of relaxing if the breastfeeding woman is uncomfortable or in pain during breastfeeding. "The solution to a letdown problem might be simply to try to relax; it is possible that the more you 'try to relax' the more tense you will become" (p.74). It may be argued that breastfeeding and an intimate breastfeeding moment enable women to relax. The assertion that a relaxed state is *always* necessary to an intimate breastfeeding encounter is uncertain.

In this study women shared about engaging in an encounter that they recognised to be an intimate breastfeeding time with their baby or child. To speculate that a relaxed state is sought prior to the encounter suggests that the women are actively

seeking this type of encounter. If this position were evidenced in the data the women should have reported recognition of discomfort and some behavior of adaptation in order to relax. I would have expected this to have been located in the concept 'adaptive breastfeeding' as a response to uncomfortable situations, previously mentioned in the category 'coming to know self' (see Chapter Eight). However, this contextual premise was not substantiated. Rather, the women recognised that the alteration in mood is experienced in an intimate breastfeeding moment. This is substantiated in Chapter Six, in the code 'altered mood' indicating relaxation as one of the many affective aspects of intimate breastfeeding moments.

Women felt that they could nominate particular times when an intimate breastfeeding moment might occur. Often these were times of quiet or minimal distraction, such as during the night or when other family members are not likely to interrupt.

L   I suppose the most intimate times would be during the middle of the night. And when he was first little I used to quite look forward and I know a lot of women did, you got up at night and it's lovely and quiet, L1, 1104-1111

Q   [Intimate breastfeeding] happens during the evening, when the kids are in bed. I'm giving him [a breastfeed], it really would happen at night, yeah, during the evening and in bed at night. Q2, 401-404.

P   Probably it is easier like when the oldest one's at school…because then it is quieter and I just concentrate on him and talk to him. P1, 705-709

M   …whereas now, like you sort of enjoy getting up at 4 o'clock in the morning and you have that time together. M1,12, 526-529.

These breastfeeding moments were not regular predictable experiences, rather they seemed to be spontaneous. This important contextual characteristic is noted by Wynne and Wynne (1986) in a commentary on the enhancement of intimacy in families and with couples. They conclude that, "Intimacy recurs most reliably, not when it is demanded as a primary or continuous experience, but when it emerges spontaneously within the context of basic, well-functioning relational processes"

(p.383). I would argue that women in the present study found the spontaneity to also be an aspect of breastfeeding intimacy. The undisturbed environment was a pivotal contribution to an intimate breastfeeding moment. It is therefore reasonable to expect women to comment on an intimate breastfeeding time occurring when the breastfeeding dyad was alone.

Res Like can you think in your mind when you consider there is an intimate time between you and your baby. Or do you just feel like that all the time.

M No, not all the time. Mostly when there's no one else around. M2, 80-88.

The women participants reported certain contextual determinants influenced intimate moments; being alone together, the quiet time, a relaxed atmosphere and state of mind, and attending to the baby. When these opportunities were offered or advanced then women expressed experiencing intimate feeding moments.

9.7. 5 Availability and time

The women consistently articulated the importance of having time to spend with the other person. They reported that they needed to be available to, or for, the other individual and this availability impacted on intimate interactions. Also included in this concept was again the idea that certain times of the day or contextual factors associated with availability offered a more conducive environment and opportunity for intimate contact. The idea of having time is central to this context for intimate interactions to occur.

P [Intimacy with partner] I do, but not as much as I'd like to, no,...We're still close... but just not as close as I'd like to be just because we don't have time. P1, 579-584

N Probably because I'm with him [the baby] more and spend more time with him and, I guess that's the only reason...Well I guess, yeah feeding time it would be or if, yeah, it could be at night, more so with the older one. When you put them to bed... It's, like yesterday when he had a big sleep, [eldest child] had a big sleep, I was able to have some quality just one to one with this little one. N2, 263-280

N   Now, um, yeah well it's tricky cause you try and share your love over the three of them really, the baby demands that much more time than any of the others. I guess it goes, well it's more obviously directed at the baby. N2, 238-244.

The participants reported that time and availability could be manipulated in such a way as to create an environment or context in which intimacy could occur. I first considered the idea of creating an intimate moment after interviewing a participant. I noted in a theoretical memo (6/4/95) 'intimacy can be created'. This theorising was substantiated by other participants' reports and earned theoretical currency as analysis proceeded. The provision of individual time, or time to themselves, enabled women to once again enter into relationships.

H   There is only so much of you to go round and (husband) gets what's left. I know that isn't fair but it's going to get better but they are going to need you in other ways, probably you will be mentally exhausted than physically (laugh). H2, 392-398

Q   Um, and then there's the other side where we do actually have to um, because it's so loud and noisy and there are bodies everywhere and children everywhere demanding…and you just can't have this other, I can't sort of sit there and talk about how I feel, cause there's just people demanding, making demands of me all the time and demands of [husband] and the phone's ringing….So in fact we have to strive to…we've got to create the environment. Q2,737-750
        It's all very well having this time alone so I feel as though um, yeah I need time for my own, I need to do things for myself and yeah to feel good about myself. Q2, 764-767

Having time on your own to restore a sense of individuality before being able to engage in intimate moments is mentioned by a number of renowned authors (Dowrick, 1991; Goldhor-Lerner, 1989). Salisbury (1992), in her thesis work on the nature of intimacy between couples, notes that in intimate relationships the paradox is "one needs to stand alone to be intimate" (p.124). The idea of extending self to connect with another has been elaborated further in Chapter Three and has remained a central feature of this work.

Length of relationship and history of relationship is linked to the influence of time as a contextual influence on intimate relationships. The history between two individuals contributes to considering the relationship as intimate.

K   [Intimate with] a couple of other women who I have known for a long time and I would share a lot with them. K1, 690-692

D   Probably because we just, I guess we [friend] have known each other for probably about nine years now I suppose. Gone through a lot together, just personal experiences. She had lots of miscarriages, yeah we have been through a lot personally. You realise how much your lives are knitted. D2, 390-397

The idea that intimate relationships are built with time is another central characteristic associated with an intimate context. This notion of history may also be an expression of knowing the other person well. While the emotional positive aspects contribute to strength and intensity in relationships, so do several others aspects that act as moderators or influences on intimate relationships. Two specific aspects mentioned are commonality and the sharing of experiences. Commonality might be situation specific, as previously mentioned, or include the sharing of time, values and shared interests. Often these shared experiences lead to a greater degree of acceptance and comfort with each other.

D   Yeah, you feel comfortable with them [intimate adult friends], I guess that's built up over time. You can read them, if they are anxious or worried, you know if they come round, I can say you're mad or what's happened? Like your husband you can tell, if there's conversation or something going on …you look at them and think oh they are thinking that or they disagree, you know. You know yourself you can look at them and think that's…what they think when someone else says something. Cos you know them that well you have discussed so many different things over time that you do you know them, like your children. D2, 490-506

E   I mean just, the people…who you can get together with, you haven't seen them for a couple of years and you stay up all night talking and you can still stay up the next night talking with. E1, 1294-1300

I   It's like that with my partner as well. Well, even just having baby is an extension of my love for my partner. That's what, I really want her cos my partner is a lot older than I am and I'd like to think that one day, I still had that love growing by looking into [Baby's] eyes. While one person is peacefully upstairs I've still got someone here that is going to grow into something special. I2, 179-189

H   We'll just even just to sit and just be together, sort of being together. Like when he was first reading stories and that. Right up until we had [second child] I was reading stories over night now [husband] does it because I'm doing other things and in some ways I'm feeling slightly cheated because my role reading him stories every night [is gone],…H2, 353-362

Q   I'll feel a really neat intimacy when we are doing things together with the kids and when he's [husband is] actually being part of it. Because his job is such that he works sort of, he works long and you know long hours, works hard, a lot of stress. I do a lot of the parenting. … So when we are doing things together with the children I do feel we are on the same plane. Q2, 720-732

The idea that one has a history and commonalties with another adult might suggest that the women are expressing a need to feel familiar. These quotes indicate the need to know, or feel familiar with the other person is part of developing an intimate relationship. This speculation supports the women's reports of 'coming to know baby' (Chapter Seven) and the need to 'know the other' in order to experience 'being with' each other in an intimate breastfeeding moment (Chapter Six). Along with shared time is the need to be able to share feelings and emotions with each other particularly with adult relationships that are considered to be intimate.

9.7. 6 Self disclosure and communication

The idea that one can exchange thoughts and share personal information with another individual is an essential characteristic of intimacy. This has been further explicated earlier in this work where I have explored the conceptual elements of intimacy (Chapter Three). Women in the study particularly noted the need to communicate and disclose when engaged in adult-to-adult intimate relationships.

A	[Intimate with] My mum yes, my sister-in-law not so much, [my sister-in-law] a personal relationship more than an intimate. Like I tell her, I would tell her things I wouldn't tell other people. But then I'd tell mum everything, you know I don't hide anything from mum. Or keep things to my self about anything and I sort of feel I can say to mum, how I feel about people, the kids or [husband] or whatever. A2, 151-159

C	Oh my mother yeah probably, and some friends, I don't tend to share deep heart felt things you know. C1, 459-461

S	[Intimacy], no boundaries, yeah…No boundaries, yeah, no nothing. Open relationship. S2, 434-437.

F	[Friend] I would have an intimate relationship with, I can tell her anything. And I'll often have that non-communication [not verbal] with her too because she will 'pick up' very quickly if things are not right and vice versa. F2, 159-164

I	Yeah, definitely, communication is a major part, sometimes people can click better [researchers word used previously], better than others too, what you can share with one person you might not be able to share with someone else. Even though you could be just as close to that person. I2, 272-279

H	Well probably being open and you feel really close, like I've got really good girl friends and stuff but periodically you feel sort of, I mean they are there for you, and you'd be there for them, you can sort of tell them most of your secrets and that sort of stuff but, yeah. We're not, like there is no one that would know exactly what I'm thinking or I don't even know if [husband] would want to know. There's probably no one I could give my 100 percent to like all your thoughts and how you really think because you don't really want to upset them or [husband], probably because I feel I'm a bit of a loner. H2, 165-182

Communication and disclosure in the breastfeeding relationship were reported by the women as being less verbal and were expressed in 'reading' and 'coming to know the baby' (Chapter Eight). These excerpts from the women reflect a very adult aspect of intimacy, one that clearly forms part of a reference for a mother and baby intimate

interaction. The women indicated that interaction with the breastfed baby was a less personally vulnerable position.

S   But, you get close to other people and you do lay yourself open and for that, it's not the same sort of skin contact as there is with your baby. S2, 566-569.

Not only is the nature of the telling, the self-disclosure a characteristic of intimate relationships but so is openness and a certain vulnerability. Kalin and Schuldt (1991) note from their research that questions of medium intimacy elicited more intimate disclosure than questions of low intimacy, which substantiates this assertion about self-disclosure. There is some evidence that self-disclosure is reciprocal and that developmentally females are more likely to disclose intimate information than males (Rotenberg & Chase, 1991).

Chelune, Waring, Vosk, Sultan, and Ogden (1984) in a study on self-disclosure and marital intimacy found that an increase in disclosure increases marital intimacy. Falk and Wagner (1985) support this finding with similar work using nursing students and their responses to the stimulus of intimate statements on relationship development. The results from that study indicate increasing intimacy and progressive disclosures resulted in enhanced relationship development. Self-disclosure is part of an effective communication between two intimate participants. Effective communication, verbally and non-verbally, is also considered by the participants an important aspect of intimate relationships.

Q   No it's more having to do it, [talk]. If we don't talk about it...we're lost and we're just two different people...and we've got to talk about things like that now, because yeah,...otherwise... we're going to end up total strangers. Q2, 236-243.

F   Well, an intimate [relationship], how I see an intimate relationship is almost...feeling between you, almost a non communication. Intimacy to me can be non-verbal. F2, 141-149

J   Whether it be verbal with an older one [child] or touch with a younger one [baby], J1, 785-786

If I point out to [partner] that, why don't you just give me a hug first, why don't you talk to me and say nice things, he says, but I do that anyway. J2, 279-284

F   [Intimacy without physical touch] Oh hell yes I have, I had a really intimate relationship with a guy for years, and I wouldn't dare have touched, otherwise I would have been gone. That's what you call a 'head' relationship, but it was heaps more than that really. There was some kind of bonding.... F2, 239-247

In essence the connection between the two communicators is either a verbal or non-verbal communication; often when the communication is non-verbal it involves physical contact. The idea of physical contact as an essential element of intimate relationships is substantiated by the participants' reports and is frequently considered in terms of physical proximity, closeness and touch. The following quotes represent the importance of physical contact in intimate relationships.

G   I mean at this stage anyway they still depend on you quite a bit and it's nice, that feeling of being needed. For me anyway, I still quite enjoy that, you can give something to them and they're happy, for a cuddle or...G2, 448-457

L   Like [child's name] is nearly eight and he always comes up and he will always give me a cuddle and a kiss and you know, they always come for a kiss at night and go to bed. L1, 1396-1401

H   Yeah, I do feel like that with baby [intimate], but in some ways, [toddler] sort of borders on that as well, because I suppose she's past that [breastfeeding] but its sort of you want to cuddle them and hold them close and that sort of stuff. H2, 111-117.

L   [Intimate relationship with baby] at the moment,...the baby. Mm, more so than anybody,...cause you end up cuddling them more than you cuddle anyone else in the family. Until they're at least 12 months old or they start to become more independent, like sitting, crawling, yeah 12 months old, it would be 12 months. L1, 655-664.

The idea that physical contact sustains and cements an intimate relationship is implicit in the women's reports. The constant opportunity to touch, cuddle and hold a breastfeeding infant offers opportunity to foster an intimate relationship.

The one participant who did not feel she had experienced intimate breastfeeding moments responded to the model by suggesting that she could relate to the various aspects from her experience with adult intimacy. This woman had in her interviews expressed her concern about why she might not have an intimate breastfeeding experience when she had heard other women speak about breastfeeding in this way.

E I've thought about it, on and off, the sort of thing when you read about these wonderful loving little interactions with mothers and babies while they are feeding and I think what's wrong with me [laugh]. E1, 1219-12224.

When I shared the model with this participant she was able to relate to feeling that her breast was in demand. As a tandem feeder she had previously recounted the demand of her toddler at her breast. I found her experience to be affirming of the model in that this participant's experience of breastfeeding, at that time, focused on the demand of her breastfeeding child and the need to feed her baby. As such the experience could be considered uncomfortable. This relates directly to the theoretical proposition, that recognising comfortable and uncomfortable contexts and seeking to maintain comfort contribute to the intimate breastfeeding experience.

E I think he [child] wants it. He varies, sometimes he's really good at letting [baby] have hers, sometimes he's not, E1 346-249
I have gotten quite angry with [child] when he's sort of into me and all that... E1,514-517.
Well he's [child] probably more demanding there [at a friend's place] it's probably one of the least comfortable places I take him, E1, 588-590.

These reports support the theoretical proposition that uncomfortable experiences that remain uncontrolled or fail to be reconciled, inhibit intimate breastfeeding moments. Clearly one account does not substantiate this theoretical premise however, it is

important to acknowledge that not all women will experience intimate breastfeeding moments and yet breastfeed despite this.

9.7.7 Pleasure, Love, Trust and Acceptance

The participants also noted that intimate relationships with either the baby or others are often pleasurable and can be an expression of love. These more affective, positive emotional characteristics indicate an intensity and strength of affiliation between the intimate parties. This emotional aspect often is associated with well-being and self esteem.

O   It's not um how would you describe it – it's not the love that you feel for your husband as such but it's the love, it's a different sort of love that sort of grows within, you know from within inside...How would you describe that? Would you describe the love that you have for your husband, which is different. O2, 554-572.

I'm just trying to think of the love you feel for your children. It's just totally, it's the protection side of it. O2, 575-577.

I   my beautiful son, brings back memories ...recapturing that [past breastfeeding experience], reminds me too of the nice beautiful intimate things that I shared, I2, 135-278.

F   ...more than anything else it is just such a lovely feeling...F1, 126-127.

R   Yeah, I mean I always tell her she's special and stuff like that and that I love her very much, you know all that sort of thing. R2, 267-270.

P   Happy being with them. I find it hard when I have to leave him [baby]. P1, 951-956.

I   Sometimes people don't feel they can be complete unless they are with somebody, I guess I'm a little bit like that although I am fairly independent. I do enjoy living on my own, I think if my partner walked out of my life now I would be devastated. I think that's more because I love him than [anything else], I2, 296-304.

I think it makes me feel very good because I'm, I pointed out earlier, I'm a very affectionate person and it makes me feel good. I2, 320-321

The idea of completeness and satisfaction is demonstrated in these quotes. The women related intimate interactions as affirming of themselves and beneficial to them. I was prompted to consider the importance of breastfeeding as a satisfying experience after considering the transcript of one of the participants and noted in a theoretical memo 9/4/95, "marked maternal satisfaction query, linked to intimate support". As the data were further compared and analysed it became apparent that intimate moments do advance maternal satisfaction. Breastfeeding moments invoked pleasure and satisfaction for the participants.

I returned with the model to the participants after analysis was complete. Amongst other comments one participant asserted "the relationship [mother/child] is safe, less vulnerable [than other relationships] it doesn't hurt you, the joy and pleasure is intense" (Field Note 16/1/95).

The idea of intimacy promoting individual well-being has been argued by Prager (1995) in a work on intimate relations and further substantiated by the earlier work of Levine (1991). I have argued elsewhere that satisfaction with breastfeeding is relative to perceived success and maintenance of breastfeeding practice. Another aspect of intimate relationships reported by the women was the experience of trust, loyalty and acceptance. The following quotes capture these aspects,

A   [We have] been through so much together that I just trust her [another adult]. Like she was there A2,165-166

K   Acceptance and two way sort of, got to be mutual and love I guess, yeah some sort of emotional bonding and commitment and loyalty, K1, 695-699

D   I think just the trust, that I trust that is as far as it goes, you know, I know that she doesn't take it any further and I don't take it anything further. I suppose it's like in a marriage relationship too. I know whatever I discuss with him he doesn't use anywhere else, you trust them to be open enough to say well hey this is going on with me or I need to deal with that, you know this is. I suppose that's it really that trust that it's not going to go any further and you can just bear your soul and they are there to help. They are going to back you up not just leave you deserted and say well sorry I'm no use. They are going to be aware of it D1,597-613

Trust as a concept has been considered by Johns (1996) in a comprehensive analysis and is associated with defining attributes of vulnerability, reliance, relationship, performance and expectation (p.81). Earlier work on the concept of trust by Meize-Grochowski (1984) identified the defining attributes as reliability and confidence that are subjectively mediated. These attributes seem fitting when considered in light of the participants' reports. Again these characteristics were most often associated with adult relationships but form part of the reference point of the participants' understanding of intimacy.

Dandeneau and Johnson (1994) have demonstrated the importance of trust as a positive influence on marital intimacy in a study investigating the effects of trust interventions. Interestingly many women in this study referred to the infant while discussing these characteristics and thus included the infant.

H   Well I suppose you don't have to prove anything to them [baby], and it's you and him and you don't have to pretend you are a wonderful person, and you can just be yourself and grump at them. H2, 5, 187-191

A   I think trust and just being accepted for what and who you are, respecting your choices. "Isn't it?" [Asked the question to the baby] A2, 195-198

T   Not just a physical, not just an emotional thing. It's quite a physical thing as well, 'cos I suppose with an adult, you actually, part of interaction and intimacy is that, a certain amount of it is it, or small amount whatever is some part of compromise. Because, …if you want to be intimate with an adult, you have actually got to accept whether you like it or not some things. … whereas with a baby it's sort of unconditional in a way, whereas that's a love that you feel for your children totally unconditional. T2, 142-154.

Perlmutter and Hatfield (1980) suggest some essential characteristics for intimate relationships. These include intensity of feelings, length of relationship and depth and breadth of information exchange. Brother (1991, p.105) considered intimacy as both behaviors and dimensions and describes intimacy as a matrix with many contextual elements. These dimensions include, breadth, depth, mutuality, temporal duration enmeshed with characteristics such as self-disclosure, emotional support,

sensual physical contact and companionship. This work supports the participants' accounts of the contexts and characteristics they associate with intimacy. Brother further suggests that "Our definition of intimacy is an emotional closeness which evolves from a dyadic process of self disclosure, emotional support, physical contact and companionship" (1991, p.104). I found this work affirming of the participants' perspectives and a most adequate description of the quintessential essence of intimacy. In order to understand the basic social psychological process 'linking as one' (Figure 9-1) it is important to return to the voice of the breastfeeding women and their interpretation.

9.8 Linking as One

Intimacy, according to the women in this study, is the close or knitted connection experienced between two individuals such that a distinction between the two is blurred. The two individuals are intertwined or one. Intimacy as defined by the women of the study was reported in the following phrases,

E   It's just sort of a strong sort of connection,...on an emotional and intellectual level I suppose. E1, 1300-1303.

F   well if you look at the definition of intimacy [it]is I guess...a closeness, I guess it's hard to explain because it is almost a soul thing. F1, 410-413.

D   ...you realise how much your lives are knitted. D2, 390-397.

H   There is a little distance, I don't totally feel like this (fingers crossed), you know how you can just sort of click with someone. H2, 146-150.

The idea of being connected is substantiated in work by Piorkowski (1994) who notes "Women's greater need for intimacy is manifested in a preoccupation with relationships and a strong desire to maintain intimate contact" (p.131). One woman used the metaphor of a band, which is always present between the two but has moments of stretch (distance) and moments of closeness. While another talked of 'keeping in touch'.

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Q   ....I'm really close...I know it's a cliché thing that they talk about that sort of band between you and the baby, .. that's tight and it stretches...I need to have him [baby] close to me and I feel that he's got a need to be close to me. Q2, 256-266.

L   Yes, you have still got that touch, you haven't lost that touch...L1, 1453-1456.

The idea of being connected and keeping in touch is central to the notion of intimate relationships. Staying in touch physically is one of the aspects associated with marital intimacy in a study of five couples by Salisbury (1992). Staying in touch physically, was one of the distinguishing characteristics between intimate couples and non-intimate couples.

Piorkowski (1994) suggests that "experientially, we know what it feels like to be emotionally intimate with another person, but we would be hardpressed to put that experience into words. Feeling 'close' or 'connected' are the terms that most readily come to mind..." (p.10). One woman when talking about the breastfeeding moment and describing the experience commented about the baby looking up to her during the breastfeeding encounter.

I   ...I sort of feel like we are one. I2, 123-133.

I assert that this quote best summarises the intimate breastfeeding moment. Katherine (1991) considered intimacy as an expression of emotional distance and you-ness, that is the moving of boundaries between self and other. It is the intertwining and connected experiences with intimate breastfeeding moments that are captured in the basic social psychological process 'linking as one'.

'Linking as one' describes the essence of the interpersonal dynamic occurring between mother and baby in a breastfeeding intimate moment. It reflects both a dynamic action - that of linking, a direction or purpose - to be as one, and the affect - oneness. In order to explore these aspects I will consider each of these propositions drawing on the substantive theory and data to elucidate the dynamics represented in 'linking as one'.

Linking is defined as, "to couple or connect by a link", to "join" (Websters New Collegiate Dictionary, 1976, p.670). To join by forming a link is represented by this woman's report on holding and encircling the baby while breastfeeding,

T   Sometimes he moves it [baby's hand] out and sometimes I can hold it, he's unconscious of it and it [baby's hand] sits there….[mother holds the baby's hand] I just like doing it, it just um, I don't know if it's sort of full contact from there right round the back, in, so it makes a circle… T1, 978-988

In this instance the mother was breastfeeding the baby and the two were linked together. However, the idea of 'linking' suggests that there is action between the breastfeeding pair. One woman shared this about her breastfeeding a relatively young baby.

B   …when the baby is so new it is a lovely, it is a very intimate thing to be able to hold that baby to you, B1, 378-380.

Taking the baby to the breast and holding the baby in close physical contact advances a sense of being connected,

E   It's just sort of a strong connection…E1, 1300.

S   My interpretation of that word would be special. …sort of an undivided attention. S2, 224-226

The idea of undivided attention, moves some way toward describing the action 'linking as one'. This understanding is furthered by the characteristic of needing each other in a positive way,

O   Oh you know that they depend on you entirely…O1, 674.

Q   …he's actually really needing me…I know from the fact that…I'm the only one who can make him really happy, Q2, 435-439.

p   I'm feeling satisfied that he's getting satisfied just from me and nobody else, P1, 742-744.

However needing each other is only part of the becoming one, it is also that the women know the baby and the baby knows them.

S   There's the sense of us needing each other or not even [so much] needing, perhaps not the word.. a sense of knowing each other. S2, 241-244.

The interaction is so focused that the environment becomes less important, the women are less aware of other distractions.

A   It doesn't matter what's going on around us. A1, 386-387.

M   …When it's all quiet and it's just you and the baby,…I don't think of what I should be doing…M2, 237-244.

O   You're not really thinking of anything…your brain just sort of, I say it turns to mush [laughs]. Quite literally it does. It's almost like stops functioning while you're feeding because you're not, you just can't think. O2, 219-224.

While the women report that the environment does not distract them, they do report being focused on the baby, the interchange and reactions of the breastfeeding baby.

H   I just like sitting there and just probably watching him. H1, 218-219.

D   …it's quite nice too when you are feeding them you watch their toes and their hands and just the way they respond to you. I mean it's just the milk you are giving them but it's sort of quite nice too, D1, 720-728.

G   She likes holding my hand… the uppermost hand and when she'll turn away she'll often keep looking up at me…I am looking at her, she wants me to look at her, I have to be looking at her, G1, 282-288.

The concept of mutual gifting in an intimate moment as explained in Chapter Six is consistent with women's reports of new mothering experiences (Sethi, 1994). Sethi notes that first time mothers report the experience of new motherhood as a process of giving; giving of self, redefining self, redefining relationships and redefining professional goals.

In respect to refining the self, the work of reconceptualising or reconsidering the breast occurs; this is not a conscious activity. I asked about the reconsideration of the breast when seeking feedback, about the model, from the participants. One participant noted "I don't think that reconceptualising the breast is conscious, when you talk about it [the model] it all fits into place" (Field Note, 10/11/95). Certainly the women in this study indicate that breastfeeding contributes to redefining self and giving of self.

As one woman reported,

F   Well I think, because there is a dependency there...sometimes you might see that dependency as stressful, but at the same time when everything is nice and calm and there is **that wonderful link between you and that child**, I think I really love it, I've had a think about it. I think ...I'm giving to this child. F1, 351-359.

The wonderful link between mother and baby when breastfeeding is reflected in a sense of being one, note the following statement by one participant.

A   Well when,..I'm feeding him it's just him and I, A1, 385-386.
       He looks up at me while he's feeding and he might close his eyes and then open his mouth, sticks his little tongue out and he'll smile and it's just, you know, just you and me mate, that's sort of how I feel. A1, 399-405.

The central aspect of a breastfeeding relationship is summarised by Bloom (1981) who asserts, "For me this center is that nursing is an intimate relationship which can be best described as 'Romantic'" (p.259). The participants have reported on various facets of the expression, an intimate breastfeeding moment. The expression, 'linking as one' is facilitated by the process of 'coming to know self' and 'coming to know baby' in order to experience 'being with' each other in an intimate breastfeeding moment (Figure 9-1).

I presented the participants with a summary of the model after I had completed analysis. Some of the specific feedback I have incorporated into the previous data chapters. It is worth note that the women recognised the model as representative of their experience. Participants' comments on the model include, "wonderful,

particularly the gifting" (participant C). "That's how it is" (D, 20/11/94; F, 20/9/94: G, 20/9/94; I 21/9/94; J, 22/9/94, B, 24/9/94).

9.9   Conclusion

In this chapter the theoretical model that represents the basic social psychological process 'linking as one' has been explicated. The model has been elaborated by considering the assumptions that underpin the theoretical work. Further the antecedents have been clarified and commonplaces have been defined. It is the thesis of this work that breastfeeding is the intimate act of gifting, for comfort, pleasure and growth, human milk and human contact to a dependent baby or child. The act is mutually exclusive and mutually satisfying to both participants. The consequences of breastfeeding, 'linking as one' include perceptions of satisfaction, success, growth and comfort. The following chapter identifies aspects of the theory 'linking as one' and elaborates on the implications for nursing practice, education, and further research.

Chapter 10: The implications for practice

10.1 Introduction

It is the thesis of this work that breastfeeding can be experienced as an intimate moment. Such intimate moments are represented in the basic social psychological process 'linking as one'. In the previous chapters I have presented this process in a model that provides a visual representation of the basic social psychological process, main categories, theoretical propositions and concepts. The dynamic processes I have presented are substantiated in the data given by the participants of this study, from interview and observational record, and from other data sources as theoretically directed by the grounded theory method. Other contributing data sources include life space drawings (Gills, 1989) on closeness, pictorial work and relevant literature. The model supports the position that when women experience intimate breastfeeding moments these are satisfying and pleasurable and as such promote maternal well being. I can deduce from this, that maternal satisfaction is advanced as a result of intimate breastfeeding moments.

Evidence previously presented (Duckett, Henly & Garvis, 1993; Leff, Gagne & Jefferis, 1994) supports the association of maternal satisfaction with breastfeeding success. It is therefore important to facilitate satisfying breastfeeding experiences for breastfeeding women. The most obvious application of this work, is for nurses in practice to enable breastfeeding women to experience satisfying breastfeeding exchanges, by exploring, understanding and negotiating the mother-infant dynamic and social experiences of breastfeeding which may impede intimate breastfeeding moments.

My involvement with breastfeeding as a result of this thesis work has extended over a range of public work and a variety of communication media. I have spoken on numerous occasions, on the radio (Benn & Dignam, 1996), and at conferences and seminars (Dignam, 1994, 1994a, 1995a, 1996, 1996a). I have published some aspects of the work, both my early thinking on breastfeeding and social support (Dignam,

1995) and the work in progress, about breast ownership, sexuality and breastfeeding demands, (Dignam, 1998). I have been published in the regional newspaper (Rodney Times, 2nd Sept, 1997) about breastfeeding comfort and the social aspects of breastfeeding. Over the years of my study I have experienced involvement in national policy development and acted as a consultant to health services. I submitted consultative comment (1997) on policy development about the International Code for the Marketing of Breast Milk Substitutes (World Health Organisation (WHO), 1981). I have also acted as Consultant to the National Health Outcome Targets, Ministry of Health (1998) on breastfeeding definitions and for a scoping project on breastfeeding for the Health Funding Authority in Northland, New Zealand. As a direct result of this study I have been able to contribute to teaching breastfeeding to nurses and midwives enrolled in postgraduate study at Massey University, New Zealand. I have been able to offer (1997, 1999) the only postgraduate paper on breastfeeding (Albany News, Massey University, 1996, p.5) in the country. I have given considerable thought to and received a range of feedback on the implications, practical application and credibility of this work.

The implications for this work are essentially threefold; the theory offers some direction for health professionals such as nurses when working with breastfeeding clients. The model provides a framework for the breastfeeding educational curriculum both for health professionals and breastfeeding women. Finally, the theory provides rich material for further research and analysis, including concept refinement, assessment tool development and instrument testing. In this final chapter I elaborate on these implications, keeping a focus on the relevance for nursing practice. Firstly I revisit the initial aims of the study in order to confirm the relevance of the work.

10.2 The aims of the study

I made explicit the aims of this study in Chapter One and listed them as follows,

1) to allow breastfeeding women's perspectives to be heard,
2) to describe, by inductive substantive analysis, intimacy as perceived by breastfeeding women, and

3) to develop a grounded theory that describes intimacy as experienced by breastfeeding women.

This study sought to allow breastfeeding women's perspectives to be heard, in such a way as to locate the experience in the substance of their data. In order to do that, inductive comparative analysis has been applied in a manner consistent with grounded theory method. The topic of interest was presented to the women as an open question; *tell me about the topic, intimacy as experienced by breastfeeding women?* The participants' responses enabled the development of a descriptive model of the basic social psychological process 'linking as one'.

I note in Chapter One, that I originally held the position that theory generated from the experience of breastfeeding women may assist nurses to better understand and support the practice of breastfeeding. The basis of this argument was founded on the position that no work to date had identified specifically the interpersonal dynamics of the breastfeeding exchange. Therefore, nurses were working without any substantiated framework from which to explore the experience of the breastfeeding client. This position has now been addressed, the dynamics between mother and baby when breastfeeding have been identified in this work. No other work has provided a description of the interpersonal dynamics and represented by theoretical abstraction the affective response of the breastfeeding dyad to intimate breastfeeding moments.

The theory 'linking as one' provides a number of categories that offer a useful understanding for nursing practice. It is important to remember at this stage that theory is a type of short hand for complex ideas. For many nurse practitioners, dealing with complex health issues, theory can provide a short cut to enable effective communication, assessment, diagnosis and intervention. However, the complexities of theoretical language are not always so useful and I acknowledge a certain resistance by many nurses to utilising theory and applying it to practice.

Much has been written about nurses' resistance to theory utilisation and many strategies have been advanced to facilitate the application of theory to nursing practice (Gioiella, 1996; Levine, 1995; Mitchell & Cody, 1993; Speedy, 1989). I

would argue that the nursing profession is concerned with the applicability of theoretical work to practice and that theory is inherently understandable. Keeping these two factors paramount I offer my considered position on this work's application to nursing practice.

10.3 Nursing practice and the breastfeeding client

Effective nursing practice is dependent on a range of assessment, diagnostic and interventionist practices. I would assert that with a breastfeeding client much of the approach is in the therapeutic use of self. McMahon and Pearson (1991) in a comprehensive text on therapeutic nursing assert that the therapeutic nursing encounter includes the nurse-patient relationship as well as nursing interventions and patient teaching. McMahon and Pearson suggest the nurse can be therapeutic by being in the presence of the client, by offering emotional support and self-affirmation. The nurse can convey these messages to a client by touch, effective communication and a range of nursing interventions; this is all part of effective nursing practice. Nursing practice is much more than effective communication between individuals or groups. The therapeutic use of self in nursing requires more involvement of the nurse with client, to include partnership, intimacy and reciprocity (Muetzel, 1988).

The position dominant in interpersonal nursing theory adheres to the assertion that nursing is a form of therapy. That is, nurses promote health and healing for their clients, as a direct and deliberate result of nursing decision making (McMahon & Pearson, 1991). According to Muetzel (1988, p.89) "The crucial determinant of whether nursing is therapeutic or not is the quality of the relationship between nurse and patient". Muetzel poses a framework depicting the therapeutic relationship, which combines three overlapping concepts. These concepts are intimacy, partnership and reciprocity. In this framework the atmosphere of the therapeutic encounter is captured in intimacy and partnership and in the attitudes held by the nurse. The atmosphere, engendered by partnership and intimacy, is one of security and freedom. The dynamics of the encounter result from both partnership and reciprocity and include the things the nurse does. The spirit of the encounter

demonstrated by reciprocity and intimacy is demonstrated in the way the nurse is present in a client-nurse encounter. The spirit of the encounter is expressed as a sense of closeness, vulnerability or openness between the two participants. According to Muetzel (1988) these three interpersonal dynamics; the atmosphere of the therapeutic encounter, the dynamic between the two and the spirit, combine to provide a whole therapeutic relationship.

Partnership between nurses or midwives and breastfeeding mothers as a modus operandi features strongly in both nursing and midwifery literature (Bradfield, 1996; Davies, 1989; Fellow, 1994; Guilliland & Pairman, 1995; NZCOM, 1992). The partnership approach is captured in a statement by Ellis and Hewat (1984) who suggest nurses and midwives need to 'do with' rather 'do for' women in their care. In essence these authors suggest that working alongside the breastfeeding mother is more effective rather than taking an authoritarian approach. The partnership approach works toward mutual goal setting and respect for the client's judgement (Gigliotti, 1995).

Nurses' attitudes and knowledge about breastfeeding are significant in affecting the ability to influence or support the breastfeeding mother (Barnett, Sienkiewicz & Roholt, 1995; Chalmers, 1991; Freed, Clark, Harris & Lowdermilk, 1996; Lewinski, 1992; Nyqvist & Sjoden, 1993; Patton, Beaman, Csar & Lewinski, 1996). Negative attitudes and incorrect information reduce the likelihood of the nurse or midwife encounter with a breastfeeding mother resulting in a positive outcome. Dykes and Williams (1999) note that incorrect advice given by some health professionals may have contributed to the perception of inadequate milk supply, mismanagement of breastfeeding and undermining the woman's confidence.

McMahon and Pearson (1991) elaborate that partnership involves the client as a partner in their own care. Intimacy occurs between the client and nurse in that intimate physical care can lead to psychological intimacy and reciprocity in that both partners contribute to and benefit from the nursing encounter. It is nursing practice that encompasses these therapeutic and partnership approaches that is most likely to be effective with breastfeeding clients.

I consider these types of nursing approaches in the following discussion about the implications for nursing practice of the core categories 'coming to know self' and 'coming to know baby'. Located within each of these core categories are the theoretical propositions that link concepts and codes. Firstly I draw on the propositions within 'coming to know self' as a framework in which to explore the implications for nursing practice of 'comfortable and uncomfortable contexts'. Within this framework are the processes of reconciling 'the sexual and functional breast', 'breast in demand and breast ownership' and 'altering breastfeeding to maintain comfort'. Then I explore the theoretical proposition 'coming to know baby' which includes the processes 'interpreting baby's intentions', 'being mutually exclusive', 'gifting' and 'dependence versus independence'.

10.4 Uncomfortable breastfeeding moments

The theoretical proposition endorsed in the category 'coming to know self' included the assertion that breastfeeding women come to recognise comfortable and uncomfortable breastfeeding contexts. 'Coming to know self' from the practice of breastfeeding is influenced by social approval. As a result of this influence breastfeeding behavior is often modified so that comfort is maintained. The data support the assertion that women recognise breastfeeding experiences that make them feel uncomfortable. These might be physical discomforts, such as altered breast size, painful breasts and leaking breast milk, or emotional discomforts, such as the awareness of others when breastfeeding in public, or feeling like the breast is in constant demand by others. Whatever the type of discomfort, women reported redressing these either by altering their behavior, or changing their attitude and perceptions toward the initial uncomfortable experience.

It is useful then for nurses to consider with breastfeeding women any context that promotes discomfort and strategise about how that uncomfortable feeling might be relieved. One tangible example of discomfort is the distinguishing between the breast as sexual and the breast as functional.

10.4.1　　　Sexual and functional breast

The need to reconcile both an individual perception about breasts as sexual or functional and a social perception about breasts as sexual was an obvious source of discomfort to the breastfeeding women in this study. Evidence suggests (Carter, 1995; Maclean, 1990) that such discomfort is so for a number of breastfeeding women. By illuminating aspects of the distinction between the sexual-functional breast, women may be able to work toward an articulation of breastfeeding that creates a culture where breastfeeding experience is redefined as normal. This research supports the premise that considering the 'voice' of breastfeeding women enables a breastfeeding culture defined in terms of the woman's experience and not that of others.

I first considered the importance of this aspect, breast as sexual or functional, in 1994 when I posed the questions at a seminar in Adelaide, Why are women working toward comfort? Is this not also something the male partner might not legitimately work toward? The reason I posed these questions is that women in the study reported the influence of males' perceptions on their breastfeeding behaviour and perceptions.

Women reported feeling uncomfortable breastfeeding in front of males, who they considered were disapproving because the practice was immodest, or were seeing the breast as a sexual object to be perversely enjoyed for their pleasure. These experiences combined with overt comments by men about breastfeeding away from public view or covering their breast reinforced the idea that the breast is a sexual object in many western societies. This assertion was further extrapolated to mean that any individual having contact with the breast must have been engaging in a quasi-sexual if not sexual experience. Hence males often assumed the breastfeeding sensation was sexually pleasurable. These are essential positions to be discussed with breastfeeding women, particularly young women (Benson, 1996) who may have little experience with or exposure to breastfeeding and are only just coming to terms with their own sexuality.

It is useful for nurses to draw on other breastfeeding women to share these experiences and relocate breastfeeding within a woman-centred perspective. A support group discussion or group clinic environment might offer such an opportunity. It is my

opinion that the woman's perspective will locate the functional breast as the dominant understanding of the breast for women who are breastfeeding. Women quickly voice the perception that the breast is for feeding their baby and provides nourishment for growth, that is vital and upon which the baby depends. Baumslag and Michels (1995) note that breastfeeding women, "…not only discover that very little of the breast needs to be exposed in order to nurse, but they also alter the image of their own breasts from being sexual organs to being magnificent feeding vessels" (p.xxx). This is not to say that women will not also recognise the breast as sexual but that the sexuality of the breast is reconciled with the breast as a functional feeding tool.

The contextual environments that provoke discomfort are those that most obviously project the breast as sexual that may be wherever sexual activities occur. For example bedtime can be a time of reconsidering the breast as available for sexual touch and contact. For some women this may be a time of dissonance as they reconsider the breast from that of the infant's for food, to the partner's for sexual pleasure. This reconsideration is something women may want to discuss particularly if it is causing emotional difficulty with either the partner or baby. Nurses are in a unique position to foster discussion about these aspects and discuss the duality of breasts as a singular extension of the multiple activities women engage in.

On a more macro level Rodriguez-Garcia and Frazier (1995) argue that the cultural notion of the female breast as primarily sexual has impeded women's decision to breastfeed, and call for health workers and policy makers to address the social acceptability of breastfeeding. Nurses may take up this challenge and be mindful of contributing a client's perspective to policy development. Most obviously nurses can advocate for consumer voice in national breastfeeding policy.

Women's sexual 'breast' experiences directly influence their perception about the sensual aspects of breastfeeding. Women experienced inappropriate touch from their babies or toddlers that included touch such as stroking the nipple, squeezing or playing with the nipple while breastfeeding. This touch was associated with the sensations experienced during sexual encounters and prompted the women to feel that the touch was inappropriate. Escott (1996) notes the sensual aspects of breastfeeding and the impinging associations with sexuality. Health professionals

might well approach a conversation about baby or toddler touch and explore the underlying perceptions, considering the child's intentions and 'talking through' the discomfort.

It would be particularly important for nurses to be aware of the impact of sexual abuse and trauma that might be associated with breast contact. Cook (1995) notes that the sensual aspects of breastfeeding can result in maternal guilt. This guilt is compounded for survivors of sexual abuse. Nurses need to be aware of any history of sexual abuse and the complications this can cause the breastfeeding woman. Careful and considered discussion and counseling may be required. In this way women may come to recognise that the discomfort is experientially constructed and can be redressed. Whatever the strategy, the outcome should be the maintenance of breastfeeding comfort.

The concept 're-conceptualising the breast' provides a framework for health professionals to attend to the perceptions about the breast and breastfeeding. The context of breastfeeding, the social and environmental aspects, impact on the dynamics of the breastfeeding experience as does the physical change associated with lactation. Exploring with women their attitudes about breast ownership and allowing them to talk about how they perceive their breasts may illuminate their perceptions and recognition of comfort and discomfort.

10.4.2   Breast in demand and breast ownership

I have noted in other published work (Dignam, 1998) that considering concepts such as 'breast in demand' provides a platform for exploration of the mother and baby relationship. Breast in demand is essentially a breastfeeding experience where the mother perceives an uncomfortable sense of demand on herself and most particularly her breast. Often this demand is associated with the idea that others 'own' the breast. I found during the course of this study that asking women, "who owns your breast?" provided a very good prompt for some revealing discussion. I would not suggest that this is an opening line to a nursing assessment. Indeed a nurse–client therapeutic relationship would be most important. However, if the woman expresses a perception of being in constant demand, then such a question might illuminate the

issues. I found that women related well to this line of questioning, on both an intellectual and emotional level.

It is obvious that a woman's breast is of course a part of herself. However, those that have access to the breast can engender a sense of loss of personal boundary and an emotional discomfort as self-integrity is dissipated. Nurses can discuss these aspects of emotional discomfort. It may be possible to share the experience of other women drawing directly from the study to elaborate on the type of adaptive behaviors that women employed to maintain comfort. Most obvious of these behaviours is the reassertion of a sense of personal control. Recent work by Hoddinott and Pill (1999) on the experience of breastfeeding mothers includes a diagrammatic representation of the breastfeeding woman's confidence cycle. In this model support is a central concept and is influenced by a range of influences such as unrealistic expectations, a sense of failure and lack of close regular exposure to new-born breastfed babies. These authors suggest that changing feeding methods facilitates coping and the regain of control. Thus the perception of control is a powerful influence on the breastfeeding experience. Women can adapt their breastfeeding behaviours in order to exercise and establish control. Another example of adaptation is when women alter breastfeeding behaviours to maintain comfort.

10.4.3   Altering breastfeeding to maintain comfort

As previously mentioned, women have essentially two options in order to maintain a comfortable breastfeeding experience. They can alter behavior in response to an accepted perception or they can change their perception. Either way this is adaptive behavior, and provides a clear indication of how breastfeeding women maintain breastfeeding comfort. As a result of these adaptations women are reconsidering the breastfeeding self. In a real sense they are coming to know self through the breastfeeding experience. I have previously suggested that nurses might discuss the various discomforts and explore the underlying perceptions and contexts that provoke uncomfortable breastfeeding moments. That approach is consistent with both assessment and diagnostic phases of nursing care. The identification of actual behavior or perception changes is now consistent with the intervention aspect of nursing. I would stress that interventions must be acceptable and are best determined

in a negotiated fashion between nurse and client. As such the following discussion recognises that not all women would select these suggestions as a preferred choice or find it relevant to alter their breastfeeding or perceptions about breastfeeding.

The following adaptive behaviors were useful because the breastfeeding women acknowledged the social perspective presented to them. For example in the instance of breastfeeding in public, women isolated themselves so as not to offend those who considered breastfeeding to be immodest. Similarly women covered their breasts with clothing to be discreet and to maintain as much cover over the breast. This type of isolation and covering can be problematic. Women felt left out from social engagement, while the covering of the breast impeded in their choice of clothes. It has been previously noted that embarrassment and secrecy about the practice of breastfeeding can lead to isolation and a sense of failure (Hoddinott & Pill, 1999). Often the discomfort is reconciled by the thought that breastfeeding is a temporary activity and life will return to normal. This thought process illuminates the lack of change in perception. In taking this position women are perpetuating the idea that breastfeeding is not 'normal'.

Women reported that they needed to wear a bra to bed at night, in order to pad the breast, stop any leaking and support the breast when it was tender and full with breast milk. This behavior meant that the women had to alter their usual sexual foreplay, as the breasts were no longer accessible to the partner's touch. Thus, while the women altered a behavior for physical comfort, the captivity of wearing a bra to bed prompted some emotional discomfort as partners complained about the lack of access to the breast and women perceived it to be unromantic. These techniques for managing breastfeeding comfort can in fact prompt further problems, such as pressure on the breast which may lead to obstruction of milk flow. Another example of altered behavior is managing the sense of demand associated with constant breastfeeding.

Women who were breastfeeding both baby and toddler (tandem feeding) were able to maintain comfort by controlling or altering the access to the breast. Some women had rules for breastfeeding, allowing the baby or toddler the breast only at certain times or in certain acceptable places. These rules were communicated to older

breastfeeding children and boundaries for breastfeeding were identified. These boundaries and rules were problematic when the breastfed baby or toddler required comfort feeding in a place or time that had been deemed inappropriate. Thus a degree of flexibility was the important moderator when controlling the access to the breast. Clearly the nurse can explore behaviors, such as breastfeeding in public, covering and being discreet, changing sexual contact, and controlling access to the breast, and alert the client to the potential implications of behaviors that do not address perceptions.

The women in the study identified behaviors that do address a change in perception. One example is breastfeeding in public despite the knowledge that breastfeeding in public is usually a socially unacceptable practice (L1, 515-535). Women also were able to manipulate their environment so as to achieve their breastfeeding in public without offending any one. They sat some distance from people, so vision was not so acute, or believed their anonymity protected them from feeling uncomfortable or vulnerable. Occasionally women considered that the perceptions of others were wrong and chose to breastfeed in spite of the disapproving glares or comments. Similarly tandem feeding women gave free and unreserved access to the breast and gave up the idea of personal space as important for a period of time.

The relevance of this for health professionals is the importance of social, family and partners' attitudes/values with regard to breasts and breastfeeding. In this respect nurses must acknowledge their own experiences and attitudes and broaden their approach to include a unit of care, the mother and infant within the family. The nurse must consider the care unit as one located within social and cultural contexts. A tendency by health professionals to guide, advise and inform on the biomedical aspects of breastfeeding has negated and marginalised the uniqueness of the breastfeeding experience, perpetuating discomforts and failing to address the interpersonal and social aspects associated with breastfeeding.

10.5 Knowing the baby: interpreting baby's intentions

Within the breastfeeding exchange a variety of communications occur. It is useful for nurses to consider, with breastfeeding clients, what the women understand by infants' actions and cues and how they interpret these behaviors. If women are unable to feel they know or understand their infant they may not experience intimate feeding moments, further they may not feel as satisfied with their breastfeeding experiences. When women express that they can read the baby and that they know the baby, they are illustrating a sense of maternal confidence in their breastfeeding. If women do not make these comments or demonstrate in their engagement with the infant a sense of knowing the baby then the implications can be imperative for breastfeeding success.

An example of the imperative nature of understanding and interpreting the baby's intentions is in the reading of hunger cues. The baby offers feeding cues which prompt mothers to feed and attend to the baby; it has been demonstrated that depressed women are less likely to attend to these cues (Tamminen & Salmelin, 1991). Babies who may be premature or physically compromised are therefore particularly vulnerable to the need for their mothers to read the cues for breastfeeding (Kavanaugh, Mead, Meier & Mangurten, 1995). It can be appreciated that the failure to read the baby's cues may have life endangering consequences. However, in this study I argue it is the development of a relationship that is compromised when women fail to read or understand their infants.

It is my assertion based in this work that failure to read the baby and gain a perception that one knows the baby threatens the opportunity for intimate breastfeeding moments and ultimately for sustaining the practice of breastfeeding. I have previously argued that in spending breastfeeding time with an infant a woman is coming to know the baby. Breastfeeding offers opportunity for physical contact that is close and affirming. As Baumslag and Michels (1995) note "To know that you are providing your child with a miracle food and medicine, while at the same time achieving an unmatched bond and sense of closeness, is a unique experience" (p.xvii). Nurses can observe the sort of mother-infant interactions that occur during

feeding for interactions that indicate a shared understanding between the pair. In particular the infants' behaviors are often reflected back, by the women, as specific communicated messages.

The following excerpt from Auerbach (1991) provides an observational description that is characteristic of the breastfeeding process,

> When one observes breastfeeding—the behavior—one is struck by the ever changing nature of the relationship between mother and baby. One moves, and the other responds. One offers the breast, and the other accepts it or turns away, one mischievous eye peeking out from under the mother's arm as the baby attempts to look at the observer without first releasing the breast. The mother talks and the baby coos in response or giggles while suckling. The baby reaches up and strokes the mother's skin, or lets a pudgy hand fall and then reach for an exploring foot that is easing up along the mother's other breast. (p.115).

These are the interactions of the breastfeeding pair that the nurse looks for, and notices. These are the interactions upon which to build a conversation about the breastfeeding exchange.

The women indicate the baby is expressing a need or reflection of love when they interpret eye contact and vocalisations. Any movement during breastfeeding toward the woman by the infant, such as holding onto the woman's hand or touching the top of the breast are interpreted as intentions of affirmation or recognition. Similarly the movement of the infants' feet were interpreted by the women as expressions of infant pleasure. If a nurse is able to observe these encounters then one can assume the woman is expressing a sense of knowing the baby. Asking about the baby's behaviors and how the woman knows what a baby might want could further legitimate this assumption. This type of questioning is a good conversation prompt. Clearly this is not the same as asking about the mother's attachment or bonding with the infant, though many of the behaviors are those which are identified as expressions of attachment (Klaus, et al., 1972).

It is interesting to note that Klaus and Kennell acknowledge the role of breastfeeding in advancing mother-infant bonding in a forward in the text by Lawrence (1994).

> We will take the opportunity to comment about the association between breastfeeding and parent-infant attachment. We believe that early mother-infant contact starts a process of mother-infant interaction that gradually builds a strong affectionate tie, first the mother to her infant and then later on the infant to the mother. This is most likely to proceed successfully with breastfeeding, in which close contact and interaction occur repeatedly at the times the infant wishes and at a pace that fits the needs and wishes of the mother and the infant, with gratification for both. Thus breastfeeding provides an optimal model for the development of a strong mother-infant attachment ... (Klaus & Kennell, 1994, p.ix).

This statement rather reinforces the opportunity breastfeeding offers to promote close contact and mother-infant gratification. I would assert that asking women about being attached to their infants is a difficult concept. It is much more tangible to discuss with women if they understand and know the baby. This approach leads to practical and tangible lines of conversation, such as "how do you know that baby is hungry?" "how do you know the baby is in pain?" Such practical questions are non-threatening and most appropriate concerns for health professionals.

Nurses may observe the physical interactions between the breastfeeding pair for indications of positive emotional responses. The infant's behaviors should invoke a maternal confidence. Women in the study reported interpreting the infant's touch, vocalisations, eye contact, and smiles as affirmation that the baby knows they are 'mother' and knows them, like no other person. The nurse might be aware of attending to the breastfeeding pair for clues to this association. Questions to the breastfeeding client about the baby, such as "does the baby know you?" might also illuminate the woman's perceptions about the infant. Further, such a conversation might raise the issue of maternal confidence and self esteem. Laufer (1990) notes that breastfeeding builds up a mother's self esteem and confidence and asserts the importance of health professionals offering anticipatory guidance and emotional support.

If women do not feel that they know the baby or that the baby knows them, the likelihood of experiencing intimate moments might be compromised. Breastfeeding promotes physical and psychological growth for those who participate in the act. It is in the expression of knowing the infant and knowing the self that the exclusive and

satisfying experience of being with the baby in an intimate breastfeeding moment is fostered. 'Coming to know baby' can result in a breastfeeding moment which is essentially both mutual to the participants and exclusive to the outside world. Such moments have implications for nursing practice as they illuminate the mother-infant dynamic.

10.5.1   Being mutually exclusive

The women in this study were able to express moments of exclusivity where mood was altered and social environs and demands melted into insignificance. Women who do not experience such altered moods and regeneration from breastfeeding may feel exhausted, tired and fractious. Nurses are well placed to consider the woman's expression of affect and emotion, and explore the breastfeeding relationships for times of relaxation, uninterrupted feeding and quiet undisturbed exchanges. Health professionals have identified the lack of rest as an influence on breastfeeding success (Benson, 1996; Thomson, 1992). Lack of sleep and tiredness directly impact on the woman's ability to function effectively. Strategies and interventions to facilitate rest and quiet might be considered with the breastfeeding women. The home environments may need to be supported in tangible ways, such as home help or child care for older children. The family dynamics may be discussed and re-patterning of family activities might be considered.

The nurse may also be alert to breastfeeding interactions that involve feeding positions that physically distance the baby from the mother. The football infant feeding hold requires the baby to be placed under the arm and away from the front body surface of the mother. While this position may help with breastfeeding attachment to the nipple or ease nipple trauma and pain, it may also reduce the opportunity for closeness and attention to all of the baby's body which is characteristic of mutually exclusive interactions and physical closeness in breastfeeding. I am not suggesting that these positions are inherently problematic but if they are continued or are the predominant position for breastfeeding then it would be useful to consider the impact on the mother-infant dynamic. One change in dynamic might be the perception of giving and receiving that is associated with mutual gifting when being with a baby in an intimate breastfeeding moment.

10.5.2   Gifting

Women expressed a sense of giving of themselves during the breastfeeding encounter, they gave milk for growth, breast contact for comfort, pleasure and love to the baby. In turn the baby gave the woman enjoyment, affirmation, confidence and love. It might be that discussing with women what they are giving to their baby is a useful and significant trigger to understanding if such gifting occurs between the breastfeeding pair. Women often speak of comfort feeding and Kitzinger (1989), in a practical advice text for breastfeeding mothers, encourages the activity as *one* way to comfort a baby or child. In suggesting other comfort strategies only, women are denied the giving of comfort via the breast. I would suggest that comfort feeding is a very tangible form of giving to the baby. The nurse might draw on the idea of giving as a theme from which to discuss comfort breastfeeding. I suspect that health professionals are often motivated to suggest alternative comfort activities out of concern for the development of an 'unhealthy' dependency between baby/toddler and breastfeeding woman.

10.5.3   Dependence versus independence

Nurses as health professionals are educated in developmental theory and understand well the idea that children grow to autonomy and independence (Erikson, 1980) and that independence is asserted to be both healthy and normal. They further are aware of pathological co-dependency states such as alcoholism and drug abuse. Thus the idea of dependency as a positive and affirming experience requires something of a mind shift for many nurses.

Women in this study affirmed that interdependency between the breastfeeding pair was a most special part of the breastfeeding experience. Women enjoyed the feeling that the baby depended on them. The sense of oneness associated with intimate breastfeeding moments is essentially a moment of inter-connected dependency. I would advise nurses and health professionals to consider carefully this aspect of a breastfeeding relationship.

I was concerned to find that intimacy between a breastfeeding pair can be misconstrued as unhealthy. Trad (1991) published a paper on the development of a psychoanalytic tool called 'previewing', as a tool for understanding the dyadic relationship between infant and parent. Previewing essentially uses a projective technique illuminating the current behavior and exploring the possible impact of the behavior on child development in the future. Trad offers two case examples from which the author presents and argues the effectiveness of the previewing technique. One of the cases presented involved a 34 year old primigravida with a one month old daughter who attended a weekly group designed to heighten the awareness of new parents to the developmental events of their infants and develop skills to respond appropriately to those events. All those attending had no previous history of psychiatric illness or disturbance. The group leader noticed one participant (Katherine) displayed close attunement to her daughter (Julie).

> This attunement was manifested by Katherine's high level of visual and vocal cuing [sic] directed towards Julie, as well as her continual efforts to stimulate the infant. At the same time, however, Katherine was able to sense her daughter's tired or irritable moods and would, on these occasions, engage in comforting, stroking or cuddling that had the effect of quelling the child's distress.
>
> When sharing her impressions with the group, Katherine commented upon the unexpected sense of intimacy that infused every aspect of her relationship with her daughter. She was especially enthusiastic about her experiences during breastfeeding, episodes during which she felt she was most able to convey her affection to the infant. Katherine described feeling a 'closeness' or 'togetherness' with her daughter she had not experienced in other relationships (Trad, 1991, p.256).

The case history goes on to elaborate about the overwhelming loss and rejection this woman experienced when the baby weaned. The case indicates that Katherine subsequently required psychotherapy for her depression as a result of weaning and other past unresolved loss and grief. What is not clear from this account is the relevance of her intimate experience during breastfeeding on her later presentation. The implication is that such an experience is part of a disturbed and unhealthy psyche. I would assert that this is not so, given the considerable conceptual work on the importance of intimate relationships for self development and the work of this thesis regarding the affirming and positive aspects of intimate breastfeeding moments. Perhaps the key difference for this case study was that Katherine expressed she had not experienced intimacy like this in any other relationship. The

importance for health professionals to consider carefully the woman's expression of intimacy is highlighted in the Trad case study.

The woman's experience of breastfeeding can be charged with tensions and discomforts. Nurses can influence the breastfeeding experience by raising the questions that illuminate the environmental constraints. Further nurses can attend to the emotional aspects of breastfeeding by considering the other aspects of feeding an infant breast milk, such as expressing breast milk.

10.6 Expressing breast milk

The model, 'linking as one' provides a unique explanation for the well-documented account of women's experience with breast expression (Morse & Bottorff, 1988). The authors reported on a grounded theory study that determined women either found breast expression a relaxing and affirming activity that provided breast milk for their infant or that breast expression was messy, mechanical, embarrassing and awkward. This latter negative perception perhaps epitomises the opposite experience to that of an intimate breastfeeding moment.

I drew on the responses from the participants in the present study and published an account of the participants' reports on breast milk expression (Dignam, 1995). The women reported that breast expression is often a bothersome activity, is solitary, non-reciprocal, and mechanical (Dignam, 1995). Often the expressing experience lacks both physical and emotional comfort. While, the participants' accounts of expressing breast milk do not contribute to the substance of the model 'linking as one' other studies do provide a standpoint from which to distinguish experiences that are not intimate moments. Breast milk expression can be focused on the product and not the process (Bottorff & Morse, 1990).

Morse and Bottorff (1988) suggest that providing private space and encouraging women to feel comfortable handling their breasts may enable them to more effectively express breast milk. Both these suggestions are substantiated by the model 'linking as one'; women who handle their breast may further their emotional comfort, and feel less awkward and embarrassed. I have previously identified relaxation activities as one

of the contextual influences associated with comfortable breastfeeding. It is also associated with improved breast milk expression.

Relaxation and creating a relaxing environment has been shown to enhance breast milk expression (Feher, Berger, Johnson & Wilde, 1989). The images that were used to enhance relaxation in the Feher et al. study include the descriptions of the baby's skin against the mother. Clearly that is an essential component usually missing in the activity of breast milk expression. Renfrew, Fisher, and Arms (1990) in their book on breastfeeding advice for women, note that women can help their breast milk expression if they hold their baby close or have a picture of the baby present when they express. Montagu (1986) noted it is the breastfeeding woman's total relatedness to her child that makes skin to skin contact, like that found in breastfeeding, to be so significant. Interpersonal relatedness is clearly not present in the experience of breast milk expression, unlike intimate breastfeeding moments that feature close contact and physical touch.

Nurses who have breastfeeding clients that want or need to express breast milk, may find it beneficial to consider the issues about comfort, privacy, and relaxation prior to a breast expressing event. Interventions such as holding the baby or breastfeeding off one side, while expressing off the other, may also aid in breast milk expression (Dignam, 1995b). If however women feel uncomfortable about their breasts both physically or emotionally they may be likely to feel uncomfortable expressing breast milk and their source of discomfort may need to be considered before encouraging them to perpetuate a negative experience.

10.7 Key questions

Throughout the discussion on the implications for nursing practice I have indicated that certain lines of questioning might act as effective prompts for discussion about aspects of breastfeeding that may impede or reduce maternal satisfaction. As I have indicated, the model presents a number of fundamental aspects of the interpersonal processes that occur between the woman and her breastfed baby. A range of relevant questions might illuminate many of these processes.

I have listed the questions in Table 10.1 as examples of the type of questions that the nurse might use in conversation with a breastfeeding client. I have located these in a table format to enable identification of the category or theoretical proposition that each question relates to. It is important to note that these questions are not intended to be conversation leads or indeed definitive and comprehensive assessment criteria. Rather they are suggested approaches to the various issues that have been identified within this study. As with any nursing encounter the clinical judgement of the practitioner remains imperative to the process of nursing care.

Table 10-1   Breastfeeding Management

Key Question	Category	Concept	Theoretical proposition
Who owns your breast?	Coming to know self	Contextually defined breast	Recognising comfortable and uncomfortable contexts
Is your breast sexual?	Coming to know self	Contextually defined breast	Recognising comfortable and uncomfortable contexts
Do you ever feel uncomfortable when breastfeeding?	Coming to know self	Theoretical Proposition	Recognising comfortable and uncomfortable contexts
When do you feel uncomfortable breastfeeding?	Coming to know self	Theoretical proposition	Recognising comfortable and uncomfortable contexts
What do you do in those uncomfortable breastfeeding times?	Coming to know self	Adaptive breastfeeding	Recognising comfortable and uncomfortable contexts
Do you know your breastfed baby?	Coming to know baby	Reading the baby	Interpreting intentions
What does it mean when the baby holds on?	Coming to know baby	Reading the contact	Interpreting intentions
What do the feet and hand movements mean when baby is breastfeeding?	Coming to know baby	Reading and knowing	Interpreting intentions
How close are you when you breastfeed?	Being with	Mutually exclusive	Knowing the other
Do you ever feel relaxed when you breastfeed?	Being with	Mutually exclusive awareness	Knowing the other
Do you ever feel re-energised when you breastfeed?	Being with	Mutually exclusive awareness	Knowing the other
Do you ever experience quiet uninterrupted breastfeeding moments with your baby?	Linking as one	BSPP	Environment context

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Key Question	Category	Concept	Theoretical proposition
Do you feel pleasure when you breastfeed?	Being with	Mutually gifting	Knowing the other
What are you giving when you breastfeed?	Being with	Mutually gifting	Knowing the other

These questions have been identified as those that hold some theoretical merit for the model 'linking as one'. Further research is required on this question set before any psychometric validation could be claimed. In the following discussion I consider the development of this question set and the development of the theory 'linking as one'.

10.8 Further research suggestions.

It is somewhat traditional to suggest at the end of any research the possible areas of further research and identify the deficiencies of the research undertaken. According to Glaser (1998) grounded theory has several unique contributions to make at this point. Glaser asserts that "The paramount lead to future research is all the theoretical sampling that the researcher felt was beyond his [sic] resources and limits" (1998, p.199). Glaser also asserts that the formal theorising of the substantive theory holds some research opportunity. It is these two considerations that I now focus on. The first consideration is the areas of the theory that merit further research, and secondly, the aspects of the theory that may be advanced by more formal theory development.

10.8.1 Theoretical sampling possibilities

As I consider the areas of possible further research I am also identifying the limitations of this study by identifying the aspects of concept development that might have been advanced by greater theoretical sampling. I wish to assert at this point that I do not believe this work to be incomplete, in the sense that data were theoretically directed and codes and categories were grounded in data saturation. I would acknowledge that the work is limited to be representative of a particular sample, that is New Zealand breastfeeding women, and as such is limited in generalisability in formal research terms.

This grounded theory provides a number of research leads in so far as it was theoretically directed. The theoretical sampling of women who were tandem breastfeeding provided a depth to the development of the model that would not have otherwise been added. Specifically, these women illuminated the idea of controlling breast access as a mechanism for managing breast demand. I assumed that this group of women would relate to the code 'being in demand' and would have experienced the feeling that their breast was in demand. As a group they did not express this feeling. Rather, it was the actions the tandem feeding women displayed and recounted that alerted me to the difference between their breastfeeding practice and those of the breastfeeding women who expressed feeling 'in demand'.

I acknowledge here that the assumption that tandem feeding women might experience uncomfortable breast demand is not one that I would now perpetuate. Indeed an anxious conference participant spoke directly to me after a presentation on this data in 1995 (Dignam, 1995a). The participant was adamant that perpetuating the idea that tandem feeding was a demanding activity flew in the face of the anecdotal evidence; that women who tandem feed do so because of the perceived benefits and these are maternal benefits as well as infant/toddler benefits. This position I readily acknowledge and reassured the conference participant that the theory does not support my initial assumption. It would have been useful to theoretically sample women who felt their breastfeeding to be demanding and un-pleasurable. While there are some ethical difficulties with this sample, I suggest that women who have weaned from the breast to alternative infant feeding methods would be a significant group from which to extend this grounded theory.

I did include in this study one respondent who had weaned during the time of the study and her perspective contributed to the category 'coming to know baby'. That particular participant contributed data regarding the perception that babies continue to know the mother by a variety of mother-infant exchanges. Thus I would propose that a theoretical sample of mothers who have weaned might be able to enhance and refine many other aspects of this study.

The other most obvious theoretical sample for advancing this grounded theory is women who artificially feed their babies. The model 'linking as one' claims a place

for breastfeeding women's experience. Though some of the participants in this study had experienced bottle-feeding, that was not a central concern of the study. I speculate that women who artificially feed their babies may well contribute to this substantive theory an alternative experience of intimacy. Further they would contribute data that may extend and refine the conceptual understanding of the experience of intimacy when feeding the baby. I consider that artificial feeding, is a significant infant feeding practice aligned with perceptions of choice and maternal benefit, that warrants further research from a grounded theory approach.

The theory presented in this work is representative of a certain cultural bias, in that no other ethnic grouping is explicit. I was not directed by the grounded theory process to seek theoretical sampling from any particular ethnic group. Women in the study were not all of one ethnicity and if a particular concept has been theoretically relevant I consider the method would have been faithful to illuminate that. I would recognise that further sampling may have substantiated an ethnic perspective and as such suggest that sampling for particular cultural perspectives would further develop and refine the concepts.

The final theoretical sample, for greater theoretical depth, would be a sample of adults, male and female. This is a separate social unit (Glaser, 1978) as the central concern would shift from infant feeding experiences to the development of conceptual and theoretical understanding of intimacy between adults. While there is an immense body of knowledge about adult intimacy I consider the contextual and substantive approach of grounded theory one that would illuminate inductively a fresh and invigorating approach to the conceptual understanding of intimacy. Further this unit of study would contribute and refine the understanding developed by the model 'linking as one'. I have argued in this work that the conceptual understanding of intimacy has been located in the social experience of the participants. I have further presented examples of their conceptual understanding drawing on adult and child relationships. Thus this work has invited the researcher to consider the theoretical refinements of intimacy as a concept of huge interpersonal worth. There is also theoretical merit in considering the applicability of the theoretical propositions as further research questions.

10.8.2　　　Deductive and conceptual possibilities

The model 'linking as one' provides a descriptive substantive theory that has advanced a number of theoretical propositions. These may be considered in future research as central questions of concern or formal hypotheses to be proved. I have listed a number of these propositions as statements for research consideration,

- When breastfeeding women experience physical discomfort they adapt their behavior to maintain comfort.
- When breastfeeding women experience emotional discomfort they adapt their behavior or perceptions to maintain comfort.
- In order to express breastfeeding comfort women reconcile the breast as sexual or functional.
- In order to experience maternal satisfaction breastfeeding women express a sense of knowing the infant.
- When breastfeeding women express that they know their infant they evidence an interpretation of the infant's cues.
- Women who experience intimate breastfeeding moments express maternal satisfaction.
- Women who experience intimate breastfeeding moments express breastfeeding success.

These research statements are reasonably sophisticated and require further concept refinement and operational definition. The statements are deduced from the substance of the data and suggest possible relationships between concepts and codes. These relationships might be further described by appropriate research methods such as grounded theory, thematic analysis, and survey. The relationships might be more formally measured and tested by experimental, quasi-experimental design or validation of psychometric measures.

The development of a set of questions for a breastfeeding assessment tool merits further consideration. I have listed in table form (Table 10.1) the questions, that nurses in practice might use as prompts to raise and illuminate various aspects of

breastfeeding experience. The questions are identified alongside the various theoretical aspects of the model 'linking as one'. These same questions and others might be further developed and tested as a breastfeeding assessment tool.

A number of breastfeeding assessment tools and measures exist for health professionals to use when working with breastfeeding clients. These assessment tools range from guidelines and documentation for breastfeeding assessment (Bear & Tigges, 1993; Bono, 1992; Hedberg & Per-Olow Sjoden, 1993; McLaren, Murray & Shaw, 1997) to validated breastfeeding measures (Mathews, 1988). These assessment guidelines and documentation fail to account for the affective and emotive aspects in the breastfeeding encounter. Even with the more formal assessment measures, such as the Infant Breastfeeding Assessment Tool (IBAT) presented by Mathews (1988), the emphasis remains on readiness to feed, and physiological dynamics.

Research by Hedberg and Per-Olow Sjoden (1993) provides evidence of a framework for assessing and advising appropriately about breastfeeding. The authors suggest that breastfeeding women, who have hospitalised infants in neonatal care, display adaptive roles. These roles include a maternal role demonstrated by expressions of maternal self-confidence, self-consistency and ideas about self. While these authors have attended to the maternal perceptions they are not considered to be demonstrated in breastfeeding exchange. These roles are also related directly to the context of hospitalisation. The work is a basis for assessment tool development. Numerous tools exist to measure mother infant dynamic and attachment (Casey, Barrett, Bradley & Spiker, 1993; Lobar & Phillips, 1992) and often these are without emphasis or reference to breastfeeding. In this and other literature I have reviewed (Hughes, 1984; McAdams, Lester, Brand, McNamara, & Lensky, 1988) I have not found any assessment tool that identifies the breastfeeding dynamic or affective aspects of the breastfeeding relationship. I consider the development of such an assessment tool a most useful contribution to nursing practice. I also acknowledge that assessment tool development would require further conceptual analysis and identification of operational definitions.

10.8.3   Conceptual analysis

The theory 'linking as one' would be most simply reviewed as a conceptual analysis of intimate breastfeeding moments. The concept of intimacy could be further refined by formal consideration. This might include the framework of concept analysis suggested by Walker and Avant (1983). The framework has been utilised in nursing research for concepts such as trust (Johns, 1996;Meize-Grochowski, 1984), humour, (Sheldon, 1996), and feminism (Allan, 1993) to name a few. The Walker and Avant framework involves an eight step process that includes identification of the uses of the concept, the defining attributes, construction of a model case, construction of alternative cases (borderline, related, contrary and illegitimate), antecedents, consequences, empirical referents and areas for further study. There are a number of other frameworks from which to engage in concept analysis (Norris, 1982; Rodgers, 1989) and also varying research approaches for concept development (de Jong-Gierveld, 1989; Foddy & Finighan, 1980). All these approaches, for concept analysis, involve the identification of the defining attribute and, operational definitions for identification of empirical referents.

A salient article by Timmerman (1991) presented a concept analysis of intimacy, a work I acknowledged in Chapter Three. Timmerman considers the relevance of the concept for psychiatric nursing practice. The work indicates the importance of adult intimacy, social support satisfaction and emotional illness. I consider that a concept analysis of intimacy considering the breastfeeding unit would contribute a new and vital approach to understanding the role of intimacy in health. The implication of better understanding the intimate relationship that occurs in breastfeeding is the application of this work in the nursing care of clients and their families. In order to convey the concepts and attributes of an intimate breastfeeding moment the model may also be applied to health education programs.

10.9 Linking as one: A framework for curriculum

I consider that the substantive descriptive theory 'linking as one' provides a practical framework for curriculum development and educational delivery for breastfeeding. I

have been able to apply the theory as a framework for curriculum in a unit of study within the postgraduate program for nurses and midwives at Massey University, Albany, Auckland, New Zealand. The paper was offered as a special topic in 1999 and attracted a small group of paediatric, neonatal and community health nurses, and midwives.

The general assumptions of the theory, 'linking as one' were also foundational to the special topic paper and as such the students discussed their own beliefs and perceptions about breastfeeding. I would suggest that any breastfeeding program would invest time wisely by allowing health professionals to share their own experiences of breastfeeding and explore the attitudes they hold. This course addressed in part the need for increased education on the practice of breastfeeding for nursing students, a call from international authors (Barnett, Sienkiewicz & Roholt, 1995; Bergh, 1993; Freed, Clark, Harris & Lowdermilk, 1996) and one that has resonance in the New Zealand health scene.

It was with some real anxiety that I first presented the model, as a framework for the course, to the student group. Many of the students had not previously studied breastfeeding and the topic was relatively new to them. For these students the ability to discern the appropriateness of the theory for practice was limited. However, one student in particular had studied breastfeeding and was practicing as a neonatal nurse practitioner and certified lactation consultant. The following was her response to the model and the course,

> Having studied breastfeeding for many years, from the biophysical and counselling aspects of breastfeeding support, I found your framework presented in the course and followed in the course outline both innovative and insightful. Having a framework to consider the breastfeeding process in relation to intimacy was like opening the door on a whole different perspective. As a breastfeeding woman the processes and descriptions that were identified in the framework were something that I immediately felt comfortable with...This is also an excellent tool for health professionals and lay people offering support and assistance to breastfeeding mothers (S. Jones, personal communication, 1999).

The model 'linking as one' provided a most workable and fitting curriculum framework. The material would also be an acceptable framework for health

education sessions with breastfeeding clients. Client groups such as postnatal and antenatal breastfeeding classes could utilise aspects of the model. The educational sessions might offer discreet units such as the main categories of the model, 'coming to know baby', 'coming to know self', 'being with', and 'intimate breastfeeding moments'. The health professional could consider, with the group, the application of the model to breastfeeding practices. This application of the model for health education would meet in part the call by various authors for education on maternal obstacles to successful breastfeeding (Bergh, 1993), psychosocial factors affecting choice (Cox & Turnbull, 1994), embarrassment and male perceptions (Sullivan, 1996), guilt and regret (Wilson-Clay, 1996). These and many other topics would surface as women and health professionals together attend to the interpersonal and emotional aspects of breastfeeding women's experiences. Such a platform for discussion acknowledges the validity of women's experiences and provides opportunity for considering the aspects that are most likely to influence breastfeeding success.

10.10 The importance of intimate breastfeeding moments

I have argued through this work that women do experience intimate breastfeeding moments that contribute to maternal satisfaction and promote breastfeeding. As I reflect on the central thesis of this theory I am reminded that for many women their experience of breastfeeding is not pleasurable, intimate or even comfortable. Despite this reality women persist (Bottorff, 1990) believing that breastfeeding is best for their baby. Health professionals can no longer consider that physical breastfeeding problems are their central concern when so many of these manifestations are interpersonal, experientially and socially prescribed responses. Health professionals such as nurses must consider and address the social and emotional issues that influence breastfeeding women and prevent them from experiencing the positive and affirming relationship they could have with their breastfed child.

In many instances women wean from the breast because they find the practice socially restricting, socially unacceptable, cannot reconcile their breastfeeding with their sexuality or are unsupported by partners and social networks to practice

breastfeeding. Many of these social issues reflect the lack of breastfeeding culture within society and this may underpin the presentation of perceived insufficient milk syndrome (Beasley et al., 1998). It is a constant waste of research resources to once again consider the reasons women wean, and then intervene assuming that particular reason is the cause. Literature is starting to reflect this concern for answers to a seemingly complex issue (Bysshe, 1997). It is well understood that a very low percentage of women are physiologically unable to produce sufficient breast milk to sustain an infant. The psychological influence on the physiological bio-mechanics of milk secretion are most obviously reflected as in the symbiotic processes represented in the practice of breastfeeding.

Understanding the positive experiences of breastfeeding enables health practitioners to understand the difficult, uncomfortable and unsatisfying breastfeeding times and look to address these. This work is unique in that the woman's experience has not focused on the problematic; breastfeeding is not considered a set of inherently difficult activities, as is the dominant perspective expressed in most health literature. Further it is unique in that it is representative of the sample of twenty women participants in this study. While the abstraction of their experience may hold credibility for other women the work is not intended as a definitive position, rather a starting point from which to understand the dynamics between breastfeeding women and their babies. Finally this theory is unique in that it contributes, to the body of knowledge on breastfeeding, a theoretical description of the interpersonal processes between a breastfeeding pair. This process is represented by an intimate breastfeeding moment communicated as the moment when the breastfeeding pair is linking as one.

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