

1-1-2000

Constructing compatibility : Managing breastfeeding and weaning from the mothers' perspective

Yvonne Louise Hauck
Edith Cowan University

Follow this and additional works at: <https://ro.ecu.edu.au/theses>



Part of the [Family, Life Course, and Society Commons](#)

Recommended Citation

Hauck, Y. L. (2000). *Constructing compatibility : Managing breastfeeding and weaning from the mothers' perspective*. <https://ro.ecu.edu.au/theses/1374>

This Thesis is posted at Research Online.
<https://ro.ecu.edu.au/theses/1374>

Edith Cowan University

Copyright Warning

You may print or download ONE copy of this document for the purpose of your own research or study.

The University does not authorize you to copy, communicate or otherwise make available electronically to any other person any copyright material contained on this site.

You are reminded of the following:

- Copyright owners are entitled to take legal action against persons who infringe their copyright.
- A reproduction of material that is protected by copyright may be a copyright infringement. Where the reproduction of such material is done without attribution of authorship, with false attribution of authorship or the authorship is treated in a derogatory manner, this may be a breach of the author's moral rights contained in Part IX of the Copyright Act 1968 (Cth).
- Courts have the power to impose a wide range of civil and criminal sanctions for infringement of copyright, infringement of moral rights and other offences under the Copyright Act 1968 (Cth). Higher penalties may apply, and higher damages may be awarded, for offences and infringements involving the conversion of material into digital or electronic form.

USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

-

**CONSTRUCTING COMPATIBILITY:
MANAGING BREASTFEEDING AND WEANING
FROM THE MOTHERS' PERSPECTIVE**

by

Yvonne Louise Hauck

**A Thesis Submitted in Partial Fulfilment of the
Requirements for the Award of
Doctor of Philosophy (Nursing)**

**At the Faculty of Communications, Health, and Science
Edith Cowan University, Churchlands, Western Australia.**

Date of submission: June 2000

-
ABSTRACT

Breastfeeding involves phases of initiation, continuation, and weaning. Research to date has focused upon its initiation and continuation rather than the later phases, when the child is weaned from the breast. Selective aspects relating to weaning have been explored to determine infant feeding practices such as the timing of food introduction. However, that research has focused upon developing countries where the impact of infant feeding patterns and weaning practices have a significant impact on infant growth and child health. The weaning process or final phase of breastfeeding from the mothers' perspective has not been examined within the western world. In order to fully understand this important maternal task, all phases of the experience must be explored.

The management of weaning is affected by cultural, social, developmental, and psychological factors and is reflected in distinct infant feeding practices across cultures. The purpose of this grounded theory study was to analyse the maternal process of managing the later stages of established breastfeeding and, ultimately, weaning the child from the breast within a Western Australian context. A minimum time of six weeks postpartum was regarded as established breastfeeding whereas weaning was defined as the process that begins when the mother and/or the child decide to stop breastfeeding. Using the constant comparative method, analysis of thirty-three participants' interview transcripts, field notes, nine postal questionnaires from fathers, and individual and discussion group interviews with child health nurses revealed a common social problem of *incompatible expectations*. All participants faced a dilemma in the management of their experience when personal expectations were found to be in opposition to others' expectations. Although the focus of this study was on weaning, a key finding was that participants' expectations on weaning could not be easily separated from their expectations regarding breastfeeding and mothering. Expectations in the areas of breastfeeding and weaning were interrelated as achievements or disappointments reflected upon mothering expectations.

When faced with *incompatible expectations* from their child, partner, family, friends, health professionals, and society, these Western Australian mothers expressed feelings

of confusion, self-doubt, and guilt. A process of *constructing compatibility by adapting focus* was adopted to compensate for this incompatibility and comprised three phases. Prior to engaging in this process, participants arrived at a turning point where individual tolerance levels of confusion, guilt, and self-doubt were reached. The first phase entitled *shifting focus* involved participants clarifying the relative importance they assigned to aspects of their breastfeeding. This clarification enabled them to take charge of their experience and reinforce personal expectations and goals. In the second phase, *selective focusing*, participants selectively chose to focus upon specific compatible sources to accentuate their influence and thereby diminish the impact of incompatible sources. When confronted with ongoing *incompatible expectations* throughout their experience, participants moved back to *shifting focus* to re-clarify personal expectations and reinforce subsequent decisions. During the final phase of *confirming focus*, mothers reflected upon their experiences and resolved decisions by verifying that their adapted focus achieved the desired compatibility. This substantive theory of the management of breastfeeding and weaning from the perspective of Western Australian mothers is discussed in relation to existing nursing and social science theories. Additionally, implications and recommendations based upon these findings are presented.

DECLARATION

I certify that this thesis does not, to the best of my knowledge and belief:

- (i) incorporate without acknowledgement any material previously submitted for a degree or diploma in any institution of higher education;
- (ii) contain any material previously published or written by another person except where due reference is made in the text; or
- (iii) contain any defamatory material.

Signature



Date Nov 6, 2000

ACKNOWLEDGEMENTS

I would like to acknowledge and thank my principal supervisor, Dr Vera Irurita, for her wisdom and patience in guiding me through this journey of discovery and academic pursuit.

Associate supervisors Dr Lynne Hunt and Shirley Perry offered valuable input during the research process by providing feedback that challenged and further developed the critical thinking required to complete this scholarly analysis.

I would also like to recognise Dr Patricia Percival and Dr Anne McMurray who were my supervisors during the proposal stage of this thesis. Although they were not able to remain supervisors for the term of this study due to changing circumstances, they continued to offer support and encouragement from a distance.

The emotional support from colleagues within the School of Nursing and Public Health, particularly from Miriam Langridge, was indispensable and greatly appreciated. The financial assistance awarded through an Edith Cowan University Post Graduate Research Scholarship was beneficial in allowing me to pursue my studies full time for a period of three years. The collegiality and sharing of ideas with fellow Ph.D. colleagues from our Monday grounded theory research group was an essential motivating force during the highs and lows of the research process.

The patience and understanding of my partner, Edward, and children, Keith and Nicole, was priceless. Their belief in my abilities inspired me to continue pursuing my goal to its completion.

Finally, I would like to acknowledge the thirty-three mothers who generously shared stories regarding their experiences to enable development of this substantive theory of the management of breastfeeding and weaning within the Western Australian context. Additionally, the input from the child health nurses and fathers who shared their thoughts and feelings regarding women's experiences provided valuable data to further explicate this decision making process.

TABLE OF CONTENTS

ABSTRACT	ii
DECLARATION	iv
ACKNOWLEDGEMENTS	v
TABLE OF CONTENTS	vi
LIST OF FIGURES	x
LIST OF TABLES	xi
APPENDICES	xii
 CHAPTER ONE – INTRODUCTION	
Introduction	1
Background to the study	1
Literature on weaning	2
Rationale for the study method	10
Purpose	12
Research objectives	13
Review of breastfeeding literature	13
Benefits of breast milk	14
Factors influencing breastfeeding initiation and prevalence....	15
Women’s subjective experiences of breastfeeding.....	17
Breastfeeding support	21
Breastfeeding in the Australian context	24
Definition of terms	26
Overview of the thesis	28
 CHAPTER TWO – METHODOLOGY	
Introduction	29
Qualitative research	29
Philosophical dimensions of qualitative research	32
Symbolic interactionism	33
Grounded theory method	35
Theoretical sensitivity	40
Theoretical sampling	40
Constant comparison	42
Coding	42
Use of the literature	44
Use of memos	45
Overview of procedure	47
Sampling	48

Data collection	50
Profile of participants	55
Interview guide	57
Data analysis	57
Memos	62
Validity and reliability	63
Ethical considerations.....	66
Limitations	67
Summary	67
Overview of findings.....	68

CHAPTER THREE – FINDINGS

BASIC SOCIAL PROBLEM: INCOMPATIBLE EXPECTATIONS

Introduction	71
Incompatible expectations	71
The meaning of meeting expectations	74
Expectations related to mothering	81
Mothering as hard work	81
The need to give of self	82
The involvement of significant others	83
Balancing the needs of the family	85
Happy child reflects good parenting	85
Expectations related to breastfeeding	88
Best choice for the child	88
Easy, natural and convenient	91
Support will be available	93
Breastfeeding in public	96
Intimacy, closeness and enjoyment	101
Healthy contented child	104
Expectations related to weaning	106
When to wean	107
Acceptable breastfeeding duration	111
Longer breastfeeding equals difficult weaning	114
Gradual weaning is best	115
Breastfeeding and work	116
Sleep problems	121
Factors influencing mothers' expectations	123
Beliefs and knowledge	124
Experts	125
Past experience	130
Current experience	133
Experience of others	136
Partners' input	140
Summary	143

CHAPTER FOUR – FINDINGS

CONSEQUENCES OF INCOMPATIBLE EXPECTATIONS

Introduction	144
Consequences of incompatible expectations	144
Confusion	144
Self-doubt	148
Guilt	153
Conditions influencing consequences	157
Personal meaning of goals and expectations	157
Control over decision making	162
Relationship with source of expectation	166
Proximity and frequency of contact with source	169
Perceived credibility of source	171
Extent of discrepancy between expectations	175
The child's reaction	178
Impact upon the family	185
Presence of compatible support	189
Summary	193

CHAPTER FIVE – FINDINGS

BASIC SOCIAL PROCESS: CONSTRUCTING COMPATIBILITY BY ADAPTING FOCUS

Introduction	195
Constructing compatibility by adapting focus	195
Shifting focus	197
Turning point	197
Taking charge	200
Selective focusing	204
Embracing	205
Distancing	210
Avoiding	211
Dismissing	215
Confirming focus	219
Rationalising decision by focusing upon positive outcomes	221
Acknowledging feelings	224
Summary	231

CHAPTER SIX – DISCUSSION

Introduction	234
Constructing compatibility by adapting focus	234
Constructing compatibility: A comparison with existing literature	240
Breastfeeding literature	241
Mothering literature	249
Nursing theories	255
Roy's Adaptation Model	256

Mercer's Theory of Maternal Role Attainment	257
Parse's Theory of Human Becoming	258
King's Goal Attainment Theory	260
Riehl-Sisca's Interaction Model	261
Cognitive dissonance	262
Social cognitive theory	265
Health belief model	268
Conclusions	271
Implications and recommendations for health professionals ..	271
Awareness of expectations	271
Acknowledgement of mothering efforts	272
Choice: is it informed and respected?	273
Anticipatory guidance	276
Implications and recommendations for consumers	277
Implications and recommendations for society	278
Implications and recommendations for future research	280
Closing remarks	282
REFERENCES.....	283
APPENDICES.....	308

LIST OF FIGURES

Figure 1	
The process of weaning by gradual supplementation	3
Figure 2	
A maternocentric model with factors influencing the timing of supplementation	7
Figure 3	
Connection between data collection, analysis and theory development	48
Figure 4	
Example of diagramming from early data analysis.....	324
Figure 5	
Relationship between breastfeeding, mothering, and weaning expectations	72
Figure 6	
Basic social problem: Incompatible expectations	73
Figure 7	
Cartoon (Matterson, 1990, p. 27)	92
Figure 8	
Cartoon (Matterson, 1990, p. 71)	96
Figure 9	
Consequences of incompatible expectations.....	194
Figure 10	
Basic social process: Constructing compatibility by adapting focus	232
Figure 11	
Basic social problem: Incompatible expectations	236
Figure 12	
Constructing compatibility by adapting focus: A theory of the management of breastfeeding and weaning from the mothers' perspective	238
Figure 13	
Self-efficacy framework applied to breastfeeding	268
Figure 14	
Key variables in Health Belief Model	269

LIST OF TABLES

Table 1	
Benefits of breastfeeding outlined in Western Australian newspaper ("Breastfeeding", 1999, p. 15)	14

APPENDICES

Appendix A	
Consent form for participants	308
Appendix B	
Interview guide	309
Appendix C	
Advertisement used in local community newspaper	310
Appendix D	
Methodological memo.....	311
Appendix E	
Theoretical memo	312
Appendix F	
Letter to coordinators in child health	313
Appendix G	
Letter to individual child health nurses	314
Appendix H	
Consent form for individual and discussion group interviews.....	315
Appendix I	
Interview guide for child health interviews	316
Appendix J	
Letter to participants and partners	317
Appendix K	
Postal questionnaire to partners	318
Appendix L	
Code list following open coding	320
Appendix M	
Theoretical memo on contradictory messages	322
Appendix N	
Reflexive journal	323
Appendix O	
Example of diagramming from early data analysis	324

CHAPTER ONE

Introduction

Introduction

Honor and love thy child. Remember the breastfed is the best fed. Observe the four hour routine to keep it holy. Thou shalt not overfeed. Thou shalt not feed except with precision. Thou shalt not permit solid food too early. Truby King, founder of the Plunkett Society, presented the preceding guidelines for infant feeding in the early 1900's (cited in Hervada & Newman, 1992, p. 226).

This study focused on the maternal experience of managing the later phase of established breastfeeding and subsequent weaning of a child from the breast. Chapter One includes background literature demonstrating the rationale for choosing this research topic and justifying the decision to use the grounded theory method. Literature summarising current research on the topic of weaning is discussed to illustrate the gap in knowledge relating to mothers' perceptions of this process. The study's purpose and research objectives are delineated. As weaning is just one phase of the total breastfeeding experience, a brief overview of relevant breastfeeding literature is also presented, as the process of weaning can not easily be separated from the later phases of breastfeeding. Current breastfeeding trends within Australia, and specifically Western Australia, are discussed to establish the social context of breastfeeding and weaning for those participants who openly shared their stories during this investigation. Finally, pertinent terms utilised throughout this thesis are defined for the purpose of clarification and an overview of the thesis is presented.

Background to the Study

Breastfeeding research to date has focused upon the initiation and continuation of the experience rather than the later phases, when the child is weaned from the breast. The efforts of the World Health Organisation (WHO) and United Nations International Children's Emergency Fund (UNICEF) to promote breastfeeding have resulted in extensive research being undertaken to determine factors influencing the incidence and

prevalence of breastfeeding (National Health & Medical Research Council [NHMRC], 1985; WHO, 1989a, 1989b).

Selective aspects relating to weaning have been examined in the literature to determine infant feeding practices and the timing of the introduction of specific foods within different cultures. However, this research has primarily focused on practices within developing countries due to public health issues related to infant morbidity and mortality (Al-Mazrou, Aziz & Khalil, 1994; Chandrasekhar, Wasanthaviani & Thomas, 1990; Dettwyler, 1987; Jackson et al., 1992; Khan, 1990; Lindenberg, Artola & Estrada, 1990; Lipski et al., 1994; Rao & Rajpathak, 1992; Singh, Kumar & Rana, 1992; Uwaegbute, 1991; Vijayasree & Satya Vani, 1992).

Exploration of mothers' perceptions of their breastfeeding and weaning experiences has received limited attention. The maternal subjective experience of continuing to breastfeed (Bottorff, 1990; Lockin, 1995), its relationship to employment (Hill-Bonczyk, Avery, Savik, Potter & Duckett, 1994), and long-term breastfeeding beyond 12 months (Kendall-Tackett & Sugarman, 1995; Wrigley & Hutchinson, 1990) have been examined within the North American context. Australian studies exploring mothers' perceptions have focused upon their criteria for success with breastfeeding (Hauck & Reinbold, 1996) and most recently, the ongoing experience of breastfeeding (Schmied & Barclay, 1999). Breastfeeding as a phenomenon involves phases of initiation, continuation, and cessation or weaning. To fully understand this important maternal task, all phases of the experience must be explored. At the time of this study, the weaning process or final phase of breastfeeding from the mothers' perspective within the western world had not been addressed in the literature.

Literature on Weaning

Breastfeeding is more than the physiological provision of food to a child. It also involves psychological, interpersonal, and social aspects that influence the meaning mothers attach to the experience. Being able to nurture an infant is said to be symbolic for women in validating their womanliness and motherhood (Bottorff, 1990). It has also been suggested that if women view their breastfeeding experience as successful, this perception can influence self-esteem and confidence in their mothering abilities (Mercer

& Rerketich, 1995; Rubin, 1984). Positive perceptions of a breastfeeding experience can foster the development of self-esteem and confidence, whereas, negative perceptions can diminish women's self-esteem and confidence.

Although weaning is only one phase of the total breastfeeding experience, it can have a significant impact upon mothers' overall perceptions of their breastfeeding. For example, the ordering of events within an experience can influence the relative weight that is placed upon the formation of an impression (Forgas, 1985). The recency effect asserts that later, and therefore most likely remembered, aspects of an experience can dominate the overall impression formed. The overall impression of a breastfeeding experience may be greatly influenced by the most recent aspects, namely the weaning process. Therefore, the recency of the weaning process on women's memories can affect their perception of the overall breastfeeding experience.

The term weaning generally refers to the process of gradual supplementation where "the infant changes from full dependence on breast milk to complete independence from it" (Greiner, 1996, p. 123). To avoid confusion and ambiguity when interpreting literature on infant feeding, clear definitions must be presented especially when the term weaning is used (Greiner, 1996). Greiner cautions authors when using the term because lack of clear definitions has failed to accurately communicate specific infant feeding behaviours. The weaning process and its phases are illustrated in Figure 1.

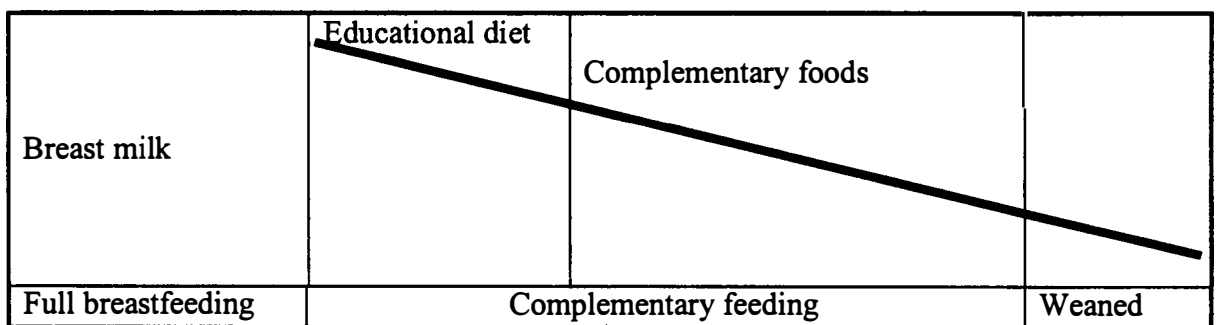


Figure 1: The process of weaning by gradual supplementation (Adapted from Greiner, 1995, p. 317).

Weaning is also used to represent each phase of this transition, such as the introduction of an educational diet in the first six months to acquaint the child with the taste, smell, and feel of other foods besides milk. Further weaning phases involve the offering of complementary foods to add to a developing diet while gradually replacing breast milk with other foods. Finally, the term weaning is also used to acknowledge the cessation of breastfeeding. This final phase involving the termination of breastfeeding was the focus of this investigation.

For the purposes of this study, the definition of weaning was restricted to the process that begins when the mother and/or the child decide to stop breastfeeding (Nursing Mothers' Association of Australia [NMAA], 1985). The child gradually receives fewer breastfeeds until he/she is completely nourished by other foods and drinks. This process can occur over days, weeks, or months.

Much of the research into weaning in its broad definition of gradual supplementation (Figure 1) has focused upon attempts to determine one or more of the following variables:

- factors influencing the cessation of breastfeeding and, specifically, early weaning at less than four months (Bailey & Sherriff, 1992; Bick, MacArthur, & Lancashire, 1998; Burgum, 1994; Coreil & Murphy, 1988; Earland, Ibrahim & Harpin, 1997; Fetherston, 1995; Lindenberg et al., 1990);
- the duration of breastfeeding and weaning in specific geographic locations and with specific populations (Dettwyler, 1987; Hitchcock & Coy, 1988; Khan, 1990; Lindenberg et al., 1990; Lipski et al., 1994; Piper & Parks, 1996; Rao & Rajpathak, 1992; Singh et al., 1992; Uwaegbute, 1991; Vijayasree & Satya Vani, 1992);
- the types of foods and fluids used to supplement breastfeeding (Greiner, 1995; Jackson et al., 1992; Morgan & Stordy, 1995; Retalleck, Simmer, Makrides & Gibson, 1994) and;
- the infant's age when these foods and fluids are being introduced (Al-Mazrou et al., 1994; Chandrasekhar et al., 1990; Dettwyler, 1987; Jackson et al., 1992; Lipski et al., 1994; Morgan & Stordy, 1995; Retalleck et al., 1994; Singh et al., 1992).

Studies in the literature that examined weaning predominantly originated from developing countries where the impact of traditional infant feeding patterns and weaning practices have a significant impact on infant growth and child health. Such investigations have been undertaken in Northern Thailand (Jackson et al., 1992), Saudi Arabia (Al-Mazrou et al., 1994), Mexico (Lipski et al., 1994), Mali in West Africa (Dettwyler, 1987), Nicaragua (Lindenberg et al., 1990), Nigeria (Uwaegbute, 1991), and most frequently in India (Chandrasekhar et al., 1990; Khan, 1990; Rao & Rajpathak, 1992; Singh et al., 1992; Vijayasree & Satya Vani, 1992).

The management of weaning is affected by cultural, social, developmental, and psychological factors (Hervada & Newman, 1992) and is reflected in distinct infant feeding practices across cultures. Not only do weaning foods differ across cultures, but the timing of when such foods are introduced varies greatly. For example, in Australia women have been encouraged to breastfeed exclusively for the recommended four to five months before offering solid foods such as pureed vegetables, mashed fruit, or rice cereal (Health Department of Western Australia, 1994; Pillitteri, 1995). In Nigeria, water with sugar, milk, and formula was found to be offered between one and three months of age and in Jamaica foods such as cornmeal with condensed milk, banana porridge, and strained oats were given between two weeks and two months (Raphael, 1982 cited in Hervada & Newman, 1992). In contrast, mothers in selective geographic areas in India delayed introducing any solid food for up to 24 months.

A biocultural analysis of breastfeeding proposed by McDade and Worthman (1998), particularly for developing countries, highlighted the dominant concern of pathogen risk for the infant. Decision-making regarding exclusive breastfeeding and weaning practices was said to be influenced by the cultural ecology of disease exposure due to factors such as water quality, human waste disposal, crowding, food handling, domestic animals, and climate. According to McDade and Worthman (1998, p. 292) “culturally defined breastfeeding supports and constraints determine the timing of supplementation, which interfaces with local pathogen risk to define the margin of morbidity experienced by infants”.

Information regarding infant feeding practices from different countries must be recognised as being relevant to their specific context and can not be readily or accurately transferred beyond cultural or social boundaries. Consequently, the focus of this research was to explore the process of weaning within the social and cultural context of Western Australia. To further delineate the historical context of this research, the study period commenced in 1996 and data collection continued until the end of 1999 as the literature continued to be examined and analysed in relation to emerging findings.

In their scholarly discussion, McDade and Worthman (1998) recently proposed a further model to highlight the complexity of weaning and presented an alternate conceptualisation of breastfeeding and weaning (Figure 2). This maternocentric model acknowledged the influence of the mother upon the weaning process, suggesting that breastfeeding duration interfaced with maternal burden and resulted in a margin of maternal depletion. Although influenced by political, economic, social, physical, and philosophical factors, McDade and Worthman (1998) speculated that mothers balance opposing forces when evaluating their efforts against anticipated outcomes.

Consequently, maternal decisions regarding weaning may be influenced by perceived constraints on breastfeeding that have the potential to increase maternal burden, widen the margin of depletion, and decrease the benefits and support for breastfeeding.

Although the model recognises the maternal impact on the weaning process, concepts such as constraints, maternal burden, and margin of depletion are proposed at a conceptual level only. The need for corroboration of these concepts with research data is indicated. Although the purpose of this study was not to provide confirmation of this or any other model, the results will be discussed in a subsequent chapter where the substantive grounded theory developed in this study is compared with existing literature.

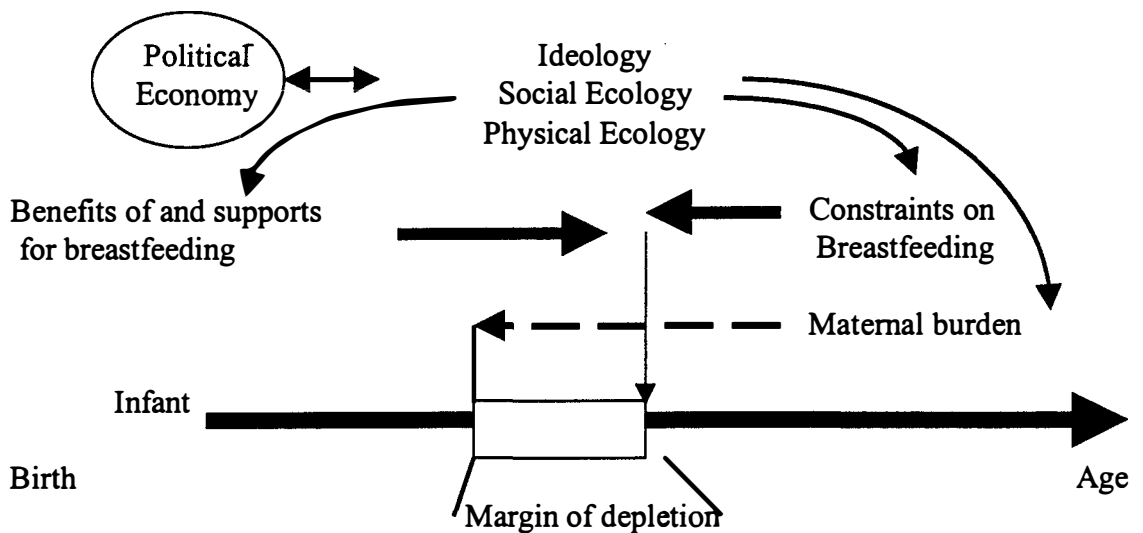


Figure 2: A maternocentric model with factors influencing the timing of supplementation (McDade & Worthman, 1998, p. 295).

The limited research on weaning in developed countries has focused on factors influencing the introduction of an educational diet and/or complementary foods. For example, in Sweden a matched case group of infants ($n = 24$) exhibiting food refusal during the first year of life and a control group ($n = 23$) were compared in relation to a number of variables (Lindberg, Bohlin, Hagekull, & Thunstrom, 1994). Results suggested that food refusal was associated with weaning problems but the depth and scope of these problems were not addressed in the Swedish study. In the United Kingdom, a study of diet and weaning patterns was undertaken with 1004 mothers representing a cross section of socio-economic groups (Morgan & Stordy, 1995). Again, the focus of the study was to identify breastfeeding incidence, weaning foods, the age of introduction of foods, reasons for choice of foods, and occurrences of food avoidance in relation to descriptive demographic data. Finally, infant feeding practices were also examined in an Australian survey conducted with 258 Adelaide mothers at metropolitan shopping complexes (Retalleck et al., 1994). Choices made regarding the types of foods and fluids offered were compared between breast and formula fed infants. Weaning diets were compared with the South Australian guidelines and the results suggested that parents were not always aware of the rationale behind weaning recommendations.

Although health professionals offer advice based upon official guidelines and recommendations, actual infant behaviour has been found to exert the greatest influence upon parents' weaning practices (Walker, 1995). The British study by Walker (1995) also found that parents knew if choices made regarding weaning did not agree with official recommendations but still based decisions upon infant behaviour. Receiving advice that conflicted with their own perceptions of their child's readiness was found to be a common dilemma parents shared regarding their child's weaning experience.

Gradual weaning has been recommended by many sources (Margiotta, 1989; Mohrbacher & Stock, 1997; NMAA, 1985); however, only one study was found that specifically examined weaning patterns of breastfeeding mothers. A descriptive study involving 100 first-time Canadian mothers was conducted to determine reasons and patterns for weaning (Williams & Morse, 1989). Tape-recorded semi-structured telephone interviews revealed that mothers' needs, infants' developmental milestones, and coercion to wean were the most frequent reasons given for the decision to stop breastfeeding. Three patterns of weaning emerged from the data. As anticipated, gradual weaning which took place over a period of one to eight weeks (42%) was one pattern revealed in the data. A new pattern, labeled minimal breastfeeding, was noted and involved reducing the number of breastfeedings over six to eight weeks and then maintaining a plateau for longer than two weeks (49%). The final pattern was sudden severance in which weaning occurred in one day (9%). Although patterns for weaning were identified in that study, mothers' subjective experiences outlining their feelings, thoughts, plans, or rationale for decisions were not specifically addressed.

Scholarly debates on weaning noted in the literature were based upon anecdotal or case study observations and also highlighted how different disciplines focused upon selective aspects of weaning. While providing limited insight into one aspect of weaning from the perspective of a small number of women, they did not offer a general insight into a process of weaning. For example, the psychotherapy literature discussed the considerable emotional turbulence in the mother-child relationship caused by the onset of weaning (Lubbe, 1996). Psychologically, weaning was viewed as a complex process with inherent struggles that placed mental burdens on both the mother and child. The impact of the struggle of letting go of the familiar and loved was described by Lubbe

(1996), emphasising the lasting psychological significance of weaning upon relationships.

In the nursing literature, Furman (1995) presented a different view of weaning. Rather than a struggle, weaning was viewed as a developmental step children take to indicate readiness to become their own person and a separate identity from their mothers. If the child was the one to demonstrate readiness to move on, Furman (1995) suggested that it was the mother who may feel weaned. The issue of readiness was an essential concept in this nursing approach that regarded weaning as a developmental milestone. However, Lubbe (1996) as a psychotherapist may question this concept of achieving readiness in consideration of what the child and mother were compelled to give up.

In summary, the literature on weaning has focused upon the factors influencing early cessation of breastfeeding, the duration of breastfeeding in specific countries, and infant feeding practices such as the timing of introducing educational and complementary foods. The term weaning is used to refer to the gradual supplementation process whereby full breastfeeding is completely replaced with complementary foods. However, weaning is also used to identify the progressive phases of this supplementation process and, therefore, clear definitions are required when interpreting results from infant feeding studies. Increased infant susceptibility to pathogens in developing countries due to environmental and cultural factors justifies why extensive research into infant feeding practices has been undertaken in these high-risk areas. Whereas, weaning patterns have been identified in one developed country with first-time mothers (Williams & Morse, 1989), the process undertaken in managing decisions during the cessation of breastfeeding had not been addressed.

The importance of breastfeeding has been supported not only nationally within Australia but globally by the World Health Organisation (WHO) and the United Nations International Children's Emergency Fund (UNICEF) (Lund-Adams & Heywood, 1995; WHO, 1989a, 1989b). To truly support breastfeeding mothers, greater understanding of the later phases of breastfeeding and weaning from the perspective of those people living the experience can offer insight to health professionals of means for improvement in the delivery of appropriate and effective support.

Rationale for the Study Method

The majority of the current knowledge on weaning is based upon quantitative research in developing countries (Al-Mazrou et al., 1994; Chandrasekhar et al., 1990; Dettwyler, 1987; Jackson et al., 1992; Khan, 1990; Lindenberg et al., 1990; Lipski et al., 1994; Rao & Rajpathak, 1992; Singh et al., 1992; Uwaegbute, 1991; Vijayasree & Satya Vani, 1992), where descriptive data have been collected to reveal specific infant feeding and weaning practices. These studies have revealed mothers' strategies and patterns in the introduction and management of complementary foods and fluids. No research was found that specifically explored mothers' perceptions, thoughts, or feelings when making decisions during the later stages of their breastfeeding and weaning experience.

The management of breastfeeding is a significant task for many women as it symbolises womanliness and motherhood (Bottorff, 1990). Perceived success with this experience can contribute to maternal self-esteem and confidence (Rubin, 1984). The meaning assigned to specific events such as breastfeeding and weaning by mothers can influence their perceptions and subsequent actions. This assumption supports the premise of symbolic interactionism, the theoretical framework for the grounded theory method, which suggests that human behaviour toward items or persons is influenced by the meanings attributed to them (Blumer, 1969).

Development of an explanatory theory to further the understanding of a social and psychological phenomenon is the goal of using grounded theory (Chenitz & Swanson, 1986). Glaser (1978) stressed the importance of the grounded theory method for generating theory to account for patterns of behaviour that are relevant to those involved. The process of managing the later stages of breastfeeding, and ultimately, weaning was regarded as being influenced by social and psychological factors. The identification of potential basic social processes is central to the grounded theory method, which was considered to be appropriate for this study. Basic social processes are "processural ... and have two or more clear emergent stages" (Glaser, 1978, p. 97). Proceeding through the final stages of breastfeeding and ultimately weaning a child from the breast suggested that an ongoing process may be occurring during the course of making these decisions.

Qualitative research provides a first level of inquiry focusing upon discovery and is ideal for studying phenomena about which little is known (Appleton, 1995). It involves exploring an event in its natural setting and interpreting the phenomenon in terms of the meaning that people bring to it (Creswell, 1998). Exploratory research can provide intricate details and richness to a phenomenon that are more difficult to determine with quantitative methods (Strauss & Corbin, 1990). The use of methods such as interviewing to ascertain moments and meaning in people's lives was deemed most appropriate in discovering the personal experience of weaning for mothers. The use of interviewing for data collection is used for most qualitative research approaches such as biography, phenomenology, grounded theory, ethnography, or case study. However, the grounded theory method is particularly suitable to explore the weaning process because it allows for use of multiple data sources (Glaser, 1978). Theoretical sampling ensures that data collection is guided by relevant categories arising within the emerging theory. Although the main participants in this study were anticipated to be the mothers who had undergone the process of weaning their children, theoretical sampling encourages the use of other data sources if deemed necessary by ongoing analysis.

The intent of the grounded theory method is in the development of a substantive theory arising from its systematic techniques and procedures of analysis (Creswell, 1998; Strauss & Corbin, 1990). The grounded theory must be built from the ground up, from data collected and analysed in the field. The use of theory from the literature does not occur until the substantive theory is complete and ready to be compared to existing theory (Creswell, 1998). As the existing literature had not addressed the weaning process from the mothers' perspective, it did not offer any theoretical frameworks on which to base this inquiry. As a consequence, the generation of a grounded theory was imperative to generate an explanatory framework for this phenomenon. The strength in developing a substantive grounded theory lies in its potential to provide a theory that offers explanation, a logic of discovery, and expresses that discovery in its unique context (Miller & Fredericks, 1999, p. 538). The following core research question regarding the phenomenon of weaning illustrates application of this explanatory power within the context of this study: what is the theory that explains the process Western Australian mothers use to manage weaning their children from the breast?

To summarise, breastfeeding is a significant event for women as their perceptions of the experience influence personal impressions of competency and success (Mercer & Rerketich, 1995; Rubin, 1984). Breastfeeding is a phenomenon with a beginning and an end. Experiences during every phase of breastfeeding contribute to the resulting overall impression women formulate of their breastfeeding. Moreover, the recency effect reinforces the importance of the later phase of breastfeeding and subsequent weaning due to their increased likelihood of being remembered. Understanding the psychosocial and cultural context of infant feeding decisions is essential if health professionals expect to be truly supportive to women (Dermer, 1998). Traditionally, breastfeeding research has focused upon its initiation and continuation, but a gap in knowledge is evident with regards to the later phases of breastfeeding and subsequent weaning. Women's perceptions of the process they utilise in managing the final stages of breastfeeding and weaning have not been addressed in Australia or internationally. This study uniquely addresses that gap in the existing knowledge by examining this phenomenon using the grounded theory method. Breastfeeding is strongly encouraged and supported in Australia and, consequently, the majority of Australian women commence breastfeeding their infants. Within the context of an established breastfeeding culture, the substantive theory presented in this thesis offers an understanding of the relationships between the major categories impacting upon Western Australian mothers' perceptions and subsequent management of the process of weaning their children from the breast.

Purpose

The purpose of this study was to analyse the maternal process of managing the later stages of established breastfeeding and, ultimately, weaning the child from the breast. A minimum time of six weeks postpartum was considered established breastfeeding as discontinuing breastfeeding prior to this time was not regarded as the weaning process but more an interruption in the development and establishment of breastfeeding. A substantive theory was developed within the Western Australian context to increase understanding of the relationships between categories influencing the maternal experience of the weaning process. This theory makes a significant contribution to the

existing body of knowledge on breastfeeding and infant feeding. The intent of this research was to more fully understand an aspect of the human experience, namely the later stages of breastfeeding and, most importantly, communicate that understanding to the people who affect or are affected by the phenomenon (Ammon-Gaberson & Piantannida, 1988). The discovery of patterns and explanations for decisions surrounding the management of breastfeeding and weaning allowed for the development of a substantive theory grounded in data specific to the Western Australian context. The theory provides insight into this phenomenon to those health professionals attempting to assist breastfeeding mothers by providing client-focused care, but also offers understanding and awareness to women currently engaged in their own breastfeeding and weaning experience.

Research Objectives

The current research study endeavored to meet the following objectives:

- To explore the final phase of breastfeeding and subsequent weaning of a child from the breast from the perspective of Western Australian mothers;
- To discover factors perceived to influence mothers' experiences of weaning;
- To determine the relationship between these factors within the weaning process;
- To develop a substantive theory which explains the shared problem and emerging social processes of mothers' experiences of weaning within the Western Australian context; and
- To add to the existing body of knowledge on infant feeding.

Review of Breastfeeding Literature

Weaning is just one important phase of the total breastfeeding experience. Although the focus of this study was on weaning or the cessation of breastfeeding, the later phase of breastfeeding was also incorporated in the investigation as the discontinuation of breastfeeding involves a process that can evolve over days, weeks, or months. It is difficult to discretely separate where weaning is initiated and the final phase of breastfeeding begins. Decisions made in managing breastfeeding can ultimately influence the weaning process. The following account of recent international

breastfeeding literature is presented to clarify current knowledge about this decision-making process and the extent to which the total breastfeeding experience influences weaning decisions.

The discussion of breastfeeding is structured in terms of the dominant themes arising from the literature: benefits of breast milk and dissemination of this information to the public, factors affecting breastfeeding initiation and prevalence, women's subjective experiences with ongoing breastfeeding, and the effectiveness of support and intervention strategies in promoting continued breastfeeding.

Benefits of Breast Milk

Ongoing research continues to demonstrate the advantages of breast milk compared to commercially prepared formulas for nutritional, immunological, allergic, cognitive, and economic benefits (Becker, 1998; Halken, Jacobsen, Host & Holmenlund, 1995; Kunz, Rodriguez-Palmero, Koletzko & Jense, 1999; Meremikwu, Asindi & Anti-Obong, 1997; Scariati, Grummer-Strawn & Fein, 1997). The findings from such research have been widely communicated in lay literature such as newspapers, parenting books and web sites (Gigacz, 1999a, 1999b; Huggins & Ziedrich, 1994; Mohrbacher & Stock, 1997). Table 1 provides one such example of the dissemination of this information in a local Western Australian newspaper.

Table 1

Benefits of breastfeeding outlined in Western Australian newspaper

("Breastfeeding", 1999, p. 15)

Benefits for mum:	Benefits for baby:
<ul style="list-style-type: none"> • Helps protect against breast and ovarian cancer • Convenient, no preparation required • Can be used as a contraceptive method in the early stages if feeding night and day • Cost effective • Promotes rest • Aids towards weight loss 	<ul style="list-style-type: none"> • Protects from illness due to antibody transfer from mum • Reduces the incidence of infantile diabetes and other disease • Aids in the development of the senses • Helps reduce the occurrence of allergies • Helps reduce the occurrence of chest infections

These messages have clearly been reaching women who acknowledged that breast milk was healthier and better for infants no matter what feeding method they chose for their children (Alexy & Martin, 1994; Dix, 1991). At the same time, as well as acknowledging the superiority of breast milk, the focus of research has been broadened to examine potential risks associated with formula feeding. Increased morbidity and mortality, learning deficiencies, cardio-respiratory disturbances, allergic manifestations, contaminants, and controversy over the composition of infant formula have been cited as evidence of the harmful effects of formula feeding (Walker, 1993). Although this information was available in the research literature, evidence of a wider dissemination in the Australian lay literature was not noted before 1996 when this study began and was just beginning to emerge in the late 1990's.

Factors Influencing Breastfeeding Initiation and Prevalence

Research into breastfeeding initiation and prevalence has revealed the influence of maternal, infant, and environmental factors on breastfeeding outcomes (Scott & Binns, 1999). Factors such as cultural background, education level, age, socio-economic status, and parity are maternal characteristics that have provided a profile of who commences and continues with their breastfeeding efforts. For example, world-wide research has found that older, well-educated mothers from a higher social class, who are living with a partner are more likely to choose to breastfeed and to continue for longer periods (Lawson & Tulloch, 1995; Piper & Parks, 1996; Quarles, Williams, Hoyle, Brimeyer & Williams, 1995). Lower breastfeeding rates have been noted amongst immigrant women from different cultural backgrounds in Australia (Hitchcock & Coy, 1988). The increasing likelihood of mothers discontinuing breastfeeding due to employment has also been supported in the international literature (Bergh, 1993; Cox & Turnbull, 1994; Earland et al., 1997; Hill, Humenick, Argubright & Aldag, 1997; Roe, Whittington, Fein & Teisl, 1999; Vogel & Mitchell, 1998). Furthermore, although first-time American mothers are more likely to initiate breastfeeding, experienced mothers tend to breastfeed for longer periods of time (Piper & Parks, 1996).

The experience of breastfeeding for first-time mothers was examined by Cooke (1996) who interviewed 19 Australian mothers with infants less than six months of age. Two

patterns of feeding experience were identified according to the mother's philosophy of being either an idealist or pragmatist. The idealist believed in a strong link between breastfeeding, maternal identity, and self-esteem, whereas this was not the case with the pragmatist. The resulting commitment to breastfeed suggested that strong determination was important for persisting with breastfeeding but, as revealed in Vandiver's (1997) work, this conviction does not indicate inflexibility. Mothers who weaned latest in that American study rated themselves as more flexible caregivers.

Maternal breastfeeding intention has been recognised as an important predictor of actual breastfeeding duration. Lawson and Tulluch (1995) examined the role of prenatal maternal intention and postnatal experiences on breastfeeding duration for 78 first-time Australian mothers. Higher levels of maternal education, an earlier decision to breastfeed, intention to breastfeed longer, and a negative attitude to formula feeding were distinguishing factors for those mothers who breastfed beyond three months. In contrast, recent American research that utilised causal modeling to test the theory of planned behaviour found that the predictive strength of intended duration had limited impact beyond six weeks postpartum (Wambach, 1997). The American study did find that attitudes and perceived behavioural control predicted intention which supported Australian women's statements that personal beliefs, motivation, and determination were important factors influencing breastfeeding continuation (Fetherston, 1995).

Identification of behaviour based variables has resulted in the development of a model to predict variability in breastfeeding intention and duration. Duckett et al. (1998) proposed a theory of planned behaviour based upon a structural model for breastfeeding and compared homemakers and employed mothers using variables such as knowledge, education, beliefs, attitudes, and perceived control to estimate breastfeeding intention and duration. The purpose of that research-based assessment was to provide theoretical guidance for the development and evaluation of future interventions aimed at increasing breastfeeding prevalence.

The impact of the infant on the breastfeeding relationship has been recognised and explored in the literature. Shrago and Bocar (1990) suggested criteria to assist in the evaluation of infant effectiveness in contributing to the breastfeeding dyad. They

argued that this assessment provided a framework for parent education, clearer documentation of feeding behaviours, and early recognition and treatment of problems. In another study by Lothian (1995), five American families were followed before and after the birth of their first infant to determine what influenced women to continue breastfeeding. The core category that emerged from the data to explain breastfeeding duration was the 'presence of infant satisfaction' associated with competent sucking, easiness of personality, and stamina or perseverance. A more recent American study supported these past findings with data from mothers' self-reported perceptions confirming that infants' easy temperaments facilitated longer breastfeeding duration (Vandiver, 1997).

Women's Subjective Experiences of Breastfeeding

The role of women's attitudes toward decisions on infant feeding has become increasingly recognised (Losch, Dungy, Russell & Dusdieker, 1995). In the past, health professionals consistently used the criteria of breastfeeding duration and infant growth to define success with breastfeeding whereas the social sciences and lay literature considered maternal subjective experiences as an important criteria (Harrison, Morse & Prowse, 1985). Recent health research has begun focusing upon women's subjective experiences of their ongoing breastfeeding as well as aspects such as long-term breastfeeding beyond 12 months, breast milk expression, and the let-down reflex. Scholarly debates have also been presented in the literature regarding psychological issues recognising maternal perceptions of breastfeeding failure and intimacy issues for breastfeeding women.

Women's perceptions of success with breastfeeding have recently been examined in two studies that highlighted differences between the perspectives of mothers and health professionals. Researchers asked American mothers to describe a recent breastfeeding experience from initiation to weaning (Leff, Gagne & Jefferis, 1994). In that study, 26 mothers were interviewed and a constant comparative analysis revealed five categories of successful breastfeeding: 'infant health', 'infant satisfaction', 'maternal enjoyment', 'desired maternal role attainment', and 'lifestyle compatibility'. 'Working in harmony' emerged as the core concept. The five categories identified in the American study were consistent with the findings of a Western Australian study that identified four major

themes within mothers' perception of breastfeeding success: 'giving', 'persistence', 'meeting expectations', and 'accomplishing personal goals' (Hauck & Reinbold, 1996). In that study, telephone interviews were conducted with 183 Western Australian women and additional in-depth interviews were carried out with 19 of these mothers to identify their criteria for successful breastfeeding. The one distinction between these two studies' findings was that of lifestyle compatibility identified in the American study that may reflect different cultural expectations. The Western Australian mothers tended to adjust their lifestyle to be compatible with breastfeeding, whereas the American mothers in Leff et al.'s (1994) study assessed success by how breastfeeding fitted with their desired lifestyle.

In another study, 35 focus groups were conducted with low-income women in America to discover their views on factors that attract and deter women from breastfeeding (Bryant, 1993). Women revealed how breastfeeding benefits were consistent with their goals for mothering by protecting their children from disease and allowing the unique opportunity to establish a special bond with their children. Conversely, women also shared the following perceived barriers to breastfeeding: lack of confidence in their ability to breastfeed; possible embarrassment when breastfeeding in front of others; loss of freedom to work or attend social activities; the necessity to change dietary or health practices; and the negative influence of family and friends.

A phenomenological approach was used by Bottorff (1990) to examine the meaning of persisting with breastfeeding as not all mothers experience the trouble-free experience they may anticipate. Interviews with Canadian women highlighted that ceasing breastfeeding meant more than the withdrawal of milk or a change of diet. Choosing a time to stop involved letting go, which was accompanied by sadness for some women in the realisation that their children were growing up. Other themes described by women were satisfaction in acknowledgment of their persistence, as well as relief in the experience being over.

The experience of long-term breastfeeding from the woman's viewpoint has also been explored. An American study by Hills-Bonczyk et al. (1994) was conducted to describe the experiences of 82 first-time mothers who breastfed for longer than 12 months.

Factors associated with longer duration were determined, such as increasing maternal age, higher education levels, and more weeks of exclusive breastfeeding. In addition, three major themes emerged during the telephone interviews: the importance of being strong in the face of social unacceptability, the significance of the mother-child bond that developed, and the perception that long-term breastfeeding was natural.

Another American study (Wrigley & Hutchinson, 1990) utilised the grounded theory approach to examine the experience of long-term breastfeeding. Twelve mothers who had breastfed for longer than 12 months were interviewed. Two key processes emerged, 'synchronisation' and 'reorientation', to explain mothers' feelings and behaviours during their breastfeeding experience. 'Synchronisation' involved the mother moving in pace with her infant while 'reorientation' encompassed the lifestyle changes undertaken to address the infant's needs. In addition, participants shared strategies they developed to keep breastfeeding a secret and hidden from people other than the immediate family.

The consequences of long-term breastfeeding were examined in an American study with 179 women recruited from La Leche League (LLL) conferences (Kendall-Tackett & Sugarman, 1995). Long-term breastfeeding in that study involved continued breastfeeding past six months, which was significantly less than previous definitions of long-term. Data were obtained predominantly from a closed-ended self-administered questionnaire, although some qualitative information was collected from supplementary letters that mothers included with their questionnaires. Social stigma was cited most frequently as a negative consequence of long-term breastfeeding and participants noted how this stigma increased as the age of the breastfeeding child increased. Social coercion to wean appeared as early as six months postpartum. Mother-to-mother support from other LLL members, spousal support, and maternal confidence acted as buffers against the negative response of others, mainly relatives and strangers. Kendall-Tackett and Sugarman (1995) commented how women were reluctant to reveal that they were long-term breastfeeders and awareness of this secretiveness was considered when seeking participants.

The issue of secrecy with long-term breastfeeding was also found in a Canadian study in which 30 mothers were interviewed (Morse & Harrison, 1987). The study noted the

social coercion mothers felt in relation to the timing of their weaning. The researchers argued that the occurrence of closet nursing indicates that breastfeeding duration is influenced by social and cultural norms. The withdrawal of support by partners, parents, and friends accelerated as the child grew older and encouraged mothers to wean.

Concurrently, this same Canadian study, discussed above, also investigated the phenomenon of minimal breastfeeding where the child was offered the breast once or twice daily to maintain breastfeeding over a longer term (Morse, Harrison & Prowse, 1986). Taped telephone interviews were conducted with 30 mothers to determine their reasons for this breastfeeding pattern. The reasons cited included the convenience due to working, fostering of a slow weaning process, and the opportunity to provide continued comfort for the infant. Once infants were weaned, mothers in that study felt a completion rather than the regret that can occur with forced weaning, where weaning occurs in opposition to the infant's wishes.

Another Canadian grounded theory study examined the emotional experience of breast milk expression (Morse & Bottorff, 1992). Research findings suggested that expressing had different meaning to individual mothers. Women who perceived expressing as mechanical and messy shared feelings of embarrassment and awkwardness. These mothers avoided expressing and chose to totally breastfeed or used supplementary formula feeds. Women who were able to express breast milk easily had a more relaxed attitude. Being able to express breast milk increased their confidence in breastfeeding and also offered freedom. A model to illustrate breast milk expression was developed comparing the process of success and failure with expressing. Four major categories were extracted from the data by Morse and Bottorff (1992) to facilitate the development of this model: 'acquiring the skill', 'justifying one's choice', 'tolerating the objectionable', and 'expressing successfully'.

The subjective experience of breastfeeding women has also been debated in scholarly papers in the literature. Intimacy arising from the experience of breastfeeding women has been the topic of one such paper (Dignam, 1995). It was suggested that research had focused upon the impact of emotional support for breastfeeding women, but had not

addressed the dynamics of intimacy other than through a physical or sexual dimension. Dignam (1995) argued that research in intimacy is necessary to gain an understanding into the psychosocial dynamics of breastfeeding. Psychological etiologies of breastfeeding have also been discussed in another more recent paper by Williams (1997) who asserted that, for most women, breastfeeding resided somewhere between idyllic dreams and dreaded nightmares. She argued that mothers' experiences tended to be evaluated by the author's measures of success. In her discussion of three individual case studies, Williams (1997) stressed the importance of exploring psychological etiology and using appropriate referrals when dealing with distressed breastfeeding women.

Breastfeeding Support

The provision of support from formal sources, such as health professionals, has identified strategies recognised as effective in the promotion of breastfeeding. For example, factors such as encouraging mother-infant contact in the immediate postpartum period have been associated with improved breastfeeding duration (Lawson & Tulloch, 1995). Assumptions that caesarean births interfered with mother-infant contact and breastfeeding initiation were also found to exist in another study; however, once breastfeeding was initiated, no differences were noted between birthing method and breastfeeding duration (Kearney, Cronenwett & Reinhardt, 1990). Hospital practices such as encouraging rooming-in and demand feeding were found to facilitate mother-infant contact and, therefore, increase the likelihood of breastfeeding success. Other practices such as introducing formula supplementation have been associated with early cessation of breastfeeding (Coreil & Murphy, 1988). Strategies such as promoting breastfeeding immediately after birth, not offering pacifiers or supplemental feeds of any kind, and encouraging rooming-in and demand feeding constitute five of the ten steps to successful breastfeeding advocated by the World Health Organisation (WHO) and the United Nations International Children's Emergency Fund (UNICEF) in their International Baby Friendly Initiative (WHO, 1989a).

Numerous research studies have investigated the effectiveness and timing of implementing supportive educational interventions with different populations of breastfeeding women (Arlotti, Cottrell, Lee & Curtin, 1998; Grossman, Harter, Sachs &

Kay, 1990; Hauck & Dimmock, 1994; Kistin, Abramson & Dublin, 1994; Pugh & Milligan, 1998; Redman, Watkins, Evans & Lloyd, 1995). Postpartum intervention strategies have included individual and group teaching sessions, telephone follow-up, contact and/or home visits with lactation consultants and peer counselors, and educational resources such as information booklets. Findings have varied in relation to their effectiveness in increasing breastfeeding prevalence but all confirmed recognition that breastfeeding women require ongoing culturally sensitive community support to successfully sustain their breastfeeding efforts beyond the hospital setting (Abramson, 1992).

The information and support given by health professionals has been the topic of a number of research studies where doubts have been raised regarding the adequacy of information and the consequent support given to breastfeeding women. The knowledge and attitude of health professionals has been found to influence the type of support they are able to offer breastfeeding women (Humenick, Hill & Spielberg, 1998; Lowe, 1990). Health professionals were found to be more knowledgeable about the benefits of breastfeeding for infants without acknowledging the mothers' perspective (Bagwell, Kendrick, Stitt & Leeper, 1993). This evidence suggested that professional breastfeeding education programs must re-examine their tendency to focus upon child health issues while excluding maternal issues. Findings from another study revealed that professionals' personal breastfeeding experience contributed to positive beliefs and those with negative beliefs were more likely to advocate weaning before nine months of age (Barnett, Sienkiewicz & Roholt, 1995). To demonstrate, the impact of personal experience in contributing to bias in health professionals was further illustrated in an article by a Scottish general practitioner advising her medical colleagues that breastfeeding does not always work, based upon illustrative comments from her own breastfeeding difficulties (Bennison, 1997).

Pediatricians-in-training have been found to have extremely limited knowledge of breastfeeding management (Williams & Hammer, 1995). Moreover, physicians are said to be more likely to recommend formula for a breastfed infant than nurses or nutritionists (Lazzaro, Anderson & Auld, 1995; Raj & Plichta, 1998). Lactation consultants, another professional group who support breastfeeding women, have been

found to give significantly more breastfeeding encouragement than nurses or physicians (Humenick et al., 1998). Conclusions regarding health professionals' knowledge and support behaviours in other countries were difficult to transfer across the world as roles and educational preparation differ. For example, the roles of Australian midwives and child health nurses are distinct from American maternity nurses or community health nurses, and therefore, direct comparisons are inappropriate.

Differences in profession, work environment, and personal breastfeeding experience were found to influence the beliefs, knowledge level, and consequent support given by health professionals (Barnett et al., 1995). Findings from an Australian study of health professionals' attitudes and knowledge toward breastfeeding reinforced the influence of personal experience, as female health professionals with a positive experience scored higher in the study questionnaire than non-breastfeeders or those with a negative experience (Lowe, 1990). A decline in relevant breastfeeding knowledge was also noted for all health professionals with advancing age and years since educational preparation. Reflection upon these findings has reinforced the need for consistent, comprehensive breastfeeding education for all health professionals working with breastfeeding mothers.

Recognition of the importance of ongoing formal support beyond hospitalisation has expanded to acknowledge informal social support networks such as partners, extended family members, and friends. Approval for breastfeeding decisions from the father of the child has been found to be an important factor influencing women's breastfeeding practices (Freed, Fraley & Schanler, 1993; Littman, Medendorp & Goldfarb, 1994; Raj & Plichta, 1998; Sharma & Petosa, 1997; Wylie & Verber, 1994). Social support from family members, such as the woman's mother and friends, was said to impact women's breastfeeding decisions (Hills-Bonczyk et al., 1993; Isabella & Isabella, 1994; Lipsky et al., 1994; Losch et al., 1995). The perceived quality of informal and formal support in the form of emotional, tangible, and educational matters has also been suggested to influence breastfeeding duration (Raj & Plischta, 1998).

Breastfeeding in the Australian Context

Current trends in breastfeeding in Australia, and particularly Western Australia, are noteworthy in relation to the social context of this current study. Breastfeeding has been strongly encouraged throughout Australia and new mothers are expected to breastfeed (Lund-Adams & Heywood, 1995). The federal government has established Australian targets for the year 2000 that aim to increase breastfeeding initiation rates to 90 percent and prevalence rates at six months to 80 percent (Nutbeam, Wise, Bauman, Harris & Leeder, 1993). The advent of breastfeeding immediately after the birth, demand feeding, rooming-in, and reduction in complementary formula feeding have become common practices in many Australian hospitals. Although these initiatives have become routine within hospitals, Lund-Adams and Heywood (1996) suggested that the decline in rates in the 1980's and current trends indicate that these national targets for the year 2000 may be unattainable.

Australia has made concerted efforts to support the World Health Organisation's (WHO) statements to protect breastfeeding aimed at ensuring the proper use of breast milk substitutes (WHO, 1981) and guiding health professionals with ten steps to follow in their promotion of successful breastfeeding (WHO, 1989a). The Baby Friendly Hospital Initiative launched in 1991 was adopted by organisations such as the Australian College of Midwives Inc. (ACMI) to encourage the implementation of these ten steps within health care facilities (ACMI, 1992). To date, however, only 11 Australian hospitals have been accredited as being Baby Friendly (McVeagh, 1999). As stated by McVeagh (1999) formula companies have signed the Marketing in Australia of Infant Formula (MAIF) Agreement and provision has been made for complaints of breaches to be submitted to the MAIF Advisory Panel. Although government priorities had not allowed for formal monitoring of the WHO code, informal monitoring had occurred by groups such as the Nursing Mothers Association of Australia (NMAA), the Australian Lactation Consultants Association (ALCA), the Australian Consumers' Association, and concerned members of the public (Lund-Adams & Heywood, 1995, p. 103).

The Nursing Mothers' Association of Australia (NMAA) has been a significant support for Australian women since 1964 when Mary Paton and five other women founded the

association (Paton, 1997). The NMAA is one of the largest non-profit self-help groups in Australia and is dedicated to the promotion and protection of breastfeeding. Its primary aim has been the provision of mother-to-mother support to breastfeeding women (Gigacz, 1999c). NMAA offers the services of voluntary breastfeeding counsellors predominantly experienced mothers who have undertaken appropriate training. The association receives approximately 50,000 counselling telephone inquiries per year. Paton claimed that “after 33 years of close involvement and observation, NMAA has been responsible for the resurgence and interest in breastfeeding in Australia” (Paton, 1997, p. 163). She further asserted that NMAA has been a catalyst behind the change in Australian attitudes towards breastfeeding over recent years.

Western Australian breastfeeding initiation rates have been higher than the national rates in the past two decades. The 1983 national survey found that up to 95 percent of Western Australian women were breastfeeding on discharge from hospital compared to the national average of 85 percent (Lund-Adams & Heywood, 1995). A more recent survey indicated that, although breastfeeding rates had been declining in other states, 83.8 percent of Perth mothers still initiated breastfeeding during hospitalisation (Scott, Binns & Aroni, 1996). These rates had also remained stable for the previous nine years.

The Western Australian Child Health survey (1995) found that the breastfeeding duration most often (26%) reported was up to three months after the birth. Two periods were reported equally as the second most frequent (20%); these periods were three to six months and greater than 12 months. These results are supported by Scott, Aitkin, Binns and Aroni’s (1999) study that also found 61.8 percent of women breastfeeding at three months then decreased to 49.9 percent at six months. These findings of breastfeeding prevalence rates are concerning given that breastfeeding has been promoted for a minimum of four to six months. Further research by Bailey and Sherriff (1992) was conducted to determine maternal reasons for stopping breastfeeding before three months. In that study, 45 Perth mothers were given a self-administered questionnaire and two problems, not enough milk (45%) and sore nipples (35.6%), were mentioned most often. These findings are supported by other Australian and international studies that cited maternal perceptions of insufficient milk supply and sore or painful nipples as common problems that were ultimately stated as reasons why women weaned their child

from the breast (Bick et al., 1998; Ellis, Livingstone & Hewat, 1993; Hauck, 1992; Lowe, 1994; Lund-Adams & Heywood, 1995).

In summary, recognition that human breast milk provides superior nutrition for the infant combined with stable and/or declining initiation rates and low prevalence rates have resulted in ongoing research to identify factors in the effective promotion of breastfeeding. Factors have been examined to provide a profile of those women who are more likely to commence and continue breastfeeding. The importance of both formal and informal support networks for breastfeeding women have been investigated as well as their impact upon breastfeeding success. Breastfeeding research focusing upon mothers' perspective have explored their criteria for success, the concept of persistence in the continuation of breastfeeding, the emotional meaning of breast milk expression, and the experience of longer term breastfeeding. As previously noted the process of weaning the child from the breast from the mother's perspective, regardless of the breastfeeding duration, had not been examined until this present study was conducted.

Definition of Terms

Breast expression: Breast expression involves manual expression or the use of a breast pump to remove breast milk from the breasts for the purpose of relieving engorgement or to store breast milk for future use. The expressed breast milk can then be given to the infant in a bottle.

Complementary feeding: A complementary feeding is given immediately after a breastfeed if there is concern that the infant is not receiving enough breast milk and does not settle.

Demand feeding: Demand feeding involves offering infants breast milk whenever they are hungry and indicate they want to be fed.

Lactation: Lactation is a physiological process of synthesis and secretion of breast milk. The establishment of lactation, where the mother's body becomes attuned to the process of milk production, occurs during the puerperium. It is during this six week period following the birth referred to as the puerperium that anatomical

and physiological changes allow the woman to adjust to her new roles in motherhood (Mosby's Dictionary, 1994, p. 1303).

Let-down reflex: The let-down reflex refers to the “sensation in the breast of lactating women that occurs as the milk flows into the ducts. It may occur when the infant begins to suck or when the mother hears the baby cry or even thinks of nursing the child” (Mosby's Dictionary, 1994, p. 902).

Parity: Parity refers to the number of live children a woman has produced (Pillitteri, 1995, p. 1829). For example, the term *para 0* can be used to refer to a woman who is currently pregnant but has not produced a live infant yet. The term *para 2* denotes a woman who has given birth to two live children.

Prenatal: The term natal refers to the birth and therefore prefixes such as ‘pre’ as in prenatal or ‘post’ as in postnatal differentiate the period before or after the birth of the child.

Postpartum: The postpartum period is used to identify time since the birth of the child. For example, a mother who is three months postpartum gave birth three months earlier. The terms postnatal and postpartum are often used interchangeably.

Rooming-in: The practice of rooming-in involves having the infant remain with the mother at her bedside on a 24 hour basis during the duration of her postpartum hospital stay (Scott & Binns, 1999, p. 9).

Supplementary feeding: Supplementation involves the replacement of a breastfeed with another food source such as a bottle of formula or solid food.

Weaning: Weaning is regarded as the process that begins when the mother and/or the child decides to stop breastfeeding (NMAA, 1985). The child gradually receives fewer breastfeeds until he/she is completely nourished by other foods and drinks. The process can occur over days, weeks, or months.

Overview of the Thesis

This thesis is presented in six chapters. Chapter One provides a background to the study and brief rationale for the study method. The purpose, research objectives, and review of relevant breastfeeding literature are discussed. Breastfeeding within Australia and Western Australia are also presented to clarify the social and cultural context of this exploration into weaning. Chapter Two addresses the methodology by discussing the nature of qualitative research, the theory of symbolic interactionism, and the features of the grounded theory method such as theoretical sensitivity, theoretical sampling, constant comparison, coding, and the use of the literature and memos. Additionally, Chapter Two outlines the methods used to conduct this grounded theory research study by describing the procedures used in sampling, data collection, data analysis, memoing, and diagramming. Issues relating to validity, reliability, ethical considerations, and limitations are also presented in Chapter Two. Chapter Three addresses the common basic social problem experienced by all participants, *incompatible expectations*. Expectations emerged from the data and revealed the link between mothering, breastfeeding, and weaning. This key aspect is discussed in Chapter Three. Factors that influenced participants' expectations are also presented in this chapter. Chapter Four discusses the consequences of *incompatible expectations* upon the participants and the factors that influenced these consequences. Chapter Five presents the basic social process of *constructing compatibility by adapting focus* that all participants adopted in response to the problem of *incompatible expectations*. Chapter Six compares the theory of the management of breastfeeding and weaning from the mothers' perspective titled *constructing compatibility by adapting focus* with existing literature. Implications and recommendations of this study are also presented in this final chapter.

CHAPTER TWO

Methodology

Introduction

If I go out into nature, into the unknown, to the fringes of knowledge, everything seems mixed up and contradictory, illogical, and incoherent. This is what research does; it smoothes out contradiction and makes things simple, logical, and coherent (Szent-Gyorgyi, 1980 cited in Morse, 1994a, p. 1).

This chapter outlines the rationale for using a qualitative approach and specifically the grounded theory method to explore the phenomenon of weaning from the perspective of mothers. For this purpose, a brief discussion of the nature of qualitative research is presented which includes its philosophical dimensions. Symbolic interactionism, the theoretical framework for the grounded theory method, is reviewed. A general overview of grounded theory is outlined along with information on the following key features within that method: theoretical sensitivity, theoretical sampling, constant comparison, coding, and the use of literature and memos.

The remainder of the chapter outlines the methods used to conduct this grounded theory research study. An overview of the procedures, including sampling strategies, data collection, and use of an interview guide is presented. In addition, a profile of all participants is provided. The process of data analysis is reviewed as the constant comparison of data occurred through a progression of coding levels. The use of memos and diagramming is discussed and issues such as validity, reliability, ethical considerations, and limitations specific to this study are addressed. Finally, an overview of the findings is presented as an introduction to the findings chapters.

Qualitative Research

The purpose of research is to apply scientific inquiry to phenomena of interest. Research contributes to the development of knowledge through the use of discovering, confirming, refuting, predicting, controlling, and refining capabilities (Morse & Field, 1995). Qualitative research arose in the social sciences as a means of exploring human

phenomena not available through traditional quantitative methods (Streubert & Carpenter, 1995). Quantitative and qualitative research both seek to provide theory as an outcome. The levels of inquiry and designs for research follow a continuum from the exploratory aspects (where little is known of the phenomenon), to the experimental aspects (where hypotheses relating to phenomena are tested). The emphasis of qualitative research is to construct a theory through exploration and discovery rather than test hypotheses of existing theory as would be appropriate for quantitative research (Morse & Field, 1995). However, theories need re-evaluating and nuances or exceptions often lead the way to alternative or evolving ways of viewing phenomena (Munhall, 1993, p. 60). Munhall (1993) promoted the use of a qualitative-quantitative cyclical continuum to represent our dynamic and changing world.

The aim of qualitative research, in particular, is to describe and explain a pattern of relationships through conceptual analysis of selected categories (Denzin & Lincoln, 1994; Munhall, 1993). Qualitative research provides a first level of inquiry that focuses upon methods of discovery where little is known about specific phenomena (Appleton, 1995), which was the case with the phenomenon of weaning in this current study. If researchers can not find adequate information to formulate a theory about phenomena, attempting to create and test such a theory would be futile (Morse & Field, 1995). Qualitative research can provide benefits such as instrumentation, illustration, sensitisation, and conceptualisation (Oiler-Boyd, 1993). For example, data obtained from participants can be used to construct an accurate instrument that reflects actual experience rather than an imagined one.

Qualitative research has been defined as “multi-method in focus, involving an interpretive, naturalistic approach to its subject matter” (Denzin & Lincoln, 1994, p. 2). Creswell (1998) referred to qualitative research as “an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social problem” (p. 15). Interpretive knowledge is noted to be sensitive to historical, temporal, cultural, and subjective conditions (Benoliel, 1996). Definitions of qualitative research seek to clarify the purpose and scope of these diverse methods of inquiry. The term qualitative inquiry encompasses a range of research methods such as biography, phenomenology,

grounded theory, ethnography, discourse analysis, thematic analysis, and case study designs.

Qualitative research has distinctive characteristics different from quantitative research that guide its focus and provide the rationale for choosing a qualitative method for particular research questions. The importance of studying a phenomenon in its natural setting to provide the best source of data is one such characteristic of qualitative inquiry (Creswell, 1998). In addition to using natural settings, commitment to the participants' point of view and concern in not disturbing the context of the phenomenon studied are also important features (Streubert & Carpenter, 1995). Creswell (1998, p. 16) presented further attributes of qualitative research to be considered when choosing a qualitative research method:

- the researcher is a key instrument of data collection;
- data can be a collection of words or pictures;
- the outcome of the research is a process rather than a product;
- data analysis is inductive and assumes that regularities can be discovered in the social world (Huberman & Miles, 1994, p. 431);
- the meaning of participants' experiences or the way they make sense of them remains the focus (Oiler- Boyd, 1993, p. 74); and
- expressive language is encouraged.

Qualitative researchers are guided by their worldview or paradigm (Annells, 1996; Creswell, 1998). It is the philosophical stance of researchers' beliefs that guide their actions (Denzin & Lincoln, 1994). This worldview provides the basis of the researcher's epistemological, ontological, and methodological premises (Denzin & Lincoln, 1994, p. 13). The formation of a research question and choice of corresponding method is dependent upon the philosophical beliefs of the researcher. An appropriate fit or match must be found between the philosophical basis of the chosen method and the inquiry paradigm of the researcher (Annells, 1996). A qualitative researcher relies on the views of participants acknowledging that it is their interpreted experience that constitutes reality (Oiler-Boyd, 1993). Finally, participants' views are faithfully presented by the researcher in context and developed inductively,

commencing from the particular and evolving to a higher level of abstraction (Creswell, 1998).

Qualitative studies are often discussed in terms of their analytic induction. Qualitative designs are analytic, and involve a process of data reduction, an essential feature of data analysis (Denzin & Lincoln, 1994). Inductive reasoning involves the formulation of theory or explanation based upon data and therefore moves from the specific to the general (Brockopp & Hastings-Tolsma, 1995). In contrast, deductive reasoning moves from the general to the specific, whereby a theory is used to examine and provide direction to data analysis. Deductive reasoning is more common in quantitative methods of inquiry, although the grounded theory method is one qualitative approach that uses both inductive and deductive reasoning (Strauss, 1987).

Philosophical Dimensions of Qualitative Research

Studies of human phenomena have been based upon descriptive modes of inquiry searching for the discovery of truth (Streubert & Carpenter, 1995). However, there is lack of agreement in the definition of truth and its composition. The positivist viewpoint asserts that objective accounts of the world can be derived as in a quantitative outcome (Denzin & Lincoln, 1994, p. 15). At the same time, reality is not always objective, reducible, quantifiable, or replicable and qualitative inquiry offers to provide answers to questions that focus on the creation and meaning of social experience. Qualitative researchers accept the concept of subjectivity, recognising that humans are not completely objective. Life is situated in reality and therefore constructed by subjective experiences and meaning. Consequently, truth must be sought through social interaction (Streubert & Carpenter, 1995).

Ontology seeks the nature of reality and addresses the question: when is something real? (Creswell, 1998, p. 254). Nature and the social world are recognised as having differing realities (Annells, 1996). Thus, Creswell (1998) asserted that reality was not “out there”, but actually in the minds of its participants. As far back as the 1960’s the generation of nursing knowledge had a basis in grounded theory. However, it was in the 1980’s that a shift to acknowledge multiple realities and new criteria for examining the meaning of truth began in the human sciences (Benoliel, 1996). The grounded theory

method, as one example of qualitative research, was based upon the assumption that knowledge changes over time and that context or accompanying conditions influence social psychological processes (Benoliel, 1996). This subjective ontological position asserted that reality was multiple, constructed, holistic, and bound by propositions based on time and context (Streubert & Carpenter, 1995). Although inquiry into multiple realities can not always provide outcomes of prediction and control, an important and beneficial level of understanding can still be achieved (Oiler-Boyd, 1993). This resulting understanding of reality must be embedded within the current social and cultural context of participants' realities.

Epistemology addresses the nature of the relationship between the knower or participant and would-be-knower or the researcher and what can be known (Guba & Lincoln, 1994, p. 108). Rather than distance being encouraged between knower and would-be-knower during the research process, qualitative researchers develop a recognised closeness due to time in the natural setting, collaboration with participants, and the impact of being involved in the research as an instrument of data collection (Creswell, 1998). Therefore, both parties are involved in a transactional process that is interactive and inseparable (Guba & Lincoln, 1994). Constructivist or interpretivist thinking, in contrast to positivist thought, supports this assumption that knowledge can be created in interaction between the investigator and study participant.

Aesthetic knowing, regarded as the art of nursing, provides a framework for the exploration of qualitative research within the discipline of nursing (Streubert & Carpenter, 1995). Aesthetic knowing is one of four ways of knowing in nursing proposed by Carper (1978 cited in Streubert & Carpenter, 1995), which partners three additional ways of knowing, namely empirical, personal, and ethical knowing. In nursing, the purpose of discovering patterns and explanation of phenomena through qualitative research provide the insight and understanding necessary to deliver client-focused care, in other words the provision of theory to guide practice.

Symbolic Interactionism

The use of theory in qualitative research has been a topic of debate (Mitchell & Cody, 1993; Sandelowski, 1993a). Theory use within qualitative research can provide a

comparative context or an organisational framework for either the interpretation of data or the representation of data after the initial analysis (Sandelowski, 1993a; Streubert & Carpenter, 1995). The purpose of the grounded theory method is to generate a substantive theory regarding the phenomenon under study, and therefore, comparison of the newly created theory with existing theory occurs toward the end of the research process (Creswell, 1998). However, the grounded theory method is guided by its philosophical foundations within the symbolic interactionist theory.

Symbolic interaction, developed by two sociologists, George Mead and Herbert Blumer, provides the theoretical framework for the grounded theory method (Hutchinson, 1993). Blumer further contributed to the symbolic interactionist approach while acknowledging the earlier work of George Mead who established its foundations (Blumer, 1969). Symbolic interaction focuses upon the meaning that people put upon events in their everyday life. It addresses how people choose to define those events and how these personal definitions impact upon their actions (Blumer, 1969; Chenitz & Swanson, 1986).

Blumer (1969) asserted three important premises in his presentation of symbolic interactionism. Firstly, how humans act toward objects depends upon the meanings given to those objects. Objects can apply to a diverse number of events, for example: physical items such as jewelry; other people and their behaviours such as family members and their expectations; institutions such as a government; particular beliefs such as honesty; and situations encountered in daily life. Secondly, the meanings derived from the above objects or events arise out of social interaction with others. Communication is symbolic. Humans communicate through language further creating and modifying these symbols (Schwandt, 1994, p. 124). Finally, resulting meanings are managed through an interpretative process that the person undergoes when encountering these objects or events. Personal definitions arise from social interaction with others and involve an ongoing interpretative process where meanings can be modified and further evolved (Blumer, 1969).

Blumer and Mead's representation of symbolic interactionism views people as purposive, thinking, self-reflexive agents who interpret their world when deciding how

to respond to what they are confronted with (Blumer, 1969; Schwandt, 1994). Blumer (1969) asserted that:

Symbolic interactionism requires that the inquirer actively enter the worlds of people being studied in order to see that situation as it is seen by the actor, observing what the actor takes into account, [and] observing how he interprets what is taken into account (p. 56).

In consideration of the theory of symbolic interactionism, the researcher attempted to construct social reality as seen from participants' perspectives while exploring the process of weaning. The investigator entered the research process without a "preformed theory" as suggested by Stern (1994) and used questioning and observation directed by propositions that emerged from the identified social reality of the participants. Strauss (1987) discussed the use of generative questions as being essential to the work of data analysis whereby distinctions and comparisons are used to identify possible concepts and their relationships.

Grounded Theory Method

The nature of the problem and existing knowledge of the phenomenon must be carefully considered when selecting a research method (Morse & Field, 1995). "The purpose of the research design is to provide a plan for answering the research question" (Brink & Wood, 1994, p. 100). As a result, the research method selected for this study was based upon its suitability in answering the research question: What is the maternal process of weaning a child from the breast? The grounded theory method was chosen as being the most appropriate qualitative research method for this question. The purpose of grounded theory is to produce an explanatory theory that will further the understanding of a social and psychological phenomenon (Chenitz & Swanson, 1986). The process of managing breastfeeding and specifically weaning was regarded as a social and psychological event and as such, the grounded theory approach was judged to be the ideal method to explore this phenomenon.

The grounded theory method, developed by two American sociologists Barney Glaser and Anselm Strauss in the 1960s, seeks not only to describe but to explain the basic social processes, phases, and properties of the phenomenon under study (Glaser & Strauss, 1967; Strauss & Corbin 1990; Wilson & Hutchinson, 1991). The aim of using

the grounded theory method is to develop theory based upon data that is systematically gathered and analysed (Strauss & Corbin, 1994). The method of theory development is from the “ground up” which uses the emerging data from participants to generate a substantive theory. Grounded data from the field are obtained from the actions, interactions, and social process of people directly involved with the phenomenon of interest (Creswell, 1998). The resultant theory must be relevant to the social environment from which it emerged. It is the emphasis upon theory development that differentiates grounded theory from other qualitative research methods.

The grounded theory method “uses a systematic set of procedures to develop an inductively derived grounded theory about a phenomenon” (Strauss & Corbin, 1990, p. 24). The systematic techniques allow for the development of a substantive theory that addresses issues of significance, theory-observation compatibility, generalisability, reproducibility, precision, rigour, and verification.

Grounded theory can be utilised to generate substantive or general theory. A substantive theory is grounded in one particular empirical area of inquiry (Glaser & Strauss, 1967; Streubert & Carpenter, 1995), such as becoming the mother of a preterm baby (Brady-Fryer, 1994) or the process of infertility for women (Harris, 1994). In contrast, a general theory is developed for a conceptual area of inquiry (Glaser & Strauss, 1967). General theories often begin with a substantive theory that is further elaborated into a general theory by further comparative analysis with other substantive theories within related phenomena (Strauss, 1995). Examples of such general theories are ‘uncertain motherhood’ and the process of negotiating the risks of the childbearing years (Marck, Field & Bergum, 1994), ‘truthful self-nurturing’ as women’s process of addiction and recovery (Kearney, 1998) and ‘negotiating with helping systems’ the study of women’s caring (Wuest, 2000). The purpose of this current study was to develop a substantive theory for the maternal process of weaning a child from a breast within the Western Australian social and cultural context.

Researchers using the grounded theory method assume that participants undergoing a particular phenomenon share a specific social psychological problem that may not be clearly articulated (Hutchinson, 1993). The following quote by Alberta Szent-Gyorgy

and cited by Morse and Field (1995, p. 1) reinforces this assumption of qualitative research being able to contribute to knowledge in this manner: “research is to see what everybody has seen and to think what nobody has thought”. The production of a substantive grounded theory can assist the “man in the know ... to start to transcend his finite grasp of things” (Glaser, 1978, p. 13).

Grounded theory was initially presented as a qualitative research method in 1967 by Glaser and Strauss in their classic book “The Discovery of Grounded Theory”, but the method has undergone transformations over the past 30 years. In 1978, Glaser published “Theoretical Sensitivity” to further continue the discussion of grounded theory commenced in 1967. There has been considerable debate regarding the evolving nature of grounded theory in subsequent publications by Strauss (Strauss, 1987; Strauss & Corbin, 1990, 1998) and Glaser (Glaser, 1992, 1998), to the extent that terms such as Straussian and Glaserian have been developed to identify corresponding opinions (Melia, 1996).

Strauss and Corbin argued that grounded theory is a “way of thinking about and conceptualising data” (1994, p. 275). The publication of the book “Basics of Qualitative Research” by Strauss and Corbin (1990) resulted in considerable discussion regarding the faithfulness of this new model to the original grounded theory method introduced in the 1960’s. Procedures outlined by the authors were designed to give the analytic process precision and rigour in conducting a grounded theory study. Although the coding procedures and techniques presented were stressed, creativity was also encouraged as an important element to enable the researcher to ask questions of the data, make comparisons to reveal insights into the phenomena, and enhance the development of theoretical propositions. Strauss and Corbin’s (1994) procedures were designed to guide the researcher in developing a grounded theory that is “conceptually dense, that is with many conceptual relationships” (p. 278). Nonetheless, Strauss and Corbin’s (1990) model has been criticised for being “programmatically and overformulaic” (Melia, 1996). Glaser (1992) referred to this new model as being full conceptual description that can force data. He suggested that this model is preconceived and verificational rather than representative of grounded theory.

Glaser (1992) asserted that the essence of developing a grounded theory is through the analytic modes of emergence and discovery. Rather than agreeing with the rigid procedures and techniques outlined by Strauss and Corbin (1990), Glaser suggested the requisite skills for grounded theory were to “absorb the data as data, ... be able to ... distance oneself from it, and then to abstractly conceptualise the data (1992, p. 11). Theoretical sensitivity requires analytic distancing and at the same time assimilating theoretical knowledge and data to allow the emergence of concepts and patterning (Glaser, 1992). The danger of forcing the data rather than allowing emergence was reinforced by Glaser (1998) who suggested that although it is in man’s nature to force data, researchers can suspend what they know in order to study, conceptualise, and compare the data.

A number of differences were noted between the fundamental attributes of the grounded theory method suggested by Glaser and Strauss. For example, Strauss and Corbin (1990, 1998) stated that the research question identifies the phenomenon to be studied, whereas Glaser (1992) stated that the focus for the research emerges out of coding, theoretical sampling, and applying constant comparison. Strauss and Corbin’s (1990) work did not specifically address the basic social processes discussed by Glaser (1978). Finally, the techniques introduced by Strauss and Corbin (1990) were criticised as being “fractured, detailed, cumbersome and over-selfconscious” (Glaser, 1992, p. 60). Glaser suggested that these techniques obstruct emergence and discovery, which are the outcomes of constant comparison. He argued that his method produced a “grounded theory by a systematic model of induction and emergence” (Glaser, 1992, 101) compared to Strauss and Corbin’s (1990) full conceptual description that used a preconceived model for guiding data collection.

The grounded theory method has continued to evolve as noted in the above discussion of Glaser and Strauss’s works over the years, and other scholars have also contributed to this debate to clarify or refine grounded theory. Leonard Schatzman developed an alternative method entitled dimensional analysis in response to suggested difficulties in identifying a core category or comprehending theoretical sampling (Kools, McCarthy, Durham & Robrecht, 1996; Robrecht, 1995; Schatzman, 1991). An explanatory matrix was proposed to provide structure to an analysis intended to “discover meaning of

interactions as they create the observed situation” (Robrecht, 1995 p. 172).

Schatzman’s method of generating grounded theory supported the discovery of a prominent dimension(s) identifying the major concern from participants over other dimensions rather than the emergence of social processes.

While undertaking this grounded theory study, the researcher chose not to focus upon the work of one author to the exclusion of another. The works of both Glaser and Strauss were examined and utilised and although Schartzman’s method was reviewed it did not provide a major input to the data analysis (Glaser & Strauss, 1967; Glaser, 1978, 1992, 1998; 1998; Strauss, 1987, 1995; Strauss & Corbin, 1990, 1998). Although Strauss and Corbin’s (1990) methods were criticised for being laborious and tedious, this systematic process was helpful in the early stages of data analysis for a novice researcher using the method of grounded theory. At the same time, Glaser’s (1978, 1992, 1998) work was especially useful once the study was underway for clarifying concepts such as theoretical sensitivity, coding definitions, theoretical sampling, basic social processes, and the importance of having trust in emergence. Although Glaser (1998) suggested that audio-taping interviews was not necessary as it presented more deficits than benefits, audio-taped interviews were used in this study to assist in the procedure of open coding where data from interview transcripts was broken down line by line and conceptualised (Strauss & Corbin, 1990).

Grounded theory studies are characterised by their systematic approach to theory development through the use of techniques such as theoretical sampling, constant comparative analysis, concurrent performance of data collection and analysis, and identification of core categories or variables through a progression of coding levels. Strauss (1987) suggested that grounded theory is more of a style of doing qualitative analysis rather than a specific method or technique. Data collection strategies often rely on interviews and observation, which are also used for many qualitative interpretive methods, such as ethnography, discourse analysis, phenomenology, or thematic analysis. Consequently, the risk of “muddling” qualitative methods has resulted in studies that claim to be following grounded theory methods but actually are descriptive studies (Wilson & Hutchinson, 1996). Generating theory moves beyond description to theoretical sensitivity involving “interpersonal perceptiveness and conceptual thinking”

(Wilson & Hutchinson, 1996, p. 124). Specific concepts related to grounded theory such as theoretical sensitivity, theoretical sampling, constant comparison, and coding levels will now be discussed.

Theoretical Sensitivity

Theoretical sensitivity refers to the researcher's knowledge, understanding, and skill, which are essential for the generation of categories and properties. These characteristics increase the researcher's ability to develop and integrate the categories and properties into hypotheses representative of emergent theoretical codes (Glaser, 1992, p 27).

Glaser (1992) further asserted that achievement of theoretical sensitivity results in relevance and fit for the grounded theory study. Theoretical sensitivity is the ability to generate categories from data, integrate the categories, and construct theory while being guided by the emerging theory (Glaser, 1978, 1992). In order to gain theoretical sensitivity, the researcher must enter the inquiry with an open mind. Predetermined ideas or prior hypotheses can filter or bias the researcher from being receptive to what is actually happening in the data (Glaser, 1978). A reflexive journal was kept, as recommended in the literature, to encourage self-awareness of potential bias by documenting personal responses (Rodgers & Cowles, 1993; Streubert & Carpenter, 1995). Theoretical sensitivity was also facilitated by the researcher's past professional, research, and personal experience. Having worked as a midwife with breastfeeding mothers provided the opportunity to cultivate sensitivity to the importance of breastfeeding and weaning to mothers. Additionally, having completed two research projects upon breastfeeding, one being a masters of nursing thesis, and the second a qualitative study into women's perceptions of successful breastfeeding, contributed to this sensitivity (Hauck, 1992; Hauck & Dimmock, 1994; Hauck & Reinbold, 1996). Finally, being a mother and having breastfed two children offered a personal perspective and enhanced awareness, credibility, and motivation in pursuing this area of inquiry.

Theoretical Sampling

Theoretical sampling, a technique unique to grounded theory, involves the process of making decisions regarding data collection dependent upon the emerging theory (Glaser, 1978). While collecting data through interviewing, the researcher codes and

analyses these data to assist in the decisions of from whom or where to collect further data. Until theoretical saturation is achieved, theoretical sampling continues and predictions can not be made regarding how many participants will be interviewed or whether other forms of data will be necessary. In consideration of this sampling technique and based upon reading of the qualitative literature (Sandelowski, 1995), an estimate was made that between 30 to 50 interviews could be required to complete this grounded theory study. Additionally, provision was made within the research proposal to approach other informants such as partners or health professionals should data analysis indicate such informants' knowledge was necessary to increase the study's scope and depth or provide confirmation of categories derived from the mothers' interview data.

In the beginning stages of sampling, the researcher guided by Glaser's (1978) recommendation sampled in all directions that seemed to be relevant to the phenomenon. Consequently, in deciding on the initial participant interviews, women with a wide range of breastfeeding and weaning experiences were chosen incorporating aspects such as breastfeeding duration, pace of weaning, and weaning strategies. As the core variables began to emerge, the researcher became more selective in focusing upon specific issues of the emerging theory in line with Glaser's (1978) approach. To illustrate, the emerging issues of guilt and grief guided the choice of participants who felt dissatisfied with their experience and were able to elaborate on those feelings. During selective sampling, potential negative cases were also sought in an attempt to test or challenge the core categories. This search provided an insight into instances of where the core category was or was not supported as suggested by Strauss and Corbin (1990).

Sampling continues in a grounded theory study until theoretical saturation of each category is achieved. Saturation means that no new information is being revealed (Morse, 1995). Furthermore, categories must demonstrate clear conceptual density and variation within categories must be accounted for. Data richness is dependent upon detailed description and not how often something is cited and recited.

Constant Comparison

Constant comparative analysis is a fundamental feature of the grounded theory method that guides generation and treatment of data (Streubert & Carpenter, 1995). This process involves concurrent data collection and analysis, taking the data and comparing it to emerging categories (Creswell, 1998). The constant comparative analysis in grounded theory is based upon the argument that theory can be created from data systematically collected from the social setting (Robrecht, 1995). Continually comparing incidents and categories generates properties and provides a richer yield of concepts and relationships (Glaser, 1998). Particularly during open coding, data are broken down into incidents, to be closely examined and compared for similarities and differences (Glaser, 1992). Patterns are identified and similar incidents labeled so compared incidents can act as “interchangeable indices for the same concept” (Glaser, 1992, p. 40). The constant comparative method of analysis proposed by Glaser and Strauss (1967) was used in this study and supplied the grounded theory method with its precision and specificity in systematically generating theory grounded in context-based data.

Coding

The grounded theory method involves both inductive and deductive analysis. All three aspects of inquiry, induction, deduction, and verification are used in a grounded theory analysis (Strauss, 1987). From the inductive position, theory emerges from the data that are generated (Streubert & Carpenter, 1995). The deductive aspect involves testing of the resulting theory empirically to develop predictions and hypotheses. Emerging theories must be established, elaborated, and finally confirmed. The process is not linear as implied but rather represents a fluid process of moving between coding levels, using memos, and modifying data collection strategies based upon theoretical sampling. Strauss (1987) referred to these phases of research as a coding paradigm. The procedures for discovering, verifying, and formulating a theory continue throughout the research project. This “back-and-forth” re-examination of data occurs throughout the life of the research until theoretical saturation occurs and further analysis does not contribute any new information about the categories or theory (Strauss, 1987). Creswell (1998, p. 57) regarded this movement as a “zigzag” process as the researcher moves

from the field to gather data, analyses that data, and returns to the field to gather further data deemed necessary from the analysis.

The process of data analysis in the grounded theory method is systematic and rigorous. The process of constant comparison and coding procedures ensure these characteristics. The terms used to describe the coding procedures for the grounded theory method vary depending upon different authors. Glaser (1978) outlined two types of codes; substantive and theoretical. Substantive codes conceptualise the empirical evidence through open coding, where the data are coded in every possible way. At this stage the researcher constantly asks: what is this data a study of, what category does this incident indicate, and what are the basic social psychological processes occurring in this data? (Glaser, 1978, p. 57). Once the researcher has discovered a core variable or variables, she/he selectively codes for that variable, which also guides further data collection and theoretical sampling. Theoretical coding conceptualises how the substantive codes relate to each other. These theoretical codes from a higher conceptual level, “weave the fractured story back together again” (Glaser, 1978, p. 72). Consideration of the six C’s of causes, contexts, contingencies, consequences, covariances, and conditions assist in establishing connections that provide scope and a fresh perspective to a phenomenon.

The coding procedures outlined by Strauss and Corbin (1990) focus upon three levels of coding: open, axial, and selective. Open coding involves a “breaking down, examining, comparing, conceptualising, and categorising data” from codes or concepts extracted from a line-by-line, sentence, or paragraph analysis (Strauss & Corbin, 1990, p. 61). Properties and dimensions of the categories are also noted. Throughout the coding process, constant comparisons are made while asking questions to open up the data to potential categories, their properties, and dimensions. The next level of coding, termed axial coding, involves putting data back together in new ways and making connections in a coding paradigm with conditions, context, action/interactional strategies, and consequences (Strauss & Corbin, 1990, p. 96). Questions derived at this stage focus upon distinguishing types of relationships between categories. Finally, during selective coding the researcher systematically selects the core category by relating it to other categories, validating relationships between categories, and further refining and

developing categories to conceptualise the story of the phenomenon under study (Strauss & Corbin, 1990).

A core category or variable should emerge from the data and its relationship to the other categories integrates all categories into a whole (Glaser, 1978, 1992; Strauss, 1987).

The process of reduction and comparison are essential to discover the core variables or social processes (Streubert & Carpenter, 1995). The core category must be central; reoccur frequently in the data; link various data together; become more detailed as the theory moves forward; permit maximum variation and analyses; and relate meaningfully and easily with other categories. The core category or variable can be a dimension of the problem. However, in this current study two core variables emerged. One core variable was labeled the basic social problem and was termed *incompatible expectations*, whereas a second core variable became the basic social process that evolved in response to the problem. This basic social process was titled *constructing compatibility by adapting focus*.

Streubert and Carpenter (1995, p. 157) argued that three steps expand theory by making it dense and rich in explanation: data reduction, selective sampling of the literature, and selective sampling of data. The use of literature within the grounded theory method will now be addressed.

Use of the Literature

The appropriate pace and timing of reading literature within a grounded theory study is a frequently asked question (Glaser, 1978). The concern is to not “contaminate one’s effort to generate concepts from the data with preconceived concepts” (Glaser, 1978, p. 31). Therefore, Glaser (1978) suggested that use of the literature should begin after the emerging theory is developed. However, in order to justify that a phenomenon requires further investigation it is essential that some of the relevant literature be consulted.

Glaser (1998) acknowledged the traditional conditions of obtaining institutional approval in pursuing research or seeking funding requires that a pre-research literature review must be undertaken. This approach was utilised in preparation for the current study whereby literature was consulted to establish the need for an exploratory study into the phenomenon of weaning and to become familiar with qualitative research in

order to select the appropriate research design. However, it was important to keep the literature “in abeyance” and separate from the data to prevent “contamination” of the data or researcher’s objectivity (Morse, 1994b, p. 26; Morse & Field, 1995, p. 126). Therefore, once the study was underway, research literature specific to breastfeeding or weaning was not consulted. When such relevant literature became apparent, the researcher collected the information but set them aside until the resultant substantive theory was sufficiently developed to avoid introducing bias. Awareness that bias could inadvertently be used to lead participants with focused questions in the direction of previous knowledge was recognized (Streubert & Carpenter, 1995). It must be noted that information used by mothers from lay literature such as breastfeeding books, newspapers, magazines, or parenting web sites was used as a source of data as indicated necessary by theoretical sampling.

Additionally, literature can also provide the theoretical context for the study (Morse, 1994b) and the literature on symbolic interactionism was examined to assist in justifying the choice of the grounded theory method and also to become familiar with the theoretical assumptions of this concept. Once the theory was developed from the data, the researcher then returned to the literature for comparison and discussion of the new theory with existing knowledge. Conducting a literature review at this stage establishes what has been previously published about the emerging categories. The existing literature was then used as data and woven into the matrix of the resulting substantive theory (Streubert & Carpenter, 1995). In his discussion of the use of theory in qualitative research, Creswell (1998) placed different research methods on a continuum with one end indicating theory use before the asking of questions or gathering data and the opposite end representing theory use after data collection. The grounded theory method was located in the “after” end of the continuum.

Use of Memos

The use of memos is not exclusive to the grounded theory method, as other qualitative research methods also advocate their use. However, the core stage in generating theory according to Glaser (1978, 1992) is the writing of theoretical memos. “Memos are the theorising write-up of ideas about codes and their relationships as they strike the analyst while coding” (Glaser, 1978, p. 83). They provide a method of storing ideas that are

essential when compiling the theory. Diagrams can also be used to provide graphic representations or visual images of the emerging concepts and their interrelationships (Strauss & Corbin, 1990). Memoing and diagraming begins at the beginning of the research and continues until the theory is finally written.

Strauss and Corbin (1990) suggested that code notes be written during the open coding stage of data analysis. As the process of analysis continues, theoretical notes are used to document provisional properties and dimensions of categories. During axial coding, memos are used to record attempts to link relationships between categories and subcategories while noting variations within properties and their dimensions (Strauss & Corbin, 1990). As the theory evolves, the memos reflect the depth and complexity needed to integrate concepts around a core category. Operational notes contain detail regarding sampling decisions, questions, and possible comparisons with the purpose of guiding the researcher during data analysis.

Through memoing the emerging theory is captured and recorded (Glaser, 1998). Memos accumulate and mature during the process of data analysis. Once saturation is achieved, the memos are sorted to aid in the process of writing up the theory. Glaser (1998) asserted that the goals of memoing incorporate four concepts: ideas, freedom, memo fund, and sortibility. Ideas are captured, tracked, and preserved through memos. The term memo freedom recognises the importance of “moment capture” and advocates that the researcher may need to interrupt research procedures in favour of memoing (Glaser, 1998, p. 182). Finally, as the collection of memos builds and matures, the process of sorting assists in discussing the substantive codes and their relationships.

In summary, the grounded theory approach has been recognised as an appropriate method to study many nursing phenomena as it allows exploration of the richness and diversity of human experience (Streubert & Carpenter, 1995). This exploration has the potential to contribute to knowledge that directly influences clients' care. The intent of research is to more fully understand an aspect of the human experience and most importantly, communicate that understanding to the people who affect or are affected by the phenomenon (Ammon-Gaberson & Piantannida, 1988). Interpretive research allows for needs identification which is important to the provision and justification of health

care strategies (Jasper, 1994). In the case of this research, health professionals such as nurses who come in contact with breastfeeding women and have the opportunity to support them can use this knowledge to improve the quality of the care and advice given.

Overview of Procedure

In order to develop a substantive theory using the grounded theory method the processes of data collection, coding, and memo writing occurred concurrently. Data were collected from interviews, questionnaires, field notes, books, parent magazines, local newspapers, and web sites. The selection and generation of data were directed by theoretical sampling. This sampling technique was guided by ongoing data analysis and the discovery of categories pertinent to the emerging theory. Data analysis involved a series of coding levels. Initially substantive codes were sought through open coding (Glaser, 1978; Strauss & Corbin, 1990). Data were broken down, compared, and conceptualised into categories using a line-by-line and then sentence analysis. This constant comparison revealed potential categories, properties, and dimensions within the data. Comparisons were made throughout data analysis that progressed in coding levels from the line-by-line detail in participants' stories to putting data back together to reveal connections between categories and the core categories or variables to conceptualise the story of mothers' management of breastfeeding and weaning. The writing of memos or code notes representing methodological decisions, theoretical insights, and reflexive assumptions began with the first interviews and continued through the process of theory development. Conceptualisation of the story line developed through data analysis and advanced through the use of diagramming. When the core categories were identified, verified, and fully interpreted, theoretical saturation was achieved resulting in a substantive explanatory theory on the social process of managing the breastfeeding and weaning experience. An overview of the connection between data collection, analysis, and theory development is presented in Figure 3.

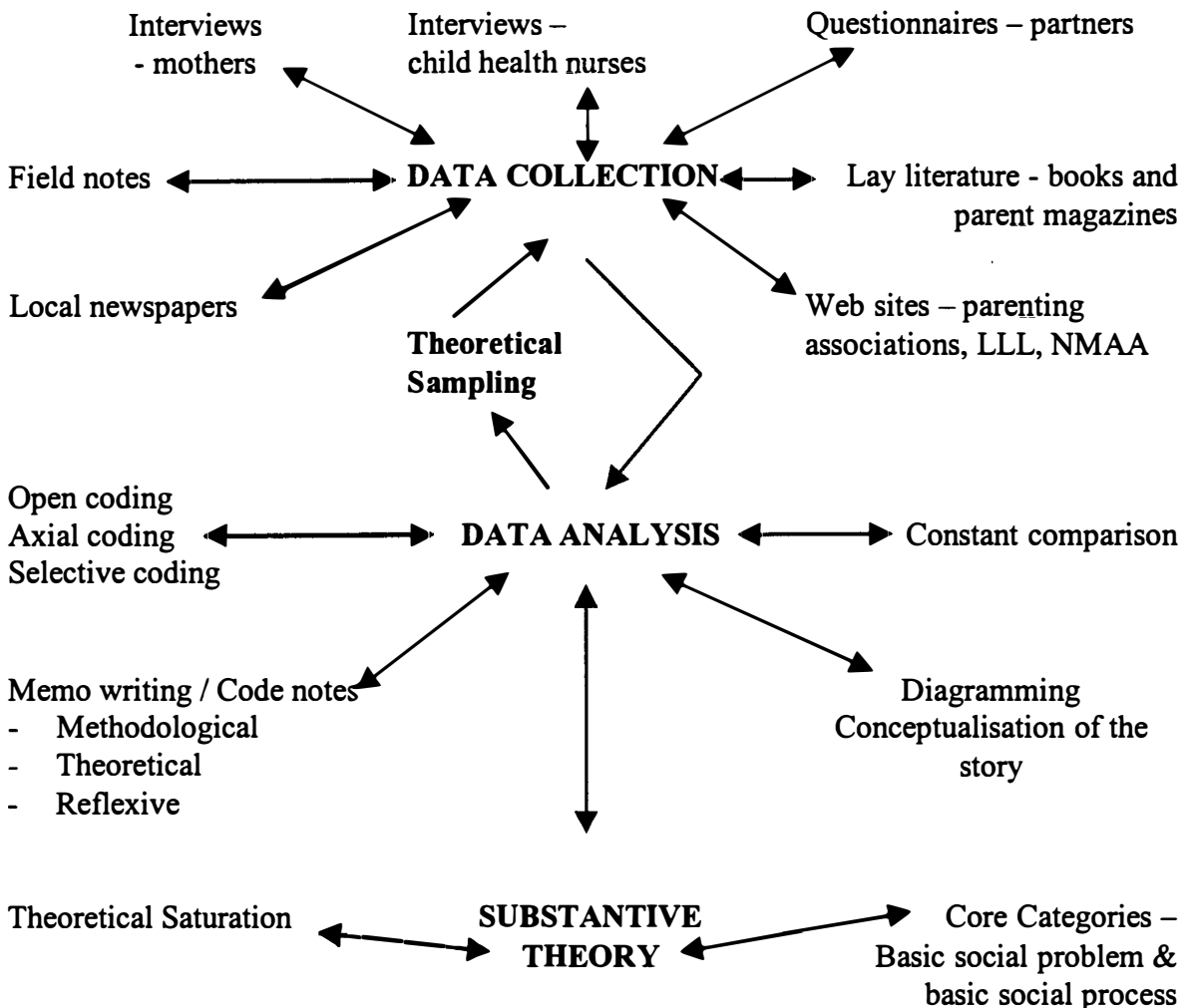


Figure 3: Connection between data collection, analysis and theory development

Sampling

Purposeful sampling was utilised during the initial phases of data collection. The purpose of this open sampling was to seek a variety of mothers who represented a range of breastfeeding and weaning experiences and were willing and able to articulate their stories. Once this sampling strategy had provided a beginning data base for open coding, the remaining decisions regarding data collection were guided by theoretical sampling, a unique feature of the grounded theory method (Glaser & Strauss, 1967; Strauss & Corbin, 1990). The aim of this sampling technique was to guide decisions on data collection based on the categories identified to be significant to the emerging theory (Glaser, 1978, 1992; Strauss, 1987; Strauss & Corbin, 1990, 1998). These

decisions involved aspects such as what data to seek and from whom. From descriptions offered by participants conversant with the phenomenon, categories were identified and their properties, dimensions, and relationships discovered. Consequently, sampling and data collection were guided by the emerging theory (Glaser & Strauss, 1967).

To determine the appropriate timing to interview women a pilot study was conducted with three women who were currently weaning and two women who had completed the process. Participants who were currently weaning presented data on past decisions with breastfeeding but were not able to predict how and when their breastfeeding would end. Those mothers who had concluded the weaning process were able to describe the process to completion. It became apparent that mothers were better able to express their thoughts and feelings of the experience upon reflection. Therefore, the decision was made to recruit women who had completely weaned their child from the breast and, to reduce the potential of recall bias, the experience had to have occurred within the past six months.

In deciding upon the minimum period of breastfeeding required, before ceasing breastfeeding could be acknowledged as weaning, the following points were taken into account. Although breastfeeding initiation rates in Western Australian were 83.8 percent (Scott et al., 1996), research into prevalence rates revealed that the period up to three months was the most common breastfeeding duration reported for Western Australian mothers (Western Australian Child Health Survey, 1995). To account for women who weaned within three months while allowing for time to establish lactation, participants recruited for this study had to have breastfed for a minimum of six weeks. Ceasing breastfeeding prior to this time was not regarded as an act of weaning the infant from an established process but more an interruption of the development and establishment of breastfeeding.

Participants were recruited from a larger study conducted by Dr. Patricia Percival within the School of Nursing and Public Health at Edith Cowan University entitled *The Antenatal, Birth, and Postnatal Experiences of Women Who Give Birth in Hospital (Longer Stay and Early Discharge)* and a Birth Centre. Information gathered in this

larger study included information on breastfeeding and weaning duration, weaning strategies, and satisfaction with weaning. This information was useful for open sampling used during the initial stage of data analysis where openness encourages the process of examining, comparing, conceptualising, and ultimately, categorising data (Corbin & Strauss, 1990). Participants with a varied range of weaning experiences were selected from this population, for example, women who had: breastfed from six weeks to 18 months; weaned gradually or suddenly; and were satisfied or dissatisfied with their weaning. Twenty-nine participants were recruited from the larger study, three women responded to an advertisement in the local community newspaper and one woman was recruited in person from the local community resulting in a sample of 33 mothers.

Data Collection

Data were collected from a variety of sources: interviews with thirty three women who had recently weaned a child, five individual interviews with child health nurses, a discussion group interview with seven child health nurses, questionnaires from nine partners of the women, field notes, books, parent magazines, local newspapers, and web sites from parenting associations, the La Leche League (LLL) International, and Nursing Mothers' Association of Australia (NMAA). Because the focus of this study was upon the process of weaning from the perspective of mothers, women were the main informants. Data obtained from the larger study previously mentioned was reviewed and prospective participants were contacted by telephone to explain the purpose and involvement required for this additional study. All but two women contacted over the telephone agreed to participate in the study. Once verbal consent was obtained over the telephone, an interview time, and date convenient with the participant was arranged. As most participants had one or several small children, it was more convenient for the researcher to conduct the interviews at the participant's home. At the interview, the study's purpose was clarified again and a consent form signed by the participant and researcher (Appendix A). A copy of the consent form with contact telephone numbers was left with each participant. Demographic data were obtained from the larger study that provided information on each participant's age, number of children, number of children breastfed, educational background, usual occupation, approximate annual income, and marital status. In relation to the most recent birth

experience, the following information was also obtained: type of birth, weeks of gestation at birth, sex of the child, and type of hospital (public or private). Four participants who were not recruited from the large study were asked to provide similar information on a demographic data form.

All interviews were audio-taped and began with an open-ended question “tell me how your breastfeeding stopped”. This question is an example of a “story-telling question” which indicates to the participants that the researcher is receptive to listening to their story (Minichiello, Aroni, Timewell & Alexander, 1995, p. 86). Participants then shared their story or stories of breastfeeding and weaning for all of their children. The interview progressed with the interviewer using reflective listening responses and clarifying questions. Once participants had completed their story or stories, an interview guide was then brought out. The original guide was based on the objectives of the study but in accordance with theoretical sampling was modified to reflect emerging findings and aspects of breastfeeding and weaning that mothers had revealed as important. The interview guide (Appendix B) was used as a prompt to stimulate an open discussion on the weaning experience of the participants but was not displayed to participants at the beginning of the interviews. This “recursive model” of using an unstructured technique during the beginning of the interviews had the potential for the interview to digress (Minichiello et al., 1995, p. 81). However, when participants occasionally chose to discuss topics such as their birth experience, it actually provided useful data to accentuate the meaning attached to particular breastfeeding or weaning decisions. Limiting participants to the final stages of their breastfeeding experience alone would have limited the depth and richness of the data.

This initial unstructured technique allowed participants to share their experience as a flowing story and was found to enhance the depth of the data, rather than participants answering one question after another based upon the interview guide. According to Morse and Field (1996) asking too many questions reflects poor interviewing skills and can interfere with the quality of the interview. The initial taped interviews were used to assess the researcher’s interviewing techniques. “Good interviews” can be detected upon transcription revealing uninterrupted blocks of text as the researcher allows the participant to complete their story without too many interruptions or questions (Morse

& Field, 1995). In most cases, the participants had addressed all questions in the guide in the flow of their storytelling. When the interview guide was presented, participants were then able to comment upon items if they felt it was relevant to their experience.

There were occasions when the presence of infants, toddlers, or pre-school children presented a distraction to the interview. These potential distractions had to be considered when trying to achieve a quality interview (Morse & Field, 1996). As the mothers dictated the timing and day of the interview, they often scheduled the interview during their child's naptime or while older children were at school. Many interviews were completed as children slept. Invariably children awoke earlier than anticipated and strategies such as using videos, toys, partners taking children out, or the researcher holding a willing child were employed to allow mothers to complete the interview. One participant arranged her interview over the lunch time period so her partner could come home and care for the child in another room while the interview was completed. Another mother requested the interview on a weekend so her partner could be present to baby-sit.

Being a midwife and a mother who had breastfed, the researcher was careful not to offer her own perspective on the phenomenon. If participants asked whether the researcher was a mother or had breastfed, these questions were answered honestly and briefly. This information was often helpful in developing rapport at the beginning of the interview but was not offered unless specifically asked. The focus of the interview remained on the participants' experiences. Rarely, participants asked for advice or presented information that was incorrect. When this occurred, the researcher asked if advice could be given at the end of the interview. For example, one participant wanted information on breast milk expression techniques for her next child and this information was collected and posted to the participant a few days after the interview. Comments such as breast milk being poor because it looked too "thin and watery" or the supply was inadequate because leaking had settled down were addressed after the interview was completed when the researcher discussed the normal appearance of breast milk or variations in leaking experiences. These examples highlight the dilemma that many researchers may face when changing roles from researcher to practitioner. The major goal of the research interview was to learn about the phenomenon under study.

However, ethics require consideration of the potential benefits and risks of the research to participants and being a midwife and educator, the researcher was obligated to provide accurate information due to the potential impact of incorrect information on future breastfeeding experiences (Minichiello et al., 1995). This educational role was not the focus of the research and formed a minor component of a small number of interviews.

Once the interview was completed, the researcher made field notes on what was observed during the interview, such as the non-verbal cues of the participant and any interaction with children or other significant persons present at the interview. Only one participant was initially uneasy with the tape recorder. Within a few minutes she overcame this “stage fright”, a term described by Morse and Field (1996, p.80). A small, discrete tape recorder was used to avoid making the equipment an intimidating dominant feature of the interview. Interviews lasted between 45 minutes and two hours. The majority of interviews with mothers occurred over an 11-month period from February to December 1997. As the larger study, used to recruit women, continued for only 18 months, an advertisement was placed in a local community newspaper to recruit women who had breastfed beyond this period (Appendix C). A methodological memo has been included to demonstrate documentation of how theoretical sampling guided decisions on further data collection based upon the emerging categories (Appendix D). Following the 33 interviews conducted in participants’ homes, a further five telephone interviews and three follow-up interviews took place to clarify gaps in the categories. Notes taken during one of the follow-up telephone interviews are provided as an example in Appendix E.

One participant was tearful during her interview and the researcher stayed with the mother until she felt comfortable and composed. Acknowledgement from the researcher that she was not alone with her feelings as other participants had expressed sadness and loss seemed to reassure the mother. A follow-up interview was conducted six weeks after that interview to determine how she was coping at that time. It is the responsibility of the researcher to ensure the safety of the participant and uphold values that lead to socially responsible research (Robley, 1995). The mother stated how the interview had been therapeutic in allowing her to talk to someone who respected her experience,

acknowledged her feelings, and listened without judging. After the interview she wrote a letter to the hospital expressing her disappointment and anger with the inadequate breastfeeding support offered during hospitalisation after the birth of her child. Her general practitioner had been encouraging her to write this letter for months but it was only after the interview that she felt ready to do it.

Sampling continued until theoretical saturation of each category. Formal, semi-structured interviews are a foundation of the grounded theory method and depending upon the study may be the only way to obtain the participants' perceptions of the phenomenon (Hutchinson, 1993). Guided by theoretical sampling based upon the emerging categories, data were also obtained from other interview sources such as the participants' partners and child health nurses. Participants indicated these people were significant in influencing their infant feeding decisions. Interviewing partners and child health nurses provided a form of triangulation whereby data from these significant people corroborated concepts revealed by the women interviewed (Creswell, 1998). Triangulation is advocated as one method to establish credibility of qualitative methods (Peck & Secker, 1999). Data in forms other than interview transcripts were also utilised. The existing relevant literature on breastfeeding was used as a data source and included local newspapers, books, and web sites for parenting associations, the La Leche League (LLL) International, and Nursing Mothers' Association of Australia (NMAA). Materials such as non-professional, popular, and ethnographic literature related to the phenomenon under study can be considered as a source of data used in the constant comparison required to generate categories (Glaser, 1992, p. 37).

Collection of data from participants' partners and child health nurses occurred over a six-month period from February to August 1998. Obtaining permission to access the child health nurses was the main reason for the time allotment. Letters were sent to the Regional Coordinators in Child Health for six metropolitan areas (Appendix F). Two coordinators expressed interest and once ethical approval was obtained from their region, they provided a list of child health nurses within that region. A letter was then sent to child health nurses in those regions seeking interest to be involved in the study (Appendix G). Five child health nurses responded to the letter and interviews were arranged. Four nurses were interviewed at their individual clinics and one nurse chose

to be interviewed at her home. A third coordinator offered contact with her region's child health nurses at a monthly meeting. To capitalise on this opportunity a discussion group meeting was arranged that included seven child health nurses. This discussion group interview occurred after the individual interviews with child health nurses. The consent form and interview guide utilised for the individual and discussion group interviews with child health nurses is provided in Appendix H and I respectively.

In order to obtain data from partners of women who had recently weaned, a letter, questionnaire, and self-addressed return envelope was sent to 31 of the 33 participants interviewed (Appendix J & K). One participant had changed her address and could not be contacted and another had separated from her partner since the interview. Modified versions of the letter and questionnaire were sent to fathers who had one child and those who had more than one child. The letter offered flexibility in the manner that partners could express their thoughts by either a telephone interview, personal interview, or by answering the open-ended questions in the postal questionnaire. The questions developed for the partners' questionnaire were based upon findings from the mothers' interviews. No partners contacted the researcher to arrange a personal or telephone interview. However, nine completed postal questionnaires were returned.

Profile of Participants

Thirty-three women who had weaned a child within the past six months participated in individual interviews in which their experiences were audio-taped. The 33 women who participated in the interviews ranged in ages of 20 to 47 years with a mean of 33 years. Seventeen of the women were first-time mothers and the remaining 16 had two or more children. These recent weaning experiences focused upon the weaning of 33 children, 17 males, and 16 females. The age of weaning for these children ranged from 6 weeks to 6 years, with one child weaning herself two weeks before her seventh birthday. The original research proposal included the term infant weaning in the title but to reflect this wide range of breastfeeding duration the term infant was replaced with child. The mean age of weaning for the 33 children was 11.5 months. This mean changed to 9.3 months when the child who weaned at 6 years was removed from the calculation. Seven women weaned their child between 1.5 and 3 months, seven weaned between 3 and 6 months, three weaned between 6 and 9 months, six weaned between 9 and 12 months, four

weaned between 12 and 18 months, and six weaned beyond 18 months. Experienced mothers were also invited to discuss their previous weaning experiences with other children, resulting in a total of 53 weaning experiences being discussed during the 33 interviews. Data on recent birth experiences revealed that 16 women attended a private hospital and 17 attended a public hospital for the birth of their children. Birthing experiences included: 18 normal births, 3 forceps/vacuum births, 6 elective caesarean births, and 6 emergency caesarean births. All participants were living with a partner at the time of weaning. One woman indicated that she had been separated from her partner for most of the breastfeeding experience and his moving back home had resulted in weaning being initiated.

Data revealed a diverse range of occupations with 25 women specifying employment ranging from waitress to secretary, receptionist, teacher, botanist, and engineer to highlight a few examples. Eight women indicated home duties under the occupation item. In addition, 20 participants had completed an Achievement Certificate or Year 12 in secondary school, 5 had obtained a trade, apprentice, certificate, or diploma from a post-secondary institution, and 8 had one or more university degrees. In relation to family income, 3 participants had an income of \$20,00 or less per year, 11 had an income of \$20,000 to \$40,000 per year, and 19 came from families where the income was greater than \$40,000 per year.

As previously discussed, data were also obtained from other interview sources such as participants' partners and child health nurses as women indicated these people were significant in influencing their breastfeeding and weaning decisions. Nine of the 31 partners responded to the postal questionnaire and provided data regarding their spouses' weaning experiences. Six partners were first-time fathers and three had two or more children. This limited response could represent potential bias in the nature of this data as feedback was generally brief aside from two respondents who highlighted the difficulties their wives encountered during breastfeeding and weaning. Five individual child health nurses representing three metropolitan regions were interviewed. A discussion group interview with seven child health nurses followed these individual interviews. This discussion was also audio-taped, but as no new data were revealed field notes were made rather than the interview being transcribed verbatim.

Interview Guide

To begin the interviewing process, an Interview Guide was developed (Appendix B) to provide general information on the phenomenon of weaning. The Interview Guide was originally based upon the objectives of the study but was modified and expanded in response to data from the participants as the interviewing continued. For example, questions were added that related to breastfeeding in public, perceptions of readiness to wean, the influence of weaning upon the partner and family, and who influenced their breastfeeding and weaning decisions.

As categories were identified and responses needed to be more specific to clarify properties, interpret dimensions, and test propositions generated from data, clarifying questions were used during the interviews. Additionally, comments were made that reflected data analysis and feedback and verification was sought from participants in the later interviews. For example, when participants discussed their experiences of breastfeeding in public, relevant questions were asked, such as, “some mothers used specific strategies to help them breastfeed in public, did you have any particular way of handling this situation?” During this advanced stage of data analysis, discriminate sampling was used to verify the relationships between categories, elaborate on categories that were missing sufficient depth, and to confirm description of the phenomenon. Due to theoretical sampling, the decision was made to recruit mothers who had breastfed longer than 18 months through an advertisement in a local community. The one participant whose child weaned when she was six years of age was known within the local community and she was individually approached to determine her interest in being interviewed. She was still breastfeeding her child during the initial interview but two follow-up telephone interviews were conducted over the period of one year until the weaning process was completed.

Data Analysis

Data from interview transcripts and postal questionnaires were transcribed verbatim and entered into the Ethnograph software program (Seidel, 1994). This program is designed to facilitate the management and reorganisation of the data but does not perform any kind of analysis (Tesch, 1991). The retrieval of coded segments is facilitated through

the use of the software program and allows for the constant comparison of data that is essential to the grounded theory method. The researcher transcribed the first eight interviews and two subsequent interviews with child health nurses where particular speech characteristics made transcription more challenging. A typist transcribed the remaining interviews. Issues of confidentiality were discussed with the typist. To ensure faithful reproduction of the interview, the researcher listened to the audio-tape while reviewing the transcription and added relevant non-verbal communication such as laughter, tears, or long pauses as suggested by Poland (1995).

Qualitative researchers seek “full-knowledge closeness to their data” (Richards, 1998, p. 321). Analysis of qualitative data requires a commitment to becoming immersed in the data through techniques of reading, intuiting, analysing, synthesising, and reporting (Streubert & Carpenter, 1995). Although the use of a computer software program to assist with handling the data is encouraged and widely practiced, the custom does pose potential problems. While achieving this closeness is important, Richards (1998) suggested that the challenge of attaining distance from the data is also critical to data analysis but may be more difficult to achieve. Computer software programs enhance the process of getting close to data due to their ease in accessing and retrieving text coded data. This “fine-fingered dissection of the data” must be balanced by the researcher also moving out and considering the data from a “wide-angle view”, a method described by Richards as an “in-out- process” (1998, p. 324).

During the phases of data analysis, to be discussed below, the researcher noted changing degrees of closeness to the data. During the early phase of open coding, closeness to the data was very evident. As major categories were being revealed by theoretical coding, a degree of distance had to be undertaken to facilitate analysis. The levels of coding presented do not occur in a linear progression but rather as a back-and-forth movement between coding. After periods of intensive data analysis, the researcher would experience the phenomenon of “being flooded by the richness” (Strauss, 1987, p. 26) and the volume of data but during a weekend or break from data analysis, revelations and insights at a more abstract level would become apparent. In addition, regular attendance at a Ph.D. peer seminar group involved discussions and presentations of

work in progress with other grounded theory researchers that assisted the researcher to extend or challenge ongoing interpretations of emerging categories.

The phases of data analysis presented advanced over the research process from open coding to theoretical coding. These phases included the four cognitive processes that occur in qualitative data analysis; comprehending, synthesising, theorising, and recontextualising (Morse, 1994b; Morse & Field, 1995). Comprehending involved learning about the participants' experiences through interviewing whereas synthesising occurred during coding and memoing. The use of theoretical sampling occurred during the cognitive processes of synthesising and theorising. Selective (Strauss & Corbin, 1990) or theoretical coding (Glaser, 1978) and diagramming were also used during theorising whereas the final process of recontextualising was demonstrated in the development of the substantive theory of *constructing compatibility by adapting focus*.

As recommended by Glaser and Strauss, (1967) data collection, coding, and analysis occurred simultaneously which meant data analysis began with the first interview. The process of data analysis is termed coding. Open coding involved the determination of categories from the data. Interview transcripts, field notes, books on breastfeeding and weaning, local newspapers, and data from web sites for parenting associations, the La Leche League (LLL) International, and Nursing Mothers' Association of Australia (NMAA) were read to help determine categories in the data. These categories or abstractions of the phenomenon are the basic unit of analysis in grounded theory. Categories can be named from concepts in the existing literature or be given "in vivo" codes, phrases used by the participants themselves. Categories were discovered by doing a word, line or sentence analysis and making constant comparisons within the data as described by Glaser and Strauss (1967) and Strauss and Corbin (1990).

Open coding allowed for the data to be divided into discrete concepts to be named and analysed further. This fracturing of the data required a "conceptual stepping back" and was important for the eventual "grounded conceptualisation" (Strauss, 1987, p. 29). The initial open coding of data produced numerous codes that were eventually condensed down to 72 substantive codes. A code list of provisional names was produced (Appendix L). Data entered in the Ethnograph program was coded with these original

72 codes and segments of interviews were extracted and compiled to provide files with similar ideas. For example, the code file 'guilt' provided rich data allowing for constant comparison between participants' stories and identification of the properties and conditions of this phenomenon. Many codes were subsumed into broader codes as major categories were discovered and described. Some codes became properties of major categories. To illustrate, in defining and describing the consequences of *incompatible expectations*, data were drawn from the codes of 'guilt', 'mothers' distress', 'experience not as expected', and 'mother questioning'.

During the process of open coding, a segment of an interview transcript was taken to a Ph.D. peer research group for their input. This group of both novice and experienced grounded theory researchers completed their own line by line analysis of the transcript. An interactive discussion ensued regarding concepts identified during this open coding exercise that were beneficial to the researcher's ongoing data analysis. Coding data alone is a difficult task and can result in superficial analysis with a novice, unconfident researcher. Strauss (1987) encouraged seeking the support of a seminar's analytic discussion and Glaser (1978) also advocated using a revolving collaboration seminar model with other committed full time contributors. The purpose of these training seminars, undertaken throughout the study, was to facilitate and encourage the thinking and analysing processes involved in the grounded theory method.

Once the categories were identified, the process of discovering linkages began by posing questions about potential relationships and propositions, and subsequently testing them. This process is described as theoretical coding where connections between substantive codes are made under the concepts of cause, context, contingencies, consequences, covariances, and conditions (Chenitz & Swanson, 1986; Glaser, 1978). These six C's helped to capture the depth and scope of the phenomenon's properties. Glaser (1992) presented an alternative method that was utilised in this study and rather than solely breaking down single observations, sentences or paragraphs and labeling them, the researcher compared incident to incident to conceptualise a pattern among many incidents. This constant comparative method allowed for emergence of categories and properties and required trust and patience. Glaser (1992) asserted that the grounded theory analyst uses constant comparison and emergence to identify and develop

categories rather than what he terms the “forced, full, conceptual description” proposed by Strauss and Corbin (1990).

Memos were made during the process of theoretical coding. Analysis of the data revealed a major category of ‘contradictory messages’ based upon the expectations of others. A memo has been provided as Appendix M illustrating the ongoing analysis and questioning of potential relationships between categories identified within the data. Strauss (1987) discussed the importance of using generative questions to make distinctions and comparisons while postulating the relationships between categories. He suggested that the question “what study are these data pertinent to” must be considered. Questions remind the researcher that the original idea of what the study was may need to be modified in response to the data (Strauss, 1987, p. 30). This statement has particular relevance to this current study as the original idea of focusing upon weaning alone was modified due to the data reflecting the need to include the management of both breastfeeding and weaning. Data from open coding were analysed for connections between major categories and their corresponding subcategories. The relationships between categories and subcategories were confirmed by constantly returning back to the data to confirm or refute possible connections.

The final coding process involved verifying the core category, or central aspect that integrated all other categories. The core category is the basic social or structural process that characterises the main story line or pattern (Corbin, 1986; Glaser, 1978). The process of refining the theory continued whilst categories proceeded to be discovered, built, and made more dense. The coding memos produced during ongoing analysis were reviewed in order to provide an abstract theoretical explanation (Morse & Field, 1996). At this stage, saturation was achieved when review of all coding levels provided no new information. Sampling, coding, and analysis continued until saturation was achieved and the major categories were characterised to provide a depth of explanation for the evolving theory. Conceptualisation of the story of the phenomenon assisted in distinguishing the core category or categories (Corbin & Strauss, 1990; Glaser, 1978). The core category or social process accounts for variation in the behaviour of participants (Glaser & Strauss, 1967; Wuest, 1995).

Two core categories or variables emerged from this study, a basic social problem and the underlying process that developed in response to this problem. *Incompatible expectations* was identified as the basic social problem faced by all women in their breastfeeding and weaning experiences. A second core category entitled *constructing compatibility by adapting focus* explained the basic social process undertaken by women in managing this problem. The explanatory power of theory was established when a theoretically plausible answer, in this instance the process of *constructing compatibility by adapting focus*, was offered as an explanation to how these women managed the dilemma of *incompatible expectations*. The value of grounded theory is demonstrated by a plausible explanation within the context of discovery that supports an inductive argument grounded in data (Miller & Fredericks, 1999).

Memos

Data analysis and coding were accompanied by the writing of reflexive memos. These provided records of the principles and practice that guided analysis until diagrams or visual representations of the categories' relationships were produced from coding and memoing. Memos or analytic notes provide documentation that illustrates progression of the researcher's thoughts (Rodgers & Cowles, 1993). Memos or notes were dated, titled, cross-referenced, and filed as described by Corbin (1986). Code notes contained the outcomes of the levels of coding: substantive and theoretical. An analytic note (Rodgers & Cowles, 1993) or theoretical note (Strauss & Corbin, 1990) contains the thoughts produced during the analysis of the categories; their dimensions, properties, relationships, variations, and processes (Appendix M). Operational or methodological notes indicate the researcher's change in questions or sampling and the corresponding rationale (Appendix D). The final form of memoing is the reflexive journal or diary recommended for the investigator to encourage self-awareness by documenting personal responses that might provide a bias (Rodgers & Cowles, 1993; Streubert & Carpenter, 1995). An extract from the researcher's reflexive journal is provided in Appendix N. Ongoing diagramming was used to visually illustrate the analytical scheme emerging from the data. An example of diagramming from early data analysis is provided as Figure 4 (p. 324) in Appendix O.

Validity and Reliability

The issues of validity and reliability are important in all research. Rigour in qualitative research has been addressed by applying specific concepts such as truth value, credibility, applicability, auditability, and confirmability (Sandelowski, 1986). Truth value lies in the research revealing the phenomenon as perceived by the participants (Appleton, 1995). Member checks or returning to the participants and asking whether they recognise the interpretations as being faithful to their experience establishes credibility of the research (Creswell, 1998). A summary of the findings of this study was taken back to five of the original women interviewed. Individual appointments were arranged and once the summary was explained, participants were asked whether the interpretations reflected their experiences. Although Sandalowski (1993b) urged caution with the use of member checks due to different agendas for participants and researchers, all five participants confirmed that the findings explained the diversity of management decisions made during their breastfeeding and weaning experiences. The purpose of returning to the participants was to inform them of the findings and obtain feedback on the clarity and scope of the proposed theory, not to allow participants to modify the results based upon their singular experience (Morse, 1998). The researcher, with her education and theoretical knowledge, continued to assume control and responsibility for the process and outcomes of the research.

The concept of transferability has also been suggested as a method to demonstrate trustworthiness. Transferability refers “to the probability that the findings of the study have meaning to others in similar situations” (Streubert & Carpenter, 1995, p. 26). To assess transferability in the current study, the researcher presented a summary of the findings to two separate mothers’ groups within the local community. These women had all breastfed and weaned children and represented a wide range of experiences. All women were satisfied that the findings explained the diversity of mothers’ experiences in relation to their breastfeeding and weaning decisions. One woman commented that it was comforting to know that other women experienced similar problems with expectations and that similar strategies to deal with this problem were practiced by other mothers. She said it was helpful to know that she was not alone or unique in her experiences. Strauss (1987) referred to the irony that occurs when the theory is

presented to audiences who do not read it as theory but as a description of what has happened to themselves. He noted that this process is an “eye-opener” to the reader who is given “a new way of seeing what we all know that’s very useful” (Strauss, 1987, p. 20).

Applicability involves meeting the criterion of fittingness that assesses how the findings fit within contexts outside the current research situation (Appleton, 1995; Beck, 1993; Sandelowski, 1986). Development of an audit trail is important to validate trustworthiness (Rodgers & Cowles, 1993). Coding notes and diagrams of ongoing analysis of the data were presented at ongoing Ph.D. peer research group meetings with other people knowledgeable in grounded theory methods. Feedback, advice, and questions were invited to assist with the clarification and explanation of emerging categories and their relationships. Defending ideas and sharing opinions assisted to verify that the research process was thorough and the findings were empirically grounded. Peer debriefing was also one of a number of strategies recommended to ensure credibility of qualitative findings (Peck & Secker, 1999). The use of memos and/or notes such as code notes, operational notes, theoretical notes, and the researcher’s reflexive journal help to provide an audit trail that included a clear description of research procedures and findings. Examples of memos and code notes have been referred to in the appendices of this thesis. As a result, the concept of confirmability is achieved when truth value, applicability, and auditability are demonstrated (Sandelowski, 1986).

Interpretative research by definition involves an interpretation of what “we observe and experience through a mesh, or sieve, of understanding woven from our previous experiences and interpretations of information from other people and sources” (Peck & Secker, 1999, p. 555). In this process of exploring how participants understand the phenomenon under study, researchers must acknowledge that theories inevitably represent our interpretations of their understanding and are not just a reflection of them. Therefore, the challenge to the researcher was to become aware and acknowledge prior assumptions while exploring how participants’ responses apply to the context of their personal, social, and cultural situation (Peck & Secker, 1999).

Discussion of the researcher's perspective is essential when considering any research due to the potential for bias (Drew, 1989), but this is particularly important with an interpretative research design. According to Drew (1989) research tends to be initiated because the researcher has a personal involvement with the phenomenon, asks questions, and has the commitment to search for the answers. An interest in the phenomenon accentuates the potential for bias as personal values make total objectivity extremely difficult. Therefore, qualitative researchers need to make conscious efforts to set aside their assumptions to accurately analyse participants' experiences (Ahern, 1999). Ahern (1999) suggested that the "ability to put aside personal feelings and preconceptions is more a function of how reflexive one is rather than how objective one is" (p. 408). The concept of reflexive bracketing was proposed whereby the researcher tries to understand the impact of personal experiences rather than struggling to endeavour to exclude them (Ahern, 1999). To enhance the sensitivity required to see and hear accurately what is reported in the data, recording biases, feelings, and thoughts in a journal is recommended (Rew, Bechtel & Sapp, 1993). A reflexive journal was kept during this study and was particularly useful during open coding (Appendix N). Awareness of personal assumptions alerted the researcher to develop a focus beyond potential biases.

The researcher became interested in the phenomenon of weaning an infant from the breast due to a number of reasons. Firstly, being a midwife and an advocate for breastfeeding stimulated an interest in the entire breastfeeding experience from its initiation to cessation. During completion of a Masters of Science Degree a clinical trial was conducted on an educational intervention (Hauck, 1992). Responses to the open-ended questions in the questionnaire provided an insight into the emotional elation and/or turmoil that some women experienced when ceasing their breastfeeding. In a further study, the criteria for successful breastfeeding from the mothers' perspective were examined using a qualitative approach (Hauck & Reinbold, 1996). This study also highlighted how emotional and momentous the breastfeeding experience can be for women and illustrated how the entire experience, from initiation to cessation, can impact not only the mother's self-esteem but also the whole family. Finally, as a mother who had breastfed two children, the researcher had an appreciation of breastfeeding and the emotional investment that women place upon the experience.

The use of the self-as-instrument within qualitative research was recognised as fundamental (Rew et al., 1993). Glaser (1992) argued that “professional experience, personal experience, and in depth knowledge of the data in the area under study truly help in the substantive sensitivity necessary to generate categories” (p. 28). This use of self is said to be particularly important when conducting interviews where the researcher is able to use her/his personal history and awareness to respond empathically to another’s experience. Developing credibility with the participants was essential in order to form the trust and rapport necessary to acquire rich, thick descriptions of participants’ personal experiences.

Ethical Considerations

Ethical approval to conduct the study was obtained from the Edith Cowan University Committee for the Conduct of Ethical Research. Ethical approval from Edith Cowan University and relevant hospitals had been obtained by the researcher of the larger study, outlined earlier, that was used for recruitment of participants for this current study. Each participant was informed of the purpose of the study and time commitment involved prior to seeking a written consent. Participants were advised that the interviews would be audio recorded and they could choose not to answer any question with which they were uncomfortable. The use of a coding system was explained for transcribing their interview to ensure confidentiality. All participants were assured of confidentiality and anonymity as no names were used on the interview transcripts. A coding system was used instead. Participants were also advised that the researcher could contact them at a future date to confirm that the findings accurately reflected their experience and they could withdraw from the study at any time. A copy of the consent form (Appendix A) with contact telephone numbers of the researcher and supervisor was left with each participant.

Ethical approval was also obtained from two metropolitan child health regions to obtain access to their child health nurses. The researcher, supervisors, and fellow Ph.D. researchers had access to the transcripts, memos, and diagrams during analysis validation. The master list with names and codes was kept separate from the audio-tapes and transcripts. The audio-tapes and transcripts were stored in a locked cabinet in

the researcher's office and will be kept for a period of five years prior to being destroyed.

Limitations

The substantive theory developed in this study must be considered in light of the social phenomenon of women managing breastfeeding and weaning in a Western Australian community that strongly advocates breastfeeding. Additionally, the fact that a majority of mothers in Western Australia in the 1990's attempted to breastfeed further defines and clarifies the context of this grounded theory study. Analytic generalisability is a goal of qualitative research and applies to the usefulness of the concepts and constructs in explaining a particular social phenomenon (Hutchinson, 1993). Although the context of this research study involved a culture that firmly advocated breastfeeding, the concept of *incompatible expectations* can be considered and compared within different contexts, such as a strong bottlefeeding climate. The unique contribution of individual substantive theories can be further extended in the process of developing a general theory. Comparison of multiple grounded theories from related substantive areas can result in the development of a general theory with wider scope, range, and conceptual complexity (Strauss, 1995).

Summary

The grounded theory approach was utilised to explore the phenomenon of breastfeeding and weaning. Although the initial focus was on mothers' perspective of the weaning process it became apparent in the early stages of data analysis that participants could not separate their weaning decisions from the management of breastfeeding. Consequently the phenomenon evolved to include the management of breastfeeding and weaning from the perspective of mothers. Data were collected from mothers who had recently weaned their children from the breast, partners of the mothers, child health nurses, field notes made following interviews, books and magazines, local newspapers, and web sites. Analysis of data involved the constant comparison approach and incorporated substantive and theoretical coding (Glaser, 1978, 1992). Techniques of theoretical sampling, constant comparison, coding, memoing, and diagramming continued until theoretical saturation was achieved and the core categories of a shared problem of

incompatible expectations and a process of *constructing compatibility by adapting focus* evolved to provide a substantive explanatory theory for the management of breastfeeding and weaning in Western Australia.

Overview of Findings

As data were analysed using the constant comparative method, it became clear that two major categories, a basic social problem and basic social process, emerged in relation to the management of breastfeeding and weaning. The basic social problem that emerged from the Western Australian mothers in this study was the existence of *incompatible expectations*. Firstly, all participants expressed the reality of expectations, either self-imposed or imposed by others, in relation to their mothering role in managing their breastfeeding and weaning experiences. These expectations were interrelated and one aspect impacted upon the other. In other words, how a participant managed her breastfeeding influenced her weaning decisions, which in turn was viewed as a reflection of her mothering abilities. This common problem expressed by all participants demonstrated that there was no consistency or agreement between different expectations. On the contrary, expectations often conflicted resulting in an incompatibility between expectations.

The issue of being seen as a good mother, both introspectively and by others, was important for participants. The answer to the question, “how does a good mother manage her breastfeeding and weaning?” was based upon expectations from many sources, but consistency amongst expectations was the exception rather than the rule. Expectations originated firstly from the mother herself. She brought to her experience her own expectations. Other significant sources of expectations were the breastfeeding child, the woman’s partner, family members, friends, health professionals such as the child health nurse or general practitioner, and society. The mother’s expectations were influenced by her beliefs, knowledge level, past and current experiences of mothering, the experience of others, and her partner’s input. Not only did expectations differ between sources but a source often modified their expectations as breastfeeding or weaning experience evolved. The consequence of *incompatible expectations* upon

mothers was varying degrees of confusion, self-doubt, and guilt. Several factors influenced the degree of confusion, self-doubt, and guilt experienced by the participants.

The basic social process, entitled *constructing compatibility by adapting focus*, occurred in response to the problem of *incompatible expectations*. The participants used this process to create congruency between their expectations and others by varying their focus. The process of *constructing compatibility by adapting focus* involved three phases: *shifting focus*, *selective focusing*, and *confirming focus*. In the first phase of *shifting focus*, participants modified their view of breastfeeding and weaning expectations by assessing the relative importance of certain aspects over others. They took charge of their experience by clarifying and reinforcing their personal expectations and goals. Taking charge resulted in mothers demonstrating greater confidence and being able to trust their own judgement. The timing of when mothers entered the *shifting focus* phase was triggered when they reached their individual tolerance levels of confusion, self-doubt, and guilt.

Phase two of the process of *constructing compatibility by adapting focus* was termed, *selective focusing*. During this phase, participants chose to pay attention or selectively focus upon certain aspects at the exclusion of others. In other words, focusing upon one aspect negated or inactivated the influence of the other. Two strategies were employed during this phase. Participants embraced or welcomed agreement and support from certain sources of expectations and, at the same time, distanced themselves from disagreement or opposition from other sources. When confronted with ongoing *incompatible expectations* throughout the course of their breastfeeding and weaning experiences, participants would move back to the phase of *shifting focus* to re-clarify their own expectations and then reinforce their decisions using ‘embracing’ and ‘distancing’ strategies in the phase of *selective focusing*.

The final phase of this basic social process was named *confirming focus*. During this phase, participants reflected upon their experiences and resolved their breastfeeding and weaning decisions by verifying that their adapted focus achieved the compatibility they desired. Two strategies were used to confirm this compatibility. Firstly, ‘rationalising decisions’ involved focusing upon positive outcomes of weaning for the child, mother,

and family. Secondly, 'acknowledging feelings' allowed participants to express mixed feelings of relief, joy, and pride combined with loss and sadness. The consequences of moving through this third phase of confirming focus assisted participants to let go of their breastfeeding role, establish a positive image of their mothering, and develop the necessary readiness to move onto the next stage of mothering.

As the findings are discussed in the upcoming chapters, extracts from the data will be presented as participant quotes to illustrate and support the researcher's interpretations. The quotes will be italicised and provided from the audio-taped interviews, or postal questionnaires and identified as originating from a mother (M), father (F), or child health nurse (CHN). The number following the letter will indicate the coding system applied to each group of participants. For example, M1 to M33 identifies the 33 women who provided data, whereas CHN1 to CHN5 distinguishes the input from the five child health nurses interviewed individually. Nine fathers, who provided data through a postal questionnaire, are identified by the number that corresponds with their partner; for instance, F28 would represent the partner of M28. Data obtained from newspaper articles, mothering magazines, Internet web sites, and professional literature are acknowledged from the original source. The general term child or children is used to refer to the infants, toddlers, and pre-school children involved in the weaning stories shared by these participants.

CHAPTER THREE

Findings

Basic Social Problem: Incompatible Expectations

Introduction

Spoken accounts allow the speaker to give more details and include concerns and considerations that shape the person's experience and perception of the event. A story of an event is remembered in terms of the participant's concerns and understanding of the situation (Benner, 1994, p. 110).

This chapter defines the basic social problem entitled *incompatible expectations*. A major category that emerged from the data was this shared problem of *incompatible expectations*. All participants faced a common dilemma of how to manage their breastfeeding and weaning when exposed to conflicting expectations. The meaning participants attached to acknowledging and meeting the expectations of others is also discussed. A key finding of this study was that expectations about weaning could not be readily separated from expectations regarding breastfeeding and mothering. Consequently, examples of incompatible expectations are presented in relation to mothering, breastfeeding, and weaning. Finally, factors that influenced participants' expectations are discussed. Data extracts are provided to illustrate the properties and dimensions of this basic social problem.

Incompatible Expectations

In the management of their breastfeeding and weaning, all participants recognised that expectations were being placed upon them in relation to these important responsibilities. Both experienced and first-time mothers acknowledged the presence of expectations although the specifics of the expectations differed considerably between individuals. Expectations were both self-imposed by the mothers themselves and imposed by others. Participants perceived the presence of expectations from the child being breastfed, other children, partners, family, friends, health professionals, and society.

Expectations in specific areas such as breastfeeding or weaning could not be easily separated from expectations of mothering. Participants viewed their performance with breastfeeding and weaning as a component of their whole mothering experience.

Achievements or disappointments in one area overflowed to other areas:

... breastfeeding gave me one little link to a positive mothering side ... I felt that I was being a good mother in breastfeeding. It was rewarding, feeling satisfied within, being happy with your nurturing abilities at that stage. (M32)

All participants approached their role as a mother with particular goals and expectations. Expectations were defined in this study as anticipated and desired behaviours and outcomes in the management of breastfeeding and weaning. Participants' personal expectations regarding their role as breastfeeding mothers influenced their decisions and management of weaning. *"Babies are meant to be breastfed ... and you feel like you're really doing a good job"* (M13). General expectations associated with mothering were achieved through the accomplishment of specific achievements in the performance of breastfeeding and weaning (Figure 5). Success with breastfeeding and weaning reflected success with mothering. Conversely, perceptions of failure with these important tasks reflected negatively upon mothering abilities.

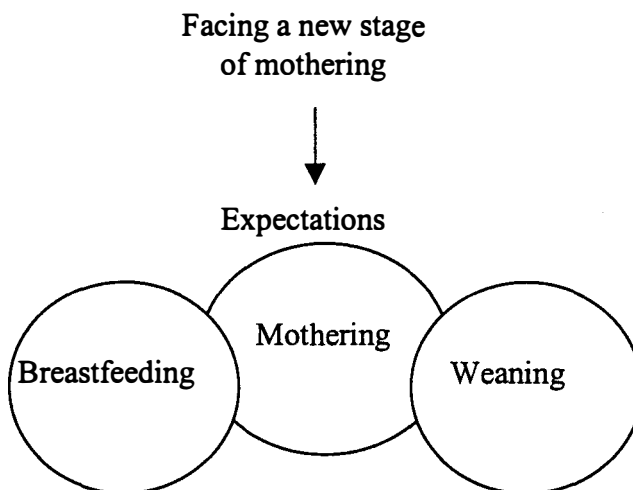


Figure 5: Relationship between breastfeeding, mothering, and weaning expectations.

Women remembered aspects of their breastfeeding experiences with an impressive degree of accuracy. An Australian study of maternal recall of infant feeding practices after an interval of 14 to 15 years, revealed a sensitivity of 82 percent for breastfeeding

recall with 60 to 70 percent agreement with breastfeeding duration (Tienboon, Rutishauser & Wahlqvist, 1994). In her presentation of a psychoanalyst's view of breastfeeding, Friedman (1996) concluded that "no matter how many years have passed since the actual experience, women are eager to share their triumphs and tribulations with regard to nursing [breastfeeding] and to offer advice to new mothers with whom they have no other connection" (p. 489). The significance and meaning attached to the breastfeeding experience can have long-term implications for women's ongoing perceptions of their mothering competencies. Therefore, the importance and impact of mothers' perceptions of their breastfeeding and subsequent mothering efforts could not be ignored.

While adjusting to their present mothering experience and trying to meet personal expectations, participants became aware that other people were placing expectations upon their management of breastfeeding and weaning. The problem occurred when mothers perceived differences or inconsistencies between their own expectations and the expectations of others. Participants found that expectations from all sources were not only inconsistent but often incompatible. Incompatibility was defined as a conflict or dispute between expectations (Figure 6). Due to the nature of the differences between expectations, it was often impossible for participants to achieve all expectations imposed upon them.

BASIC SOCIAL PROBLEM

Incompatible Expectations

Expectations of others
(children, partners, family, friends,
health professionals, society)



INCOMPATIBILITY

Expectations of mother

Figure 6: Basic social problem: Incompatible expectations.

The Meaning of Meeting Expectations

Participants were vulnerable and sensitive to the comments and opinions of others regarding their breastfeeding and weaning performance. The degree of sensitivity to comments did vary but all comments, supportive or critical, were perceived by participants as a reflection upon their mothering abilities. *“Other mothers or older people would comment on ‘are you feeding him right or are you sure he's getting enough?’ ... It didn't help, other people's comments, as if I was doing something wrong” (M3).*

In order to feel that they were successful in their mothering role, participants used their expectations and the expectations of significant others as a benchmark to evaluate the reality of their experiences. Sometimes people openly expressed their expectations as noted in the following quote: *“They [other mothers] were all saying ‘you need to teach your child to go to sleep by herself’ ... she was a child who didn't know how to go to sleep by herself” (M31).* Although some expectations from family and friends were clearly expressed as advice, others were implied from comments such as: *“why are you still doing this? You're sick ... you're losing weight. Why are you trying to feed the child as well?” (M12).* The family members did not specifically tell the participant to stop breastfeeding but this interpretation was clear to this mother. DeVito (1998, p. 191) referred to the impact of “metamessages” where rhythm or pitch are altered to accent the intention of the speaker's message and verbal modifiers such as only, still, or sure are added for emphasis. For example, the following participant could not mistake her mother's intended message to stop breastfeeding, although she chose to ignore it:

Mum is of the opinion that they should be off the breast by four months anyway and when we went to X [another Australian state to visit] that's what she said “are you still breastfeeding her?” and it's like “thanks Mum” (M20).

Participants acknowledged that how they managed their breastfeeding and weaning experience would be judged not only by themselves but also by other people. They felt this evaluation was inevitable. One participant mentioned that, after she had weaned her first child from the breast, she felt increasingly uncomfortable to be seen bottlefeeding in public. This discomfort occurred because she knew that she was judging herself and anticipated that others would be doing the same:

If I ever went out to a doctor's surgery, pulled out a bottle and gave it to him, I always felt like, I don't think people were thinking it, but I always felt like I was a failure, like people were looking and say "Look at that he's only three or four months old and she's got him on the bottle already". Maybe it was my own, maybe it was because that was what I was thinking about other people. (M21)

This same participant, who breastfed her second child for a longer time, stated how proud she felt continuing with breastfeeding when comparing herself to other women who had already weaned their children. *"When I was feeding my second one I felt so proud that I used to see other people with little babies on bottles and I used to think 'well I feed mine' [laughs]" (M21).*

Expectations changed as the reality of the experience unfolded. Therefore, the criteria used to assess success with breastfeeding, weaning, and mothering was dynamic and evolved over the entire experience. As the criteria changed over the duration of the breastfeeding experience, so did the ongoing perceptions that participants formed about their experiences. In her discussion of empowerment, Shelton (1994) asserted that women's breastfeeding expectations and subsequent perceptions of success or failure were based upon their own subjective judgement. Moreover, as each mother-infant dyad was unique, Shelton suggested individual assessment was necessary to achieve understanding of their beliefs and practices while respecting and supporting individual choices.

Participants expressed how the comments of others were very important in encouraging and acknowledging their efforts. *"And they'll [other mothers] go 'good on you, still feeding at this age [18 months]'. I got a lot of encouragement from that. People I didn't know, but I took that to heart" (M26).* Participants wanted people significant to them to recognise and acknowledge their mothering endeavours:

Whereas what I wanted was for someone to say you know keep, ... cause it was hard at first and I wanted them to say ... "keep going at first ... You're doing fine". Whereas Mum would say "oh just give it away. It's not that important you know. If it's not comfortable just don't do it". I didn't want to hear that because I wanted to do it. (M20)

How mothers viewed themselves and their accomplishments with breastfeeding, weaning, and mothering was influenced by how they perceived that others regarded

their efforts. Offers of support and acknowledgment reinforced a participant's positive self-concept in relation to being a good mother. Conversely, perceptions of non-support or disapproval from others were interpreted by the participant as a reflection of not meeting their expectations and being judged in a negative fashion. This vulnerability to potential judgemental comments of others was demonstrated in the relief noted in this participant's words: *"Everyone else [family and friends] said 'oh well you tried', there was no negative reaction which I was quite happy about because I felt bad enough in myself, but I had to stop"* (M9). Participants noted all comments from other people. However, the impact of certain comments was more significant especially if they originated from people who were important such as close family, friends, or health professionals. Johnson (1997) discussed the concept of social comparison as a method people use to assess the feedback of others to validate their own perceptions and impressions. He suggested that confirmation was used to endorse perceptions of being "normal, healthy, and worthwhile" whereas feedback that suggested otherwise had a disconfirming effect (Johnson, 1997, p. 7).

The concept of this looking glass self (Cook & Douglas, 1998; Tice, 1992) where one's view of the self was influenced by the perceptions of significant others was supported in the importance participants placed upon receiving acknowledgement from others and in the consideration and meaning given to the expectations from different sources. Cook and Douglas (1998) suggested that cues to expectations would be particularly salient and perceivable when goals between the perceiver and significant other were in conflict. Tice (1992) argued that the "looking glass self may function as a magnifying glass during self perception, so what one sees in oneself while others are present has an extra powerful impact on the self concept" (p. 449). Although the performance of breastfeeding and weaning did not necessarily occur in front of other people, the outcomes of these tasks were readily examined and evaluated by participants in this study and those around them.

Whether people acknowledged the efforts of participants was contingent upon their perception of the degree of congruence between their own expectations and those of the mothers. Compatible expectations between participants and others resulted in

participants not only meeting those expectations but also feeling truly supported by those people whose expectations were accepted by the mother:

She [sister-in-law] used to say to me. "He's really hard to feed, isn't he". So that was good. She was actually very supportive and I asked her a lot of questions. She never criticised and she always said to just give up when the time is right. (M3)

A perceived lack of acknowledgment or reassurance from significant others resulted in some participants from this study feeling criticised and unsupported:

"Why don't you just put him onto formula, it's much easier?" As soon as I did it was like, "you should have done this a long time ago". Whereas really what they [parents] should have been saying to me was "congratulations on trying for so long. You've done really well." (M3)

It has been suggested that the lack of support or encouragement withheld by others has been related to people's inability to set aside their own beliefs and values and move beyond their own personal experiences (Biancuzzo, 1999). The importance of support for breastfeeding women has been noted in the literature as those women who have not received the social and professional support they needed were significantly more likely to wean early (Bergh, 1993; Janke, 1994). Johnson (1997) asserted that social support was most important during major life transitions when stress tended to be high. This could be applied to the transition that occurs during weaning a child from the breast.

Many participants mentioned the frustrating reality of not receiving adequate acknowledgement for their efforts. *"I've fed and I've fed, I've sat there for a very long time and I think I should get some reward other than breasts that now sit round my belly button and nipples that never feel like mine anymore"* (M32). Advice on the management of breastfeeding and weaning was very forthcoming from family and friends but acknowledgment and recognition for the effort displayed by mothers was not as prevalent as some participants would have liked. *"No one was really interested, or 'you should stop feeding him by now'. Not one of them [family members] was interested in saying 'you are doing a good job' "* (M26). Partners and child health professionals also commented that mothers did not receive the acknowledgement from others that they deserved for their efforts. One child health nurse stated:

I think that we don't give enough credit to mothers for mothering really as a society, this western society. We don't say ... "you're doing really beautifully with your baby". I try and do it. The people find it unusual to be getting praise for something that is expected of you. It's a hard job being a mum. (CHN5)

The underlined segment of the above quote further reinforced the existence of expectations. Expectations became a problem when participants perceived expectations that were ambiguous, or even conflicting from their own and were then faced with the dilemma of how to approach and reconcile this situation. During the term of breastfeeding and weaning, participants became aware of discrepancies and contradictions between their own expectations and those of their partner, breastfed child, other children, parents, mother-in-law, sister, friends, child health nurse, general practitioner, and even the general public who observed and commented upon their actions:

Most of the time it was the elderly people; some would be great, but mostly European people would look and frown and make me think whether or not I should be doing it [breastfeeding in public]. (M19)

Even people who were only acquaintances openly criticised women for their infant feeding choices, with minimal regard for their feelings or individual situations:

There's a lady at my support group that decided to bottlefeed and not breastfeed whatsoever, and one of the other mothers ... she really hopped into her one day and said "Well you know, it's not really the best, do you know what your baby's missed out on?" And she really upset this other woman, terribly, terribly so, and that I thought was wrong because ... it was her choice. (M11)

Participants trying to manage their breastfeeding experiences were caught in the middle of the contradictory and confusing debate about the best or ideal way to manage breastfeeding and weaning. "[There are a] whole lot of set ideas out there about the right and the wrong way and you can really ... get bogged down" (M12). The answers to what was right and wrong were not always clear. There were no definite answers as new information continued to emerge which challenged existing practices. "You tend to listen to what other people say and think 'Oh am I doing the right thing?' " (M22). Everyone had opinions and was very willing to offer advice to participants. "Because he was hard to cope with, you know, but like everybody said whereas my sister, she was the worst one, 'stick him on a bottle, he wouldn't have colic at all' " (M26).

Consequently, participants were left to sift through all of these differing opinions and suggestions, compare them with their personal goals and the reality of their experience, and discover a balance that was attainable and acceptable. *“But you do feel a bit like a failure, you think God, you know all these people keep telling me this should happen and I should keep breastfeeding but it wasn’t happening” (M9)*. Ultimately, participants wanted to feel they were good mothers and not a failure.

All participants, new and experienced mothers, experienced incompatible expectations. The degree of incompatibility varied between individuals, as did the emotional consequences. First-time mothers were often faced with incompatible expectations from many sources that were unfamiliar to them. Because mothering and breastfeeding were new experiences, these participants did not anticipate the expectations they would be exposed to from their child, partner, family, friends, health professionals, and society. Becoming aware of everyone’s expectations and deciding how to deal with them was a new and often overwhelming experience for first-time mothers.

Experienced mothers were aware of others’ expectations from past experiences, in particular, those expectations from their partner, family, and friends. However, friendships and family members change over time with new people joining these networks. Additionally, each child was unique and expectations were often specific to each individual child’s needs and personalities. The exposure to new health professionals, media, updated information from books and magazines, and acquaintances or strangers in public places exposed experienced mothers to new expectations that were different from past breastfeeding or weaning experiences. Finally, familiar people such as partners placed different expectations upon their spouses due to changing circumstances with each breastfeeding experience, each child’s unique personality, altered financial situations, or physical difficulties not encountered previously. To illustrate, a partner who was supportive with an experience where the child weaned herself at ten months, was not as supportive with another child wanting to continue breastfeeding well into the second year of life:

I think he had this thing that you really shouldn’t be breastfeeding a baby after 12 months anyway ... I think I probably would have still kept breastfeeding [child] just out of that niceness but my husband really had quite a bit to do with influencing me and encouraging me to wean him off. (M24)

Reassurance and support for decisions made during breastfeeding and weaning contributed to women's self-esteem by re-affirming their mothering efforts and endorsing the perception that they were capable respected mothers. As far back as 1988, Jane Price, a psychiatrist, acknowledged how a woman's self-esteem impacted upon her perception of success or failure with infant feeding:

It is important to recognise just how much the early experiences of breastfeeding [or bottlefeeding] are important in the development of the woman's self-esteem as mother. If she feels she has failed such an early hurdle she may well become increasingly uncertain of her abilities across the whole spectrum of mothering activities (Price, 1988, p. 57).

Self-esteem was also found to be a major predictor of maternal competence for experienced and inexperienced mothers in an American study (Mercer & Rerketich, 1995). This exploratory study compared self-reported maternal role competence with competence at hospital discharge, one, four, and eight months postpartum with 136 experienced and 166 first-time mothers. The groups did not differ in their perceived competence over the eight months; however, inexperienced mothers' competence demonstrated a gradual improvement over time indicating a developmental process in maternal role achievement. Additionally, women involved in a Finnish study who believed that society appreciated motherhood felt they received important affirmation from their social network and consequently coped better with their breastfeeding (Tarkka, Paunonen & Laippala, 1999). Although the Finnish data were obtained when infants were only three months old, it does reinforce the importance of this acknowledgment during the earlier stages of breastfeeding.

Vulnerability to others' comments was also noted by Bryant (1993) who found that first-time American mothers were particularly sensitive to others' anecdotes about their breastfeeding experience. The vulnerability was most concerning when it involved negative experiences. Data from 35 focus groups with low-income women in the Southeastern United States unveiled a number of barriers that deterred women from continuing to breastfeed (Bryant, 1993). In particular, the influence of family and friends, especially the woman's mother and partner were significant barriers to some women's attempts to breastfeed successfully. Raj and Plichta (1998) also found that the

friends and mothers of breastfeeding women were a significant influence upon the breastfeeding behaviours of women. Dix's (1991) study into factors influencing choice of feeding method and attitudes toward breastfeeding also noted that women received information on infant feeding from health care providers, family and friends; however it was the family members who had the most influence on the choice of feeding method. Health professionals have also acknowledged the impact of family and friends upon mothers' breastfeeding decisions (Lazzaro et al., 1995). Thus, it was evident that other study's findings supported these aspects of this study's findings.

Examples of *incompatible expectations* will now be presented across the spectrum of expectations relating to mothering, breastfeeding, and weaning.

Expectations Related to Mothering

Confronting the experience of mothering was new and overwhelming, especially for first-time mothers. These participants felt vulnerable and ill prepared for the role facing them: "*Because I had no idea, I had no idea what I was in for really*" (M11).

Participants had to contend with expectations in relation to many tasks of mothering, such as the management of breastfeeding, bottlefeeding, weaning, sleeping, crying, and colic. Participants' perceptions of success in the performance of these tasks were used to verify meeting their expectations regarding mothering. Participants wanted to be able to see themselves as good mothers. "*This [breastfeeding] is mothering; this is nurturing; this is what we are for*" (M32).

Mothering as hard work.

Being a mother is something that many women do; therefore participants anticipated that because this role was so common and other women adjusted easily, they should also be able to adapt. "*But why should I need this help? Why shouldn't I be able to feed all day and get two minutes sleep, cook the dinner and be all pleasant and lovely*" (M33). Participants, particularly those who were first-time mothers, anticipated that mothering would be easier than the reality that eventuated. "*I just didn't expect it to be the way it has ... Just from the crying, the constant crying that babies do that's all*" (M23). They did not expect the impact of adopting the mothering role to be so significant:

There's this expectation that I think motherhood won't affect you so ... so the harsh reality is well it does ... I had the expectations at the beginning anyway so that I would be able to carry on as usual, go here, go there with one hand and then do it all with the other hand. (M33)

The time, commitment, and effort required for infant care surprised many participants.

"Our garden didn't get touched for the first six months and that I found very frustrating. And I'm also someone who likes a clean house" (M3). Participants who anticipated this period of adaptation were still surprised by the reality of the task:

[I'd] say to myself ... "It's going to be hard", but still it was a shock ... Just to have a shower [laugh] it's like finding the time to have a shower, you're constantly ... you just haven't got that free time anymore. (M13)

Partners also commented upon the unanticipated commitment and effort required by the participants in this new role as mothers. *"I don't think he realised how much work was going to be involved even to this day he still says that 'I really hadn't imagined how much' and he didn't use these words but it was along the lines of 'how much help you'd need'" (M32).*

The need to give of self.

The expectation that mothering involved self-sacrifice for the sake of the child was confirmed by the perseverance some participants demonstrated during their experiences. Breastfeeding and weaning provided opportunities for participants to demonstrate to themselves and others their willingness to be a caring, selfless parent. *"I didn't have a very good time breastfeeding, but for the baby's sake I did persevere with it" (M19).* Participants expected to put the needs of their child first and, as long as the child was happy and thriving, they tolerated pain and discomfort for long periods of time. *"For the first three or four months I had a lot of trouble with his feeding ... I had quite severe thrush that wasn't diagnosed for nine weeks, so feeding was very painful" (M12).* When faced with opposition to the expectation that mothering involved self-sacrifice, participants expressed confusion and frustration as some people advised them to stop breastfeeding or introduce a bottle at any early signs of difficulties:

It was mostly extended family "why are you still doing this?" ... But again I was really determined to do it. I really stuck with it. And then when I got to six months, "are you still doing it. When are you going to give up?" (M12)

Participants who were trying to persist and overcome problems were often confronted with comments indicating that self-sacrifice was not necessary. “ ‘Just give it a break.’ So that perception. Other people's perceptions didn't help either and next time around even if I do have problems I don't think I'll say anything to my mother-in-law or my mum” (M3). Participants were very aware that their efforts were being judged by themselves and others and wanted to be seen as attempting to do the best for their child. “So I talked to them [reunion of mothers from a prenatal class] and said ‘well why did you stop?’ and one said ‘she bit me’, another one said ‘he got a cold and couldn't breathe so I stopped’. They were all very trivial reasons” (M12). This example demonstrated how one participant judged these reasons as trivial based upon her personal expectation that self-sacrifice was a necessary part of mothering.

The involvement of significant others.

Participants anticipated that their partner and family would want to be involved in the care of their children. “Because it was his [father] first child and he wanted to be involved” (M17). Encouraging this involvement was seen to be an expectation of the mothering role. Some participants facilitated the involvement of partners and family members by offering a bottle of formula. “I felt glad that he'd taken the bottle because my husband wanted to feed him, wanted to give him the bottle. He wanted to feel that closeness to him and he couldn't you know” (M7). Bottlefeeding allowed the opportunity for fathers and grandparents to be involved in this one aspect of the child's care. “In a way as much as breastfeeding is good, I think the bottle is good for the partners because it gives them a little bit of extra bonding with the baby as well” (M16).

Participants expressed how the support and involvement of their partners and family was very important to them. “Even though X [husband] didn't have any experience with that [breastfeeding], his help was more important to me [than anyone else's]” (M20). Mothers also noted how valuable this involvement was to their partners, family members, and children. “He was doing a lot of country work with his job and as much time as he could spend with X [child] was very precious to him” (M24). Participants appreciated the special bond that formed between their child and significant others. Friends who indicated a desire to be involved and supportive to parents met

participants' own expectations and were regarded as a valuable resource. *"The big thing was support from family and friends that was really good"* (M9).

Information from textbooks and parenthood classes acknowledged this expectation of including partners and extended family members in the care of the child (Health Department of Western Australia, 1993, p. 84; Huggins & Ziedrich, 1994, p. 65).

However, these resources presented suggestions with the priority of not jeopardising the continuation of breastfeeding. Therefore, providing the child with a bottle of formula to enhance involvement as revealed by some participants' stories was not included in the professional literature, which promoted other strategies such as assisting with bathing, dressing, providing comfort, or playing with children.

Some partners were receptive to adapting their involvement needs in ways other than feeding their children. *"My husband is good, really helpful, he is one of the modern dads, he'll change nappies, bath them, dress them, feed them, he helps out"* (M16).

However, in reality, many participants were faced with expectations from others to be involved with feeding. *"I did feel a little bit of pressure although I sort of resisted it from him [spouse] to put her on the bottle so he could feed her"* (M2). This potential pressure upon mothers, whereby partners encourage or lobby mothers to bottlefeed to facilitate their involvement with their child has been noted in other research (Jordan & Wall, 1993).

For others, the prospect of not being involved with the feeding limited their level of involvement with children. For example, not being able to bottlefeed meant they were not able to baby-sit for long periods of time. *"She [mother-in-law] kept saying that 'when she's on the bottle she can stay' so as soon as she found out, that was it, 'so when can she stay?' "* (M20). Expectations by family members, often grandparents, of wanting to be able to support parents by baby-sitting over longer periods put pressure on participants to weigh the benefits of continuing breastfeeding over the benefits of enhancing greater family involvement.

Balancing the needs of the family.

Participants, especially those with more than one child, expressed the expectation that they needed to be receptive to the needs of all family members. Although a challenging task, mothers expected to be aware of and responsive to the needs of their infant, partner, and any older children. If they felt any aspect of their mothering, such as feeding, dealing with sleeping problems, or providing emotional support, was compromising their obligations to other children or partners they reassessed their options and evaluated the impact of potential changes:

So it did give me hands free to give the older boys a little bit more attention. Because many a time I'd be breastfeeding and they'd come up and say "can you do this for me?" "Well, I'm busy now." And they'd say "you are always feeding." Which was true. (M2)

Participants also considered their partner's needs as they reviewed options in their decision making. The following example demonstrated this consideration as the wife debated her desire to continue breastfeeding and her partner's desire for her to return to work. *"He [partner] wanted me to go back to work and he thought if I didn't wean X [child] off at 12 months then I wouldn't want to go back to work" (M24).* Another participant weaned her daughter earlier than desired to be available to contribute to a family business. *"We were looking at buying a business and she was about eight and a half to nine months old and it would've meant me working in it" (M21).*

Happy child reflects good parenting.

Participants suggested that an expected outcome of mothering was to have healthy, happy children. *"Just to make my baby happy" (M11).* Mothers wanted to see their efforts result in contented children and when that did not occur, they experienced distress:

Nature's made you listen to it [crying] and ... you can't turn it off. But so many and my mum said ... "just let him cry" but I can't just let him cry. There's no just about it even if I let him cry there's no just about it because I am so totally involved in his crying, I can't, there's no living when he's crying even if it is just five minutes it seems like pure hell to me. (M32)

A major concern expressed by participants was their ability to focus on the child to correctly interpret and meet his/her needs. *"Just baby, the baby, and so concerned,*

whether I was doing the right thing” (M11). Participants continually assessed their mothering efforts against their child’s reactions. They would continuously ask themselves, *is what I am doing making my child happy?* A child’s distress demonstrated by crying, fussiness, or being unsettled was interpreted as a demand for attention and assistance. As mothers they expected to be able to respond appropriately to that demand. An unhappy child indicated that the mother was not being receptive to the child’s needs:

She just screamed continuously and the day that I did take her for a walk so many people just stopped and stared at me like, “what are you doing to that child!” And I thought, well I can’t do anything about it, not that they could understand but I was just so embarrassed (M15).

When a child was not happy, for whatever reason, participants perceived that it was their mothering role to respond to that unhappiness and rectify the situation. Strategies in response to that distress were often justified as appropriate if they kept the child happy:

He just started fidgeting about six weeks ... And people were saying “Oh you know your milk’s not good enough, comp him. So I said “oh OK give him a bottle and keep him happy because he always seems to be happy when he’s having a bottle.” (M21)

Women’s criteria for good mothering has been examined in a recent Australian study (Brown, Lumley, Small & Astbury, 1994). Although Victorian women were not comfortable disclosing their impressions of a good mother, Brown et al. found that most mothers were able to list attributes they associated with good mothering. While examining a variety of factors relating to pregnancy, birth, motherhood, and depression, that study revealed that Australian women believed a mother should possess the following characteristics:

The good mother is required to be loving and caring, to have never-ending supplies of patience, to willingly and regularly spend time with her children, and in this time provide her children with the right sort of attention, stimulation and guidance (Brown et al., 1994, p. 141).

These challenging and often unattainable characteristics of the good mother presented expectations that women pursued toward “the possibility of perfection” (Brown et al., 1994, p. 149). However, an alarming finding that emerged indicated that because these

criteria were so difficult to achieve, many women did not see themselves as good mothers. Sadly, 15 percent of women in Brown et al.'s (1994) study used the following statement as a criterion for a good mother: "good mothers are good at what I'm not good at" (p. 140).

In this current study, the expectations that mothering required sacrifice supports one of three ideologies asserted by Bundrock (1995) in her scholarly discussion of changing ideas of maternity and work in Australian public policy, popular ideology, and health services. The ideology of mothers portrayed as martyrs, who sacrificed themselves for the sake of others (Bundrock, 1995), was supported in many participants' statements. Bottorff's (1990) work on the significance of persistence with breastfeeding also accentuated women's perceptions of the sacrifice inherent in mothering.

Mothering myths were revealed in a Canadian study that explored the psychological experience of mothering. The power of the prevailing myth that mothering comes naturally to women was common and persisted despite opposing knowledge (Barlow & Cairns, 1997). Additionally, through semi-structured interviews a British study examined how motherhood changed the life of 13 women and revealed the following themes: 'motherhood as mandatory'; 'myths of motherhood'; 'self-sacrifice'; 'overwhelming love'; and 'just a mother' (Weaver & Ussher, 1997). Again, these themes reinforced expectations that mothering required considerable self-sacrifice and at the same time was regarded as a natural and essential component to women's lives.

Not only did partners in this study place expectations upon their spouses, but Hall (1994) found that Canadian men also encountered expectations upon themselves in their role as new fathers. Men responded to a "lack of concurrence among societal expectations, others' expectations, and their own realities of fatherhood" by redefining their fathering role, particularly when their spouses returned to the workforce (Hall, 1994, p. 219). A recent Australian study by Barclay and Lupton (1999) explored the experiences of new fatherhood and found that men were unprepared for the realities of work and commitment required with an infant. Potential unrealistic expectations from the men regarding household and infant work had "negative consequences for their partners" who could not maintain the same level of household work as the period prior

to becoming a parent (Barclay & Lupton, 1999, p. 1015). The authors concluded that expectations on fatherhood are “out of step with social structures” (Barclay & Lupton, 1999, p. 1018). Harder working fathers who were facing diminishing social reform and support were expected to provide emotional and practical support to their spouses and benefit from closer, more intimate relationships with their children than past generations of fathers.

Expectations Related to Breastfeeding

The reasons participants gave for making the decision to breastfeed illustrated the importance they placed upon this feeding method. These women, who initiated breastfeeding and continued for periods of six weeks to over six years, saw breastfeeding as being integral to the role of mothering. One participant expressed her beliefs regarding breastfeeding and mothering as follows:

Because they [infants] have got to have the 100 per cent start, you've got to give them a 100 percent, I feel, because they rely on you from the word go. And that's the way I look on motherhood. You don't bring a child into the world and just because you can't stand breastfeeding stick them on the bottle. (M26)

Best choice for the child.

Breastfeeding was recognised by all of the participants as being the best they could do for their children. “*Like everybody, like most people, you just want to give the very best for your child in every way and that [breastfeeding] is the best thing you can do*” (M31). Although breastfeeding experiences varied as far as course and duration, all participants regarded their efforts as giving their children a good start. “*So he'd had, in my eyes, he had my nutrients so he had a good start*” (M11). In other studies, women have acknowledged that breast milk is healthier and better for an infant no matter what feeding method they personally chose for their children (Alexy & Martin, 1994; Dix, 1991). In Dix's (1991) study with American women of varied ethnic backgrounds, the majority of the 81 women interviewed stated that breastfeeding was better and contributed to healthier children, although 84 percent of them chose to bottlefeed.

Because breastfeeding was generally regarded as being the preferred choice, participants expressed the expectation that good mothers would at least attempt to breastfeed, even if for a short time. To not attempt to breastfeed was seen as being selfish. “*The reason*

why I didn't want to breastfeed my first child was because I was selfish, I thought I'm not going to lose my figure and expose my breasts" (M7). Participants placed this expectation of the importance of at least attempting to breastfeed upon themselves and other women. Participants acknowledged that attempting to breastfeed, for however long, did give the child a "good start" and mothers should be commended for this. "*She [friend] just said 'oh never mind you did your best, you did three and a half months" (M21).* Participants found it difficult to understand mothers who were not prepared to at least attempt to breastfeed for the sake of their children:

For instance another friend of ours knows from now, she's not even pregnant, but she knows from now that she doesn't want to breastfeed ... I think "why why don't you at least try it, it's beautiful, trust me it's beautiful", but she knows from now she doesn't want to breastfeed and I find that so sad to not even, to just write it off, "I don't want to breastfeed." (M23)

Except for X [a friend] like she put her baby onto the bottle from day two and I sort of thought that was a bit ... she didn't have any problems like she couldn't breastfeed, and then here I am sitting here talking about other people's negative reactions. But when she put her baby on to the bottle at two days old I felt sorry for the baby. Oh he's missing something. (M13)

Not only did participants expect their child would gain adequate weight from breastfeeding but breast milk promised higher intelligence for the child and protection from such threats as Sudden Infant Death Syndrome, viruses, and allergies as shown in the following data cited from the West Australian newspaper and a child health nurse:

Research collected by the WHO has found that breastfeeding boosts a child's immunity and cuts the risk of allergies, gastro-intestinal illness, respiratory disease, ear infections, diabetes, autism, tooth decay and Sudden Infant Death Syndrome (Bower, 1997, p. 35).

Children of mothers who eat a lot of seafood during pregnancy and while breastfeeding will grow up smarter and see better, according to a leading American nutritionist ("Seafood", 1997, p. 61).

I also say about some really good research from X and Y [local hospitals] about influence of breast milk on brain development and especially with boys, especially if they breastfeed for 13 weeks they get, they have a higher IQ. I've seen that research presented. (CHN1)

There is continued debate over the influence of breast milk on cognitive development and its promised benefits to children's intelligence. Accounting for sociodemographic,

environmental and biomedical factors, breastfeeding status at six months and cognitive development were analysed in a cohort of 375 Australian children over 13 years and provided a small, statistically non-significant benefit (Wigg et al., 1998). An American study of white middle class participants found that school age children who had breastfed scored slightly better than their peers (Rogan & Gladen, 1993). In contrast, another American study found no relationship between breastfeeding and intelligence quotients and suggested such observations may be due to the positive bonding associated with breastfeeding (Malloy & Berendes, 1998).

The promised health benefits of breast milk were not presented without debate as participants were confronted with contradictory information in the media indicating potential harmful effects of breast milk:

Women could be poisoning their newborn babies with lead passing through their bones and into breast milk, Australian researchers say (“Lead breastfed”, 1997, p. 27).

Ms Liston, in a paper to be presented today at an international breastfeeding conference in Sydney, says recent studies suggested that even small amounts of alcohol could have significant long-term effects on a breastfed baby (“Plea for mothers”, 1997, p. 61).

Smoking flavours breast milk. As a result, babies quickly develop an affinity to the taste and smell, increasing future risks of becoming a smoker in later life, according to the New England Journal of Medicine (Wright, 1999, p. 14).

Although participants believed that breastfeeding was best for their child, they also believed bottlefeeding was an acceptable alternative. Although exclusive breastfeeding was encouraged by health professionals, many participants combined both feeding methods depending upon their individual situation. One father commented that *“breast is best but bottles may relieve some stress if made more acceptable and are not pooh poohed in prenatal classes”* (F12). Although offering one’s child a formula feed was not perceived as ideal, it was not seen to harm the child. *“I think with the way they make the formulas now it's not going to be a huge difference to the babies, otherwise they wouldn't make it for babies if it was going to hurt them”* (M16).

The best choice in the management of breastfeeding varied for individual families. Formula feeding was used by some participants to complement their breastfeeding due

to its perceived benefits. Some mothers also felt tied to their children with exclusive breastfeeding and offering a bottle allowed greater freedom. “... when I could give him the bottle and rest the nappy on it, it was a chance for me to go and do my chores and my housework” (M11). As one child health nurse commented, women today have different expectations than their mothers did: “They [mothers] are out more and they feel they should be able to have that flexibility” (CHN1). Participants expected that bottlefeeding would allow this freedom and some mothers attempted to combine methods when the commitment to exclusive breastfeeding became too burdensome:

I've got the best of both worlds, I've still got that intimacy, can still hold him and feed him and get that feeling but I'm not sort of committed to doing that every feed, but I can leave him. I can leave him with a bottle. (M12)

Easy, natural and convenient.

Women expected to be able to breastfeed if they chose to. They anticipated that because breastfeeding was natural, it would occur with minimum effort. Participants expected breastfeeding “to work” (M1). They did not expect to have problems or any problems that could not be easily overcome:

I automatically assumed that I'd be able to breastfeed and wouldn't have any problems. I just envisaged breastfeeding and nothing else. Because no one tells you about the problems, no one tells you about colic and reflux and latching on problems. They all say it's natural and it works and the baby will just latch on and you'll breastfeed and that's really good. No one told me about all those problems and dramas and things. (M9)

Not only did breastfeeding have to be easier “because everyone does it, it has to be easy” (M17) but this naturalness would allow more time to accomplish what one wanted in a day. “I thought you could do an awfully lot more when you're at home with a baby than you actually can do” (M3). Convenience was seen to equate with increased freedom and ease in taking the child out of the home environment. This potential freedom did not eventuate for many participants due to feelings of discomfort with breastfeeding in public:

After she [child] came I was just turning into a hermit you know [laugh]. And I think that bothered him [father] a bit because, I mean although he didn't go out very much either, but sometimes he'd say, “oh come on, let's just go here and take the baby”, and I'd say, “I don't want to you know.” (M13)

This widely held assumption that breastfeeding was natural was also found in a New Zealand study where mothers were interviewed in focus groups (Vogal & Mitchell, 1998).

Additionally, participants anticipated that they would be able to breastfeed until either they or their children were ready to stop. *“And that I would be able to breastfeed until I was ready not to breastfeed or the baby was ready not to breastfeed anymore” (M5).* They did not anticipate that problems would challenge their determination and ability to breastfeed for as long as they wished.

Although information from family and friends described breastfeeding as having positive and negative aspects, participants stated that health professionals portrayed breastfeeding in a predominantly positive light. In prenatal classes, potential problems and negative aspects of breastfeeding were addressed briefly or not at all. *“There was no like can't do it, not enough milk, too much milk, none of this business, there wasn't any other complicated factors, it was an entirely personal choice, and it was easy, it just happened. But no” (M12).* This representation reinforced the expectation that breastfeeding should be easy, natural, and a positive experience. Consequently, if reality differed from this ideal image (Figure 7), this was a reflection on the mother's abilities or inadequacies, as such. *“No one covered that side of things, it was all positive breastfeeding, breastfeeding's great, which it is but no one sort of covered the negatives or the what ifs. And that's what I found really hard” (M9).*

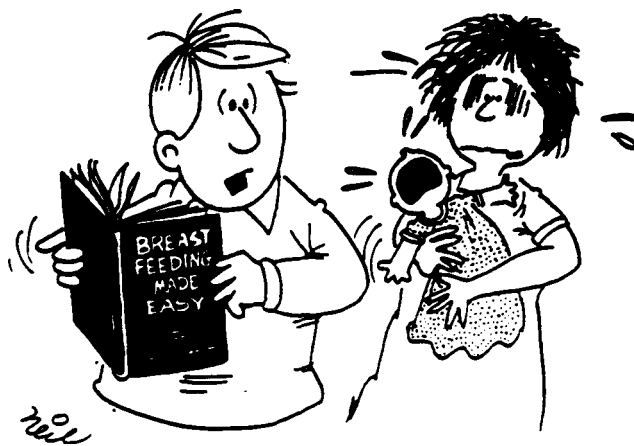


Figure 7. “Where the heck do these books find such contented looking mothers and babies?” (Matterson, 1990, p. 27). Permission to present cartoon obtained from author.

Because participants believed that breastfeeding was natural, some of them questioned the need to even discuss breastfeeding during prenatal classes because it contradicted that image of natural, easy breastfeeding. *“They did a session on breastfeeding, it’s like you sort of think why are we needing to know this, it’s just like so easy” (M12).*

Naturalness was equated with easiness. *“I mean how hard can it be? It’s like baby, breast, put them together, go for your life. I was like, what problems can there be? It’s the most natural thing in the world” (M12).* The effort required for breastfeeding was anticipated to be less than for formula feeding. *“I couldn’t think of anything worse than having to get up in the middle of the night and heating a bottle up. I would rather, I thought it was easier breastfeeding” (M18).*

Although some first-time mothers had doubts about the depth of their breastfeeding knowledge, they didn’t see this as an issue. First-time mothers were confident that if they didn’t have the knowledge, it would not matter because their child would naturally know what to do. They expected infants would be able to instinctively latch onto the breast. *“It was going to be easy, so natural [laughs]. She’d know what to do” (M20).*

After all, animals in nature do not have to be taught to suckle:

I did think that even if I didn't know what to do, the baby would know. You know what I mean. And I don't, even now, I'm not really too sure whether it's instinctual or not but it probably is to a certain extent but I think they still have to be taught how to feed and that's something I didn't know. (M3)

Support will be available.

Participants who chose to breastfeed anticipated that they would receive support from their partners, family, friends, and health professionals. Participants also expected that their decisions relating to infant feeding would be respected. They believed that they had choices. *“You [child health nurses] should be here to advise us but support us in whichever direction we take” (M16).* This participant’s expectations were supported in the following statement from a Western Australian parenting guide (Health Department of Western Australia, 1993):

They [couples] can also learn about breastfeeding and prepare to care for their baby according to their wishes. Informed choice = confidence. Which ever method they choose to feed their baby, ongoing support and help are readily available (p. 87).

Although many participants felt they were making informed decisions and were happy with their choices, they did not always feel supported by health professionals when they decided to introduce a bottle of formula. *“What I found really hard as well because they [child health nurses] are really negative towards bottlefeeding” (M17)*. The underlying message delivered to participants was that if they were truly informed about breastfeeding, they would not make the decision to bottlefeed:

And I'll do anything to get them to keep breastfeeding short of shout at them or coerce them because I think they have to do it not me. They're the ones up in the middle of the night, they're the ones at the supermarket with the boob hanging out, not me. (CHN1)

Some health professionals demonstrated respect for informed choice in their practice.

“I say it is their choice and I'll support them whichever way they want to do it”

(CHN5). Unfortunately many participants found that ongoing support from health professionals for decisions other than breastfeeding were not readily available:

I've been to a lactation consultant, done all that sort of thing, going to you know 15 people and ringing up the milk Mafia and getting them to say “just try one more time” and I'm going “but I don't want to try one more time” [laughs]. (M32)

Health professionals made their expectations clear to participants when they deliberately or unconsciously expressed their disapproval of decisions made by mothers. *“ ‘Why did you stop?’ [participant questioned by child health nurse]. Even though it was having a detrimental effect on both of us but it was still oh ‘why did you stop’, and she was sort of a bit sort of funny there” (M9)*.

The assumption that advice provided by health professionals would be appropriate and reflect current research knowledge was not always found to be the case by participants. The information and advice offered by health professionals could also be contradictory. *“There was probably only three to four different nurses, and naturally they've all got their different ways, they've all got different ways that they've seen” (M16)*. With time and experience, some participants gradually lost trust in the advice received from health professionals, such as general practitioners and child health nurses. *“When she started mucking around I thought what's going on. And all the clinic sister could say is she's going through a growing spurt so we need to change. That was the answer for*

everything” (M4). As a result, three participants used the child health nurse as a “*weighing and measuring service*” (M16, M22, M26) rather than a source of information. Alternately, some mothers chose not to return to their child health clinic. The following example illustrates a participant questioning the advice given to her by her general practitioner:

He [general practitioner] told me I shouldn't be breastfeeding him ... Because, he thought that it was causing him to have wind. For starters and I looked at him I said “it is the most natural thing in the world and you're telling me that I shouldn't be doing it” (M26).

These findings reinforce the assertion that health professionals must remain current in their knowledge of breastfeeding trends, information and benefits (Janke, 1993), which is not always the case. A recent survey of management approaches of Australian lactation consultants found that there was usually more than one approach to a particular problem (McIntyre, 1995). Although some approaches were in agreement with the literature, in some cases little agreement was found with published research.

Participants acknowledged the strong message from many sources that breastfeeding was the only option. “*You hear so much from the media, from hospital, midwives, clinic nurses; everything that breast is best so that is what you think, I have to give him breast milk, that there is no other options*” (M19). However, participants also expressed perceptions of the contradictory message that although they should breastfeed, they must not be seen breastfeeding in public. “*And I would say probably as the child got older the stranger the looks became ... [more apparent when breastfeeding in public]* (M27).

Believing that breastfeeding was recognised as being natural and the best for children, many participants anticipated they would be supported with breastfeeding in public. Although many participants regarded breastfeeding as natural and inoffensive, they did not take for granted that the general public would agree with this opinion:

It's just something that I've always thought was very, very beautiful. I've always had the image of breastfeeding and of having a child as being something that was beautiful. What's the problem with a child feeding in public, what's the problem with a child feeding on a bus or a train or wherever. I've never ever thought of it as being something that should be covered up. (M27)

Breastfeeding in public.

Breastfeeding in public had been passionately debated in the Australian media. Participants were well aware of controversial stories where breastfeeding mothers had been asked to leave public transportation or shopping areas. *“I didn’t feed on a bus or anything like that when X [child] was little: there was a big story about this girl that was put off the bus for breastfeeding” (M28).* The reality of being asked to leave a public area due to breastfeeding was acknowledged, albeit humorously in an Australia publication of breastfeeding cartoons (Figure 8).

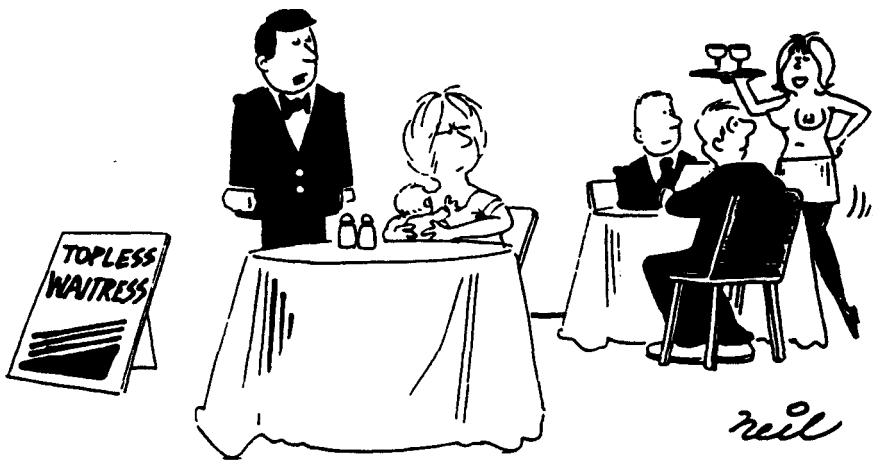


Figure 8. *“I’m sorry madam, we don’t allow breastfeeding in here” (Mattersson, 1990, p. 71).* Permission to present cartoon obtained from author.

Some participants had first-hand experience of people’s expectations in regard to breastfeeding in public:

I’ve only ever had one guy come up to me and called me a slut and how dare I expose myself in public and how dare women do this and that and the other. That’s fine I said that’s your opinion, I said I happen to find this very natural, it’s good for me and good for my baby [child six weeks old]. If you don’t like it you can remove yourself from the café instead of me. (M27)

Other participants were not prepared to risk being the target of negative public comments because they saw what other mothers experienced in those situations. *“I have seen so many mothers actually told to get off the benches and get into the mothers’ room” (M26).* The reality of women facing opposition to breastfeeding in public was supported in a recent South Australian survey regarding the topic of public breastfeeding (McIntyre, Turnbull & Hiller, 1999b). Two-thirds of restaurant managers and 52 percent of shopping center managers stated they would “discourage

breastfeeding anywhere in their facility, suggest a mother move to a more secluded area if she wished to breastfeed, or were unsure how they would react” (McIntyre et al., 1999b, p. 131).

The issue of how to manage breastfeeding in public was a common dilemma faced by all participants. Prior to mothering, some participants expressed similar perceptions to society and regarded breasts as a sexual object not to be displayed in public. However, that image had changed when they began to breastfeed:

I know before I think before I was pregnant like if I saw anyone breastfeed, I just think look I think I'll breastfeed but ... I don't know whether I'll be doing it at a picnic or whatever you know. Because that's all I related them they were sexual organs whatever you want to call them. But that changed immediately [when she became a mother]. (M32)

The sexual image of breasts was not seen to be compatible with the current mothering role. “We're mothering here, you know. You can't be really seen to be attractive and everything and be mothering at the same time” (M33). The incompatibility of these two roles for the breast was illustrated by the following participant's statement comparing her feelings during breastfeeding and following weaning:

[Sexual images of the breast] didn't fit at all. It's like “how can my husband touch these things when five minutes earlier our daughter's being suckling on them” ... [After weaning] I felt sex, things like that came back too. And just the top half of my body I felt like I could wear my bathers and exposed it to a point without feeling ... that's the milk in there, that's dinner in there. I can't go flashing it about. (M33)

Participants also commented how their partner's image of breasts as sexual changed during the breastfeeding experience. “As far as sex and everything came he'd [partner] tend to think that they [breasts] were the babies and you keep away from them because that's baby food” (M22). Participants from Stearn's (1999) qualitative study into the experience of breastfeeding in public supported this finding as they also chose to ‘redefine their breasts’ and regard breastfeeding as a natural use of their bodies. The role of the breast changed from being a sexual object to being the producer of nourishment for a child.

Experienced mothers were more confident to address their child's need to breastfeed regardless of the location. “I felt like I'm the mother of two and I'm entitled to

breastfeed in public whereas of course with your first one, you're thinking am I doing the right thing and maybe I shouldn't be doing this" (M24). First-time mothers were more reticent with their expectation to breastfeed in public. "If I went out to someone's house I'd think 'Oh I can't feed in front of everybody. Oh I've got to feed' and I'd go out of the room" (M21).

Participants shared differing approaches to breastfeeding in public when the necessity arose. Being discrete was regarded as an important strategy as it demonstrated respect for the feelings of others. *"I'm thinking about the general population, they don't like to see my breasts and in the same token I don't think that I need to expose it" (M23).*

Breastfeeding in front of males, the elderly, and people who didn't have children was avoided if possible:

I sensed that other people felt a bit embarrassed that I was breastfeeding, so that was sort of... you know, that made me feel a bit funny, you know you can sort of tell [laugh]. You're breastfeeding and they're trying not to look at you sort of thing, and that was with the males. (M13)

It was either older people or people where you could tell didn't have children or no tolerance to children, but mostly older or younger people who didn't have children. (M19)

Participants who were sensitive to the comments of others regarding breastfeeding in public were extremely restricted in their daily routine:

And then I'd go home having these mixed feelings about I should be able to breastfeed and you know, feeling annoyed with them that they [female strangers in public] made me feel uncomfortable and then turning it around and saying I can do it, I can do it if I want to because I'm nourishing my baby if it happens to be while I'm out then surely that doesn't make any difference. (M24)

Some women adjusted their day around breastfeeding to avoid having to do it in public, but this wasn't always easy. *"I tried to avoid it unless he was screaming. I was quite surprised at people's attitudes in this day and age" (M18).* One Australian woman speaking on a local radio program, where a discussion was being held about breastfeeding in public, had this to say about the issue:

They say that mothers shouldn't do it in public but they don't offer any options and they don't think about the fact that what they are really saying is the mother must not go out in public if she's a breastfeeding mother because babies don't feed to a timetable. They don't feed at predictable times and a mother needs to

be able to go out in public and go about her daily business (Australian Broadcasting Corporation [ABC] 7.40 am radio program April 6, 1998).

Other mothers who had children with predictable feeding routines, which was uncommon for breastfeeding children, used the routine to predict when they had to be home to breastfeed:

I just used to time it. I mean feed him before you go out, the stop watch starts, we used to drive out the drive and say right, we've got four hours, we can go out and do what we want but we have to be back in four hours. (M12)

Some participants would take a bottle of formula with them when going out for their own peace of mind. *"I made sure that if we did go anywhere I had bottles on me and I wouldn't have to worry about doing it [breastfeeding] in public [laugh]" (M15).* The juggling required to avoid having to breastfeed in public was stressful for many participants:

I found you couldn't do it in shopping centers or anything like that. You had to go to the mother's room and a lot of the times the mother's rooms weren't there. There isn't one. Or if you do go in there you get these chairs to sit on [refers to uncomfortable chairs without arms]. I hated that. (M26)

I was feeling uncomfortable breastfeeding out and as much as I wanted to go out, it was this conflict between going out and breastfeeding and then I'd try to work out my routine so that I could be out and back before the next breastfeed. And then I thought, "oh what's the point, I may as well just put him on the bottle." (M24)

Once the bottle was introduced to the child, several outcomes were possible. Some children then indicated a preference for the bottle whereas others were receptive to a combination of formula and breast milk. Either way, these practices threatened the mother's milk supply especially when she began introducing more and more bottles of formula. Many participants began to then question whether continuing to breastfeed was worth the effort and often decided to initiate weaning:

While I'm out, I'm feeling really uncomfortable. He's getting stressed. So I'm going to bottlefeed when I go out if I'm in public or if there are a lot of males around ... So I started just giving him a bottle when we went shopping of something, I'd sit down and give him a bottle rather than the breast and then when I got home I'd breastfeed him. And then slowly he decided well this is just too hard, I want the bottle all the time. He started refusing me. So that was basically how he weaned himself off. (M5)

Breastfeeding in front of other women, especially other mothers, was anticipated to be more comfortable and relaxing than breastfeeding in front of men. *“In front of women I don't mind we'll often go in my bedroom or just chit chat while the baby's feeding, but in front of my husband's friends, it's just not necessary [to breastfeed]”* (M23).

Breastfeeding in front of immediate family presented a dilemma for some participants although they anticipated that it would be acceptable and supported as the wellbeing of child was the foremost concern. *“I didn't worry in front of my husband, my mum, or you know immediate family, but other people it was like, you know”* (M13). Some mothers expected family members to suppress feelings of embarrassment for the sake of the child:

It was a little bit uncomfortable in front of my father-in-law or my father ... but I mean after a couple of weeks it was like sorry guys [laugh] this is part of having a grandchild ... it just became very natural after that with my father-in-law and my father and my brother. (M12)

The concerns participants expressed in relation to public breastfeeding was supported in the findings from an American qualitative study that explored women's experiences with breastfeeding in public (Stearn, 1999). The women interviewed in Stearn's study found breastfeeding in front of males was a problem. Because the breast was regarded as sexual, the issue of 'monitoring the male gaze' was a major category extracted from the interview data.

Scholarly debate has also ensued regarding society's sexual image of the female breast as being a dominant negative influence to women attempting to breastfeed in contrast to the nurturing image of the suckling breast (Dykes & Griffiths, 1998; Hall, 1997). The influence of values was demonstrated in an American analysis of socio-cultural factors affecting women's decisions where the sexual image of the breast influenced women to choose not to breastfeed (Rodriguez-Garcia & Frazier, 1995). This sexual image was not confined to America, as an Israeli study utilising quantitative and qualitative methods revealed that “sexuality and motherhood were mutually exclusive in the perception of women: the more sexual a woman was perceived to be, the less she was seen as a good mother” (Friedman, Weinberg & Pines, 1998, p. 781).

Intimacy, closeness and enjoyment.

Participants stated how their decision to breastfeed was influenced by the anticipation of intimacy and closeness promised for their mother-infant relationship. *“I think I did it mainly because I want that closeness”* (M32). The achievement of intimacy with their child was the desired outcome of breastfeeding that participants perceived to be separate from a sexual connection. *“I don’t think I felt anything very sexual about it other than being very close to another person with skin contact ... it’s lovely to be needed by your child and to give pleasure and to be that close ”* (M32). Being able to give one’s child something that no one else could offer was a unique component of that intimacy. *“Whereas when you’re breastfeeding you get him [child] back and you’re the only one that can do that”* (M8). Some participants stated that breastfeeding allowed them a greater access to their child as other people could not feed them. Once a bottle was introduced a loss of closeness was accentuated by family and friends’ offers to help with the feeding:

Every time she’d wanted a feed someone would say “I’d feed her, I’d feed her, I’d feed her” ... I was getting angry thinking that if I was breastfeeding that you wouldn’t be able to do this. And she’d be my baby and I’d be able to feed her and you wouldn’t be able to have that choice. (M5)

Aspects of mutual enjoyment, closeness, and giving of oneself noted by participants were also supported in the findings of another Australian study that examined women’s criteria for success with breastfeeding (Hauck & Reinbold, 1996). This assertion that breastfeeding encouraged the development of a warm, close mother-child relationship has been recognised in professional textbooks (Thompson, 1995) and lay literature (Maushart, 1997). First-time mothers from a low-income area expressed similar beliefs regarding breastfeeding in a recent American study (Libbus, Bush & Hockman, 1997). The expectation of bonding or a special connection being fostered through breastfeeding was also revealed. Further characteristics associated with intimacy, namely, reciprocity, harmony, and trust, were noted in the literature but not specifically expressed by participants in this current weaning study (Dignam, 1995).

The intimacy described by participants in this study was expected to be exclusive to breastfeeding in that bottlefeeding was not anticipated to provide the same degree of closeness. *“I find when I feed her with a bottle there’s no connection ... It’s just like*

this artificial thing, definitely. I feel like I'm distanced from her now"(M21). Many participants did experience and enjoy the anticipated intimacy that breastfeeding promised. *"I did thoroughly enjoy it and I would do it if I got pregnant again"* (M28). Another participant expressed her enjoyment of breastfeeding through her advice to other women: *"if you can breastfeed, do so. It's magical"* (M27). Unfortunately, this enjoyment was not a reality for all mothers as one child health nurse noted from her experience with working with new mothers over many years: *"Not all mums enjoy breastfeeding; I think that it's a myth that everyone thinks it's wonderful"* (CHN5).

Not only did participants expect enjoyment from breastfeeding but they anticipated that their child would benefit. *"I still was quite happy to breastfeed her though because I was enjoying it and she obviously liked it better [than bottlefeeding]"* (M22). It was more difficult for participants to achieve the enjoyment and closeness they anticipated with breastfeeding when they perceived their child was not benefiting from the experience:

It wasn't, it felt like a chore, it wasn't going to work and I kept thinking that this is just a pain and because she was upset it wasn't a comfortable feeling like having her lay there because she was always, she was crying or upset it was always frustrating and ... I could never relax and just enjoy. (M15)

In these situations, participants often stated that putting their child on a bottle did not interfere with the closeness between mother and child. Rather, if changing to the bottle improved the child's feeding behaviour, mothers were often more likely to relax and enjoy the closeness:

When I gave them the bottle and they snuggled into me I did not feel like I missed out because I still felt like, a lot of people say that when you breastfeed you don't get as close if you bottlefeed, but I found that when I was bottlefeeding, they were happy. (M15)

Participants expected to eventually enjoy their breastfeeding experience even if this enjoyment may not have been present at the beginning of the experience. Some mothers anticipated that difficulties could occur when initiating breastfeeding, but believed that problems would be overcome with perseverance and the resultant enjoyment would be worth the effort. *"I enjoyed the whole thing. Enjoyed just the whole thing, very difficult to begin with though, but no, it was just great"* (M33). If the enjoyment for mother and

child was achieved but not sustained or if the enjoyment attained did not meet personal expectations, participants questioned the value of continuing breastfeeding. *“And it was getting to the point where it was, it wasn’t enjoyable to breastfeed anymore because she messed about and didn’t really want it or then the next day she’d want more” (M25).*

Achieving some degree of enjoyment from breastfeeding was anticipated for all participants. *“I still enjoyed it but I didn’t enjoy it as much as I could have done. Because of the frustration with this child continuously wriggling around all the time” (M3).*

The more mothers and children were enjoying the breastfeeding experience, the more reluctant they were to begin the weaning process. *“Well we do enjoy it. I mean I enjoy feeding her and I enjoy having her sort of cuddle up when we go to sleep. So I mean I wouldn’t like to stop it” (M1).* Diminishing enjoyment by either party was one criterion used by participants to indicate a readiness to wean. When participants did initiate weaning for reasons beyond their control, such as another pregnancy or returning to work, but were still enjoying the closeness breastfeeding afforded, they expressed greater sadness and loss in ending the experience.

When women experience their anticipated enjoyment, they are more likely to continue breastfeeding. An Australian study evaluated an intensive education program with written materials and sessions with a lactation counsellor designed to increase breastfeeding duration to at least four months with first-time mothers (Redman et al., 1995). No significant differences were noted between the experimental and control group. However, those women who enjoyed and were satisfied with the experience were most likely to continue breastfeeding to four months. Results from a South Australian study also revealed that women continued breastfeeding when they perceived the experience was natural, enjoyable, and beneficial (Stamp & Crowther, 1995).

Moving from the breast to the bottle did not necessarily mean a loss of intimacy for all participants. Some mothers stated that, although the closeness remained by using strategies like extra cuddling it was not the same; it had changed:

Even though I wasn’t breastfeeding, when she was in your arms and you’re feeding you still feel that sort of closeness but I think it’s a little bit different to breastfeeding. I think you feel a little bit more special [with breastfeeding] ... I

didn't like feel ... I was really missing out on anything major, but, it did feel a bit different. (M13)

Other participants noted how they maintained a physical closeness while bottlefeeding but felt the degree of intimacy was diminished:

So it doesn't feel as close then but then he's very very cuddly when he's finished his bottle ... He'll lay awake for awhile and he just grabs your face and plays with your face and just strokes you and in that sense it's still very close but still not as, I don't think you still don't feel like you've got that real intimacy with them. (M5)

Contributing to the enjoyment that participants expressed was a sense of pride in accomplishing their expectations of breastfeeding. *"Probably the thing that sticks in my mind the most is probably ... a couple of things and this one thing is to begin with, I just thoroughly enjoyed it and I was so proud that I could actually feed because I couldn't before"* (M5). The accomplishment of expectations was a reward and resulted in pride and enjoyment. *"So it was a reward in itself to see that it's visually very simulating just to see, 'look mum I'm doing it' ... It was something that could be done that was rewarding in itself and you didn't have to think about it much it was just nice and he looked happy"* (M32). The act of giving of oneself, the intimacy, the pride, and seeing the results of their efforts in a healthy, happy child contributed to this enjoyment. *"He was feeding. He had the milk off me. That was a nice feeling, as strange as it sounds. And the closeness, the bond"* (M11).

Healthy contented child.

The anticipated outcome of breastfeeding was a plump, contented, healthy child. *"I always had this picture of Johnson and Johnson's big fat roly polly lovely babies [laughs]"* (M32). Photos of breastfeeding infants portrayed in books, magazines, and newspapers reinforced the image of a plump, contented, child suckling at the breast. This image was not always present in reality. *"You're not what I pictured you, you're little, you're skinny"* (M32). Participants expected to see their child putting on weight and thriving due to their breastfeeding efforts:

She [child health nurse] weighed him and said that he had only gained 50 grams, she told me that he was obviously not getting enough milk because he should have put on more than that. I said 'look I have been feeding him, he's constantly feeding, he's fine'. She told me to come back the following week, if

he's not gaining any weight they have to give him supplements, or a boost or something to compliment feed. (M17)

Not only was the child expected to gain the appropriate amount of weight due to breastfeeding but participants anticipated happy, contented children. Participants' assessment of their child's contentment and happiness varied, however, depending upon their expectations of how healthy, normal children should behave. Some maternal behavioural expectations regarding breastfed children were not always realistic:

He [child] was happy, he was a happy loved baby, he was never upset, but he was never ever settled after feed. Like he always looked like he wanted more. And then he wouldn't last any longer than three hours and I thought, no. So that's when I gave him his first bottle. (M15)

Participants used terms like "fussiness" and "being unsettled" to describe their interpretations of unhappy, discontented children. *"She [child] used to fuss so much. It was almost like there was any milk there you know whereas you'd give her a bottle and she'd have no problems. She'd be happy and content straight away" (M22).*

When expectations that breastfeeding would provide a happy, thriving child did not eventuate participants became concerned. *"He [child] wasn't drinking a lot off me and he was losing a bit of weight and it was causing a bit of concern" (M18).* Another participant expressed her concern as follows:

Just X 's [baby] continuing decrease in weight was really worrying me because she was only 6 lb 13 ozs born anyway so she was never a big baby and with her weight just decreasing, decreasing, decreasing, it was really worrying me and then the fact that she was crying all the time. (M9)

Ongoing problems with breastfeeding that interfered with producing the promised happy, contented plump child were not anticipated by participants: *"Thinking it wasn't supposed to be like this ... all I've done is cry and feel sore and not been able to make my baby happy" (M5).* As a consequence of not having their expectations met, concerned mothers took action. *"I don't want her being cranky and upset all the time. She just wasn't happy so I decided to put her onto the bottle" (M4).* The most frequent decision made by participants was to offer a bottle of formula. *"OK give him a bottle and keep him happy because he always seems to be happy when he's having a bottle"*

(M21. If bottlefeeding as opposed to breastfeeding fulfilled the desire to produce a happy contented child, mothers justified their decisions based upon that outcome:

She [child] just was so unhappy and crying all the time and putting her on the breast didn't help her. It was like she wasn't getting anything out of it. So I tried the bottle with her and she was a lot happier. It was like she was filling up and she was more content having the bottle. (M22)

A British study found that the greatest influence upon parents' decisions regarding infant feeding practices was based upon their interpretations of infant behaviour (Walker, 1995). These decisions were affected not only by children's behaviours but also by interpretations of their children's personality, which influenced such behaviours. For example, in Vandiver's (1997) study involving 50 first-time American mothers, a correlation was noted between later weaning and mothers' perceptions that their infants had easy temperaments.

Expectations Related to Weaning

Expectations related to breastfeeding had a direct influence upon the weaning process. If breastfeeding expectations were not being met and participants were dissatisfied or disappointed with their experience, they would often begin weaning. Expectations regarding the management of breastfeeding often influenced when and how weaning was implemented. When participants did not achieve expectations, such as breastfeeding being easy, natural, and convenient or breastfeeding offering enjoyment and intimacy with a healthy, thriving child, participants questioned the feasibility of persisting with something that was not working. *"I was having doubts then because he was so unsettled, and I was uncomfortable with what was happening with him" (M11).* Effort was weighed against the gains. *"This is just too much, a big ask for the returns to either of us" (M32).*

Participants discovered specific expectations associated with the process of weaning a child off the breast. Many participants indicated that they used child-led weaning, meaning they used particular indicators that suggested that their child was ready to wean. In other words, participants were receptive to cues given by the child and responded as such. *"It was probably infant led because I was sort of responding more to their needs" (M2).* Participants had to balance the desire to be responsive to their

child's needs while also being aware of their own and others' expectations of when to wean.

When to wean.

When is the appropriate time to wean a child from the breast? Advice and opinions were offered to participants but there were often as many suggestions as there were people offering them. Mothers used different criteria to determine when to wean. Assessing readiness to wean in their child was one criterion that participants used when trying to decide when to wean. Mothers increased their level of sensitivity to changes in their child's behaviour that would indicate a readiness to begin weaning. Developmental changes such as erupting teeth, declining interest in the breast, the ability to tolerate other fluids and foods, or the skills to use a cup were used as milestones to indicate readiness to wean:

It really wasn't until he was about 15 or 16 months that he showed any interest in the cup and we seized on that opportunity and thought, right, now is the time that we can encourage him more to drink out of the cup and start weaning him. So we were really taking his cues and his development. (M24)

Readiness to wean was assessed by participants reflecting upon their opinion of whether readiness was regarded as physical, emotional, or a combination of both. It was noted by several participants and supported in the literature that most children reach a physical readiness by one year of age when they are able to tolerate solid foods and other liquids, such as juices and cow's milk (Huggins & Ziedrich, 1994, p. 113). *"Age-wise yes she was ready. And it was getting to the point where it was, it wasn't enjoyable to breastfeed anymore because she messed about" (M29)*. Another participant described this physical readiness as *"when they started eating and going onto cow's milk and their bodies accept it" (M25)*.

Emotional readiness, however, was different and referred to the desire of the child to sever the special closeness and intimacy with the mother. *"She [child] didn't need it for nutrition or anything as comfort goes you know we're sitting and cuddling having stories and she's just nuzzling in and it was nice" (M28)*. Participants determined whether this emotional need for closeness was still important for their particular child. *"And that was I think that was the clinch when I decided well if he can go to bed with*

just stories and songs then I really don't need to be involved anymore ... So I was ... very relieved that there wasn't a lot of attachments still on his part" (M32).

Factors that indicated readiness were not mutually exclusive. Some participants viewed their children's acceptance of a bottle of formula as an indication of both a physical and emotional readiness. Children who demonstrated a particular preference for one feeding method made their needs and expectations easier to interpret. *"I just kept putting him to the breast whether he liked it or not I put him to that, but then when he just wouldn't accept it, I gave him the bottle" (M11).* The child's preference was obvious when cues were clear and unambiguous. *"And every time I went to give it [bottle] to her she would scream at me and try and go for my boob and she'd wriggle at me and carry on" (M21).*

If a child's behaviour was ambiguous, participants were faced with the challenge of interpreting what particular cues meant. Many children were willing to accept an occasional bottle during the course of their breastfeeding experience. *"But I think the fact that X [child] had taken the bottle so easily it was, you know, mummy's gone shopping, stay with dad, there's a bottle on the sink, he'd take it no problems" (M7).* Although this flexibility in moving between the breast and bottle was desirable and convenient for many participants, it meant they had to rely on other factors to indicate a readiness to wean. Participants became more sensitive to the development of uneasiness with continuing to breastfeed rather than receptivity to a bottle. Participants expressed this uneasiness as a loss of interest, *"just disinterested" (M33),* in breastfeeding. *"He just didn't really want a feed at night, he just was probably so tired all day and that was it and he just lost interest. So yeah, that was sort of when I cut it out" (M30).*

Participants were not always confident in their judgement of indicators that their child was ready to wean. Mothers often turned to others to assist them in making this decision. Asking health professionals for the best time to wean was one approach to this dilemma. *"What's a good time to wean X [nurse]' and I'll say it depends upon how you feel and the baby and ... they'll ask me 'what is the ideal time' and I'll say 'it depends upon the mother and baby' " (CHN3).* When participants approached different health professionals regarding this matter, they were often given different opinions.

One participant asked her general practitioner when she should wean and received advice based upon his personal experience:

And I said, "well, you know when do people stop breastfeeding" and he said, "well, everybody's different, but from 14 months you really can't offer the child the nutrition after that 14 months" ... And he said his wife fed their kids till they were 14 months old. (M12)

Many participants stated that their doctors were most concerned about the child's weight and if he or she was not contented or gaining appropriate amounts of weight, the doctors were apt to suggest using a complementary bottle of formula:

My doctor he said, "look X [mother], it doesn't matter, if you feel better bottlefeeding, bottlefeed." Then when I saw the paediatrician, he was the first specialist actually I'd spoke to that said, "don't worry about it, why are you worrying about it, bottlefeed the baby if she's going to be happier" [child 10 weeks old]. (M15)

Child health nurses interviewed in this study felt that many doctors were too willing to offer formula as a solution to breastfeeding problems as they often did not have the time to support a breastfeeding mother. "[Mothers] probably wouldn't get as much encouragement with breastfeeding from the doctors as from us" (CHN4). Physicians have been recognised for their preference to recommend formula because they don't have the time or knowledge to support parents with breastfeeding problems (Huggins & Ziedrich, 1994).

When participants turned to other sources of information, such as books, regarding timing for weaning they were faced with more contradictory information. To illustrate, one source indicated that between nine and twelve months there is a "window for weaning", when the child's natural interest in the breast wanes (Braselton as cited in Huggins & Ziedrich, 1994, p. 123). However, another book, used by a participant (M24), suggested that weaning was not recommended between seven and ten months as this is when a child reaches the peak of attachment to the mother (Fowler & Gornall, 1991, p. 152). At the same time, when participants accessed information on Internet web sites, they were presented with further conflicting information. Dettwyler (1995a, 1995b) suggested that in societies where children nurse as long as they want, they usually wean themselves between three and four years of age. Penelope Leach, the author of several children's books, offered the following advice on her web site entitled

Your Baby and Toddler: “many babies who are allowed to nurse for as long as they like wean themselves by the time they are around a year old” (Leach, 1996, p. 1).

Participants also relied upon their partner, family, and friends to offer advice regarding the timing of weaning. Partners often based their advice on the current breastfeeding situation. *“He [partner] said ‘look enough is enough.’ He said ‘you know neither you nor the baby have had any sleep because she’s not feeding properly, we’ve got to do something’ ” (M9).* The wellbeing of the family was paramount and if a struggle with breastfeeding was occurring, he questioned the value of persisting with something that wasn’t working. *“He [partner] said it wasn’t working, and he was happy enough. I think he was pleased that I put him onto the bottle when I did because I just said ‘it’s not worth the battling with them [children]’ ” (M15).* Although partners encouraged breastfeeding, they expected to see their family benefit rather than suffer from breastfeeding. *“He was trying to encourage me but then he got to the point where he just said ‘this isn’t good enough’ ” (M5).* In an Australian study that focused upon data related to breastfeeding duration, 200 participants revealed that by six months, 18 percent of mothers had already been advised by someone to wean (Lowe, 1997).

Family members also had expectations as to the appropriate timing for weaning.

Mothers of participants offered advice based upon their previous experience or beliefs:

She had very strict regimental ideas on how it should be done and of course we were sort of a bit more laid back you know. So we had different ideas all together. And she was saying stop her at four months is enough, she doesn’t need it after four months and all this. (M20)

Sometimes parents of participants offered advice regarding the timing of weaning based upon their concern for the health of participants or their grandchild. *“Mum [participant’s mother] went through a stage at about eight or nine months where she said ‘I don’t think she’s getting enough milk you know. Maybe you should get her onto some sort of formula or cow’s milk’ and I did” (M29).* If parents of participants believed the effort of breastfeeding outweighed the benefits, they offered weaning as a solution while offering their support and help with bottlefeeding. *“She [mother of participant] was concerned for me. You know ... ‘let me just hold her while you go and*

have a sleep or something' and I mean sometimes she'd say 'look should we give her the bottle so you can have some rest' " (M33).

Friends, who were mothers themselves, based their expectations to wean upon their own breastfeeding experiences. *"You did three and a half months ... I didn't do much either or something or other and I had to comp [complementary feeding] too and it's just how it is, some people are like that. You just didn't have enough milk"* (M21). Friends were also concerned with the mother's and child's wellbeing and, if they saw breastfeeding as not working, encouraged the participant to stop breastfeeding, for their sake and the child's benefit. *"My best friend, the one that had the second baby, she did, she said you know really you've persisted long enough and it's not improving, you should go on the bottle for the baby"* (M9).

Acceptable breastfeeding duration.

All participants agreed that breastfeeding was best for an infant, but there was little conformity between participants regarding their expectations regarding the appropriate duration for breastfeeding. Some participants did not have a specific expectation for breastfeeding duration but expressed that any breast milk was valuable regardless of the time. *"He [child] had my nutrients [for 10 weeks] so he had a good start"* (M11). This expectation was reinforced by health professionals who acknowledged participants for any efforts with breastfeeding, no matter what duration. *"But many mothers they breastfeed for six weeks, eight weeks, three months and I say to them at the outset at that first meeting. I say 'any breast milk is better than no breast milk'. It's really important"* (CHN1). Health professionals who offered reassurance for even short term breastfeeding supported information presented in parenting magazines that acknowledged any amount of time breastfeeding a child as beneficial (D'Angelo, 1998; Schmitt, 1998).

In 1989 the World Health Organisation together with UNICEF issued a joint statement in support of exclusive breastfeeding for the first four to six months of life (WHO, 1989a). Although this statement does not recommend weaning at four to six months, many participants regarded the period of six months as a marker to begin weaning. *"Like I thought the first six months were probably pretty important"* (M18). Some

mothers felt this time period was crucial as a minimum goal and anything beyond that time was a bonus. *“I mean from the reading I’d done I knew that I would have wanted to feed at least for six months. I knew that that was sort of the, as you say, that they’d done research and that was a good time” (M1).*

Other participants saw the period of 12 months as an important goal for breastfeeding duration. *“I would have been quite disappointed if I couldn’t have breastfed for 12 months. I probably had an expectation I would breastfeed for at least that long” (M31).* Some mothers stated that this expectation came from recommendations from health professionals. *“They recommend 12 months breastfeeding. I think in way, way back in my mind ... I owe it to this child to feed her for 12 months” (M33).* Other participants based their 12-month goal upon the influence of family members. *“My mum, she breastfed all of us, I know, till a year and that that’s always my expectation that everyone did that” (M30).*

Some participants had specific expectations regarding the acceptable age to breastfeed a child. *“I had a very strong ... desire not to have a toddler running around looking up my shirt and saying ‘mummy I want a feed’ ” (M12).* An older child who could verbalise and assert their needs and wants was not considered by some mothers as a baby any more and therefore not appropriate to breastfeed. *“So I thought I’m not going to go beyond eight months because I know some people find it very comfortable to be feeding a 1 or 1½ year old” (M5).*

The assumption that only babies are breastfed influenced people’s perception of appropriate limits for breastfeeding. *“I felt like he wasn’t a baby any more, he had grown up” (M19).* Weaning a child from the breast symbolised the transition from babyhood to toddlerhood. *“My baby wasn’t my baby anymore. You know that he was growing up” (M24).* Weaning acknowledged this loss of babyhood. *“I was letting go my baby” (M27).* When assessing readiness to wean, participants had to resolve this issue of timing according to their children’s developmental age. Did they want to continue breastfeeding a baby, toddler, or preschool child? *“Fourteen months just seemed kind of nice because he was still sort of babyish he wasn’t really a little boy yet ... he was getting on the solids really but I just felt for me really it was, I felt*

comfortable at 14 months” (M21). If the child initiated weaning prior to the mother’s desired boundaries for acceptable breastfeeding, the mother often expressed disappointment in not meeting needs perceived by her as being important for that stage of development. “She was only ten months [child initiated weaning] And I felt she was still a little baby and she still needed me [needed breast milk]” (M24).

Perceptions of the appropriate duration to breastfeed a child were revealed to participants by others’ subtle and not so subtle comments. *“Isn’t that baby old enough to, isn’t that toddler old enough to be off the breast now” (M27). Once participants approached or even exceeded this controversial period of appropriate breastfeeding, the frequency of these comments increased. “And then towards the end [toward the end of the second year] he’d [partner] say ... we’ve got to stop this ... this has got to stop. When are you going to stop? She’s still going to do it when she’s five years old” (M31). Another participant received different expectations regarding acceptable breastfeeding duration from her own mother and mother-in-law. At twelve months, the mother-in-law felt she had exceeded the appropriate time whereas her mother’s comments were more relaxed and accepting: “oh you’ll have her weaned by the time she goes to school ” (M28). Participants were often well aware of the opinions of extended family members regarding what constituted acceptable breastfeeding behaviour. “Even with the mother-in-law, she was the same, you know. ‘He is too big for feeding now [child 18 months old]. You shouldn’t be feeding him anymore’ ” (M26). For many participants, dealing with these comments was a regular occurrence:*

Mum said “you’re still feeding that child [at seven months]” ... but I expected it so it was not a shock ... And then it was funny because my Dad didn’t get home till later that night and ... was saying something like, cause he’s a taxi driver, “there was a woman in the cab and the kid would’ve been about 12 months and she’s sitting there feeding it” and mum ... kicks him [under the table]. (M20)

Other participants who had not experienced these types of comments anticipated they would begin receiving them once their children reached a specific age, anticipated at being beyond one year:

“Are you still breastfeeding a one year old”, stuff like that. “Why are you still breastfeeding? Haven’t you weaned him yet?” So I wasn’t really conscious about feeding him because he was still a baby [at nine months of age]. (M17)

Longer breastfeeding equals difficult weaning.

Many participants expressed the belief that breastfeeding beyond a specific time period, such as one year of age, increased the risk of facing a struggle with weaning. *“I’ve got this preconception that after one they’re old enough to know what they want and tell you what they want [laugh], that it’s going to be harder to do it” (M12)*. Some mothers who wanted to avoid a struggle based their approach to weaning on these beliefs. *“I know friends who have found it a lot more difficult to wean them off once they get say beyond eight months. So I thought I’m not going to go beyond eight months” (M5)*. The information was relayed to participants from family and friends who had either experienced difficulties with their weaning or knew of someone who did. *“And I always thought it would be difficult to get her off the breast because just different friends had told me it’d be difficult so I thought it’d be difficult to get her off” (M20)*.

This expectation of weaning being a struggle was also reinforced by health professionals who told participants about other mothers who had experienced this situation. *“There are a lot of people out there who find it very hard to wean off their babies and obviously she’s [child health nurse] come across many of those” (M24)*. To further compound the notion that weaning was a negative experience, information from sources such as parent magazines offered advice on the tips to make weaning easier, suggesting that it would be difficult. For example, “going straight onto a cup from the breast avoids a second weaning” (Storey, 1995, p. 87), in other words, going through one weaning is difficult enough!

In anticipation of a struggle with weaning, some participants chose to offer an occasional bottle of formula to their child so he or she would become familiar with this feeding method and better prepared for future weaning. *“It’s easier for them to have the bottle and get ready for weaning” (M5)*. This rationale was also expressed by another participant: *“And so that in the back of my mind, I thought that perhaps if I was to supplement feed her, then she’s used to the bottle, that would make the process [weaning] that much easier” (M2)*.

Gradual weaning is best.

Many participants felt that gradual weaning was best for the mother and child. This expectation was reinforced by many sources. Participants were exposed to this opinion from books (Huggins & Ziedrich, 1994), parents' magazines (Donovan, 1998; Elson, 1997; Storey, 1995), the Nursing Mothers' Association of Australia (NMAA, 1985), the La Leche League (LaCour, 1994) and health professionals such as child health nurses:

A lot of first-time mothers will say "I'd like to wean at such and such" and we go through that weaning process together and they say how do I actually wean ... I suggest a slow weaning process. Because you don't really find the weaning process in books ... So I suggest a six to eight week period because ... that means they're weaning slowly. Gives the child time to adjust. (CHN1)

Aside from allowing the child time to adjust, gradual weaning was also seen by participants as being important for the mother's physical and emotional adjustment. *"Having mastitis [in the past]. I had to be really careful and do it very very slowly"* (M8). Mothers' expectation that this gradual process would assist in their emotional adjustment during weaning was not a reality for some participants. *"When I had to drop that feed for the week, I could tell it was succeeding ... and I would sit there and my husband would have to hold me. Night after night I would just be in tears [weaned over six weeks]"* (M8).

Many participants planned to wean gradually. *"So I thought I'd just sort of you know give her a boob, give her a bottle, give her a boob, give her a bottle and just slowly wind it down"* (M21). Based upon their knowledge of their child's feeding, some participants had specific plans to implement this gradual process:

I could just go straight to a cup because he was used to a cup drinking his water. I knew I could convert him slowly. I thought, well it will take me a couple of weeks to do it but I thought yes, that's no hassles. I could just wean him gradually down on his feeds." (M17)

Expected outcomes with gradual weaning did not always come to fruition as individual children responded differently. *"Well his was a faster weaning because he just had enough as well and he was just too busy. He'll have a drink and a little nip to tell me he'd finished and off he'd get and play"* (M28). Some children expressed their differing expectations with breastfeeding by initiating abrupt weaning that left some participants

bewildered and upset. *“I breastfed him in the morning, bought the cup, for lunch I gave him his lunch and the cup and he drank it and then refused to breastfeed from there on in” (M17)*. The personality of the child also influenced his or her response to the pace of weaning. *“He was quite happy to keep going or happy to go on the bottle because he’s a very easy going little baby so that suited me as well and it seemed to suit him” (M22)*.

Some participants in this study disagreed with the general assumption that gradual weaning was best. They felt the individual child and context of the experience had to be considered when deciding upon the pace and timing of weaning:

I just I thought, well she’s got to stop, she’s got to stop sort of thing. I didn’t think that gradual weaning would work actually. Because she wasn’t, she wasn’t using it nutritionally by that stage so it wasn’t as if she would become less and less hungry. It was “I want it because I like it.” (M31)

As mentioned earlier, in anticipation of a struggle with weaning some participants tried to lessen this difficulty by shortening its length. *“I felt that that was the quickest and easiest way. I mean what I had read, I read that weaning could take months and I wasn’t willing to start months before ... and it would only stretch out that unpleasantness” (M1)*. The expectation that weaning was a struggle contradicted the assumption that gradual weaning would be easy and gentle. Some participants did not accept the expectation that weaning could be smooth and preferred a short, intense conflict over a long, protracted one:

He literally had to scream for a day while my milk supply dried up. She [sister-in-law] kept giving him the bottle. He was a very unsettled baby especially during the night. And that’s virtually what happened. We just had to let him cry until he took the bottle. (M2)

Breastfeeding and work.

Another expectation that influenced the process of weaning was the notion that breastfeeding and work were too difficult to combine. *“If I wanted to work a day, just one day out of a week it would I don’t know ... I just found it too hard” (M18)*. Child health nurses also confirmed that many women believed returning to work necessitated weaning. *“They [mothers] think they have to wean the baby to go back to work”*

(CHN1). Mothers often had these views reinforced by other people who expected that a working mother could not breastfeed:

People that I knew who were older, like in their 40's or 50's who said "Oh I used to do that and oh I was working at the time and the baby's fussy and I used to give him the bottle, you know your milk's getting too thin, obviously your milk's dying out or you're not eating well enough. (M21)

Because of the expectation that working and breastfeeding were not compatible, many participants viewed having to work as a negative influence to their mothering. *"Like if I had to go back to work if I had to stop to go back to work I would have hated it. I would have hated it, hated it, felt guilty, everything like that" (M33)*. These strong feelings are supported by an American study that examined maternal feelings after the cessation of breastfeeding with factors related to duration and employment (Chezem, Montgomery & Fortman, 1997). Chezem et al. (1997) found that women who, due to employment, could not feed their children as planned, expressed significantly more sadness, depression, and guilt compared to women who were able to achieve their goals.

In anticipation of returning to work, a number of participants in this study introduced a bottle. *"I was going back to work and so I put him on the bottle more for that sort of thing" (M22)*. Participants who introduced a bottle did not always do it with the sole purpose of weaning. Ensuring the child would accept a bottle was necessary for offering either expressed breast milk or formula. Participants were concerned whether their child would be ready to accept the bottle and they prepared for this possibility weeks and sometimes months in advance of returning to work. *"I had to go back to work as well because when he was six months old I think I had to go back to work, and I think that was maybe anticipation I suppose on 'is he going to be ready for when I go back to work' as well" (M14)*.

Many participants who attempted expressing breast milk to offer in a bottle did not achieve their goal. *"I've never been able to express so it's the other thing I could've tried, but I've never had a lot of luck with it, didn't like that very much. Only got about 10 ml" (M12)*. Reasons for this difficulty with expressing breast milk varied from discomfort and embarrassment to the effort required to express breast milk. *"The expressing machine doesn't really feel too good" (M10)*. Having tried expressing in the

past, many participants would not consider doing it again. *“We decided that to put her in day care, [while the mother worked] we’d have to put her on the bottle because I wouldn’t be around all day and I can’t, I hate expressing” (M21).* The effort required to express breast milk was not taken lightly:

I can’t express [mother of three children]. So I am going to try and find out a way of expressing which would be better whether it is to use one machine ... Because there is such a hard time and it’s I think it’s one of the reasons why women do give up. (M27)

I tried expressing, and feeding because they said if you have to use a bottle use your breast milk. That was difficult because I felt like a cow because all I ever did was force her to feed on me, put her to bed, and sit there and express for an hour just to get enough for the next feed. (M5)

References were available to employed mothers who chose to express their milk and provided information on benefits for the mother and child, appropriate child care, types of breast pumps, and the mechanics and storage of breast milk (Bocar, 1997). However, encouraging and supporting women to express their breast milk is said to be more complicated than just offering information as revealed in a study by Morse and Bottorff (1992) that examined the emotional experience of breast expression. Canadian mothers interviewed in their grounded theory study revealed that expressing breast milk has different meanings for women. The attitude of the mother influenced the processes of success or failure with breast milk expression. Maternal perceptions of milk expression as being mechanical, messy, and painful initiated the process of failure while a relaxed attitude where expressing was viewed as a natural occurrence facilitated the process of success.

If participants introduced formula into their child’s diet during the weaning process, they were faced with other conflicting expectations. Many participants anticipated that bottlefeeding with formula was a safe and suitable option for their children. Information from formula packages specifically state “Breast milk is best for babies ... Infant formula suitable from birth” (Enfalac, Nan, S-26). However, information contradicting the message that formula feeding was suitable was starting to emerge in professional literature and in a small number of media reports. The “hazards of formula feeding” were presented in books offering advice on breastfeeding and weaning (Huggins & Zierich, 1994, p. 25) and claims that formula was safe, economical, easy to use and

nutritionally complete were starting to be challenged (Newman, 1997; Walker, 1993; Wight, 1995a). Increased morbidity and mortality, learning deficiencies, cardiorespiratory disturbances, allergic manifestations, contaminants, and controversy over the composition of infant formula have all been cited as rationale supporting the allegation that formula feeding is actually harmful (Walker, 1993). These messages suggested that adopting formula feeding was a risk to one's child and not as harmless as expected:

Babies who are fed formula instead of being breastfed run an increased risk of developing respiratory problems according to a study by the Institute of Child Health Research in Perth (Tickner, 1998, p. 42).

However, while the literature and media debated the acceptance or potential harm of formula feeding as being a safe alternative to breastfeeding, anecdotal stories from family and friends contradicted these perplexing messages. Many family members and friends had bottlefed their children and were strong advocates of that feeding method:

There is nothing wrong with her [child]. She knows the alphabet back to front ... I don't think by saying that by not breastfeeding your child is not going to develop properly. I think that is a lot of hogwash. (M15)

... my mother-in-law and she just said to me well you know her son was brought up on a bottle and she can't see what different that has made, I mean there was one that was breastfed and the other one was bottle fed, and she [said] "there's no difference." (M14)

The lay literature available to participants also presented information on infant formula that conflicted with the scientific literature cited earlier. "Babies do grow and develop normally on humanised milk formulas ... formulas that are now recommended have been modified to resemble breast milk, though they do not contain factors that protect against infection" (Fowler & Gornall, 1991, p. 151). The potential harm regarding infant formula suggested in the scientific literature was not being represented in lay literature.

Although the majority of participants were not working at the time of the study, a number of mothers were able to successfully combine breastfeeding and working. There were specific conditions in their work environment supportive of breastfeeding

mothers. Some participants worked from their home or were physically close to their workplace:

Usually expressed milk when I went to work or the occasional bit of formula but no I never had a problem ... I started back at work again because with my job I work just up the road I was able most of the time to come home and feed her and then go back. (M20)

I think I was very lucky. I mean because with being self-employed I think that does give you tremendous control that you don't have when you are working for somebody else. I was really lucky to be in that situation ... At that time we had our office actually the back of this house was the office ... I actually worked in an erratic part of way almost from about I think I had a week off when I came home. (M31)

Working part-time was another factor that facilitated the continuation of breastfeeding. "I did go back to work, returned to part-time work when he was about eight months old but that was easy because I was part-time and he was at that stage still having four feeds" (M32). Part time employment coupled with a shorter workday also fostered ongoing breastfeeding:

Yes because I was able to breastfeed X [child] three times a day because I fed him just before I left to drop him off at day care, as soon as I picked him up from day care, because I was only working part time. (M24)

Flexibility in the workplace that allowed the participant time to return home to breastfeed during the day was another factor that encouraged ongoing breastfeeding:

I went back to work when she was eight weeks old and so she had expressed breast milk and/or formula for probably only three or four feeds a week which was great. Because I could rearrange my time around coming back to breastfeed her, which was really terrific. I was really happy about that ... I worked full-time but I had close schools so I was able to nip back to my baby-sitters and breastfeed her at good times. (M29)

So I cut him down to three feeds but that I could come home at lunch times so I used to drive home at lunch time and work was supportive in that and my timetable allowed for that lunch time break. (M32)

Social change has resulted in different expectations being placed upon the current generation of breastfeeding mothers compared to former generations. Many women today expect to provide ideal nutrition for their children by breastfeeding and at the same time, achieve their entitlement to the benefits of employment (Yimyam, Morrow

& Srisuphan, 1999). How women were expected to achieve these modern expectations was not easy as the existence of competition between work and breastfeeding has been recognised in the literature (Bergh, 1993; Cox & Turnbull, 1994; Earland et al., 1997; Hill et al., 1997; Roe et al., 1999; Vogel & Mitchell, 1998). The message of the conflict between breastfeeding and working was also subtly reinforced in lay literature such as parents' magazines by statements such as: "Even if you need to return to work early, breastfeeding for one month can be beneficial for your baby" (Schmitt, 1998, p. 1).

Research has also found that the intensity of employment influenced compatibility between work and breastfeeding. Women employed on a part time basis were more likely to breastfeed and continue for a longer duration than full time employees (Fein & Roe, 1998; Lindberg, 1996). In addition, the month when mothers entered employment was most likely to be the month they ceased breastfeeding (Lindberg, 1996).

Sleep problems.

Various expectations about the links between sleeping and breastfeeding were widespread. If a child was not sleeping as anticipated, breastfeeding was often considered to be a major factor in this behaviour. Expectations about acceptable sleeping patterns meant that many participants focused upon eliminating night feeds and getting their children to sleep through the night. *"He was waking two or three times a night and I was having to feed him back off to sleep"* (M12):

We had a lot of problems getting him to have a day sleep right from the start. That's where my husband put the pressure on [to wean] and that I'm feeding him wrong and he's got tummy ache and all these sort of thing and that's why he won't sleep. (M28)

Weaning the child from the breast was recommended as the solution for most sleeping problems. *"So many have this fallacy that if you put the baby on formula that it will sleep at night and I think that is a huge issue in people weaning actually because of the baby not sleeping"* (CHN1). Therefore, due to this expectation, many participants introduced formula to help alleviate their child's sleeping problems:

He wasn't sleeping particularly well, so we sort of thought we'll try to fill him up as much as we can before he goes to bed and perhaps he'll sleep longer. We'd tried virtually everything else, so I introduced a bottle. (M12)

She wasn't sleeping through the night at that stage. A friend suggested that the formula was much bulkier and it makes her think she's full and from there she'll be guaranteed she'll be sleeping through the night. (M23)

The promise that formula feeding would improve the children's sleeping pattern did eventuate for some participants:

And then he wouldn't last any longer than three hours and I thought, no. So that's when I gave him his first bottle, and he slept for about seven hours. (M15)

Nothing else really played a part in the decision of me stopping breastfeeding apart from the fact that like I knew that she was sleeping better, there was a bigger time between feeds and I think, I don't know, I think I felt a bit more human. (M13)

However, many participants did not achieve the expectation of an improved sleeping pattern due to weaning:

No I just wanted to supplement the night feed. I wanted to breastfeed him during the day and at night when he was ready to go to sleep, so maybe he had a fuller stomach so that he would sleep that couple of hours extra, but it just didn't work out that way. (M19)

You get the story give them a bottle and they'll sleep through the night which I didn't believe. But that was what he [husband] wanted. So he was sort of not pressuring me but it was brought up quite often. That if I did that it would work. And when I did, I mean it didn't make any difference. (M6)

Using breastfeeding to assist the child to fall asleep was anticipated to cause problems and therefore discouraged. "My parents are going 'what a rod you're making for your own back.' I had her in the bed with me. She was virtually a self-serve feeder" (M31).

The expectation was that once this behaviour was initiated, it would be extremely difficult to discontinue. "I copped a bit of flack from like my sister ... from that 'you'll never get her out of the bed' you know" (M33). Participants acknowledged that there were positive and negative aspects to this practice. "It was nice to be cuddled and we'll lie there and that was part of our routine too. It was also very linked to sleeps, so that was his relaxing routine. But then that tied me down" (M32). Other participants did not see that lack of freedom as a problem. "Often the children would fall asleep in bed and I mean if we didn't wake up to move them, they would stay there all night. So that wasn't really a concern" (M1).

Western society's expectations of conjugal intimacy and privacy, safety concerns for children, and "daytime efficiency" mean that children seldom sleep with their mothers to suckle overnight (Maher, 1995, p. 17). A small number of participants practiced co-sleeping and breastfeeding during their experience. The findings from this study support the above statement by Maher (1995) as participants focused upon eliminating night feeds and encouraging their child to sleep through the night. Although breastfeeding and co-sleeping have been suggested for their potential protective effect for Sudden Infant Death Syndrome (SIDS) (McKenna & Bernshaw, 1995), no participant who used this strategy offered this reason. Research in this area was still being debated and has not achieved wide public dissemination at this time. Participants' knowledge of protection against SIDS focused upon breastfeeding in general, positioning of the child, and the avoidance of smoking or overheating their child.

To summarise, participants faced with the experience of breastfeeding and weaning revealed that while undertaking these tasks they were aware of expectations influencing their decisions and practices. Expectations were self-imposed and also determined by significant others such as the breastfeeding child, partners, family, friends, health professionals, and society. Although expectations were related to the performance of breastfeeding and weaning, they were often interrelated with mothering expectations. Participants attached specific meaning to acknowledging and meeting personal expectations and the expectations of others. Mothers and others used perceived accomplishments with breastfeeding and weaning as a reflection of the woman's mothering abilities. Acknowledgment of breastfeeding and weaning efforts was important to participants. A common problem shared by all participants was the emergence of *incompatible expectations* between sources. How participants managed these conflicting expectations during their breastfeeding and weaning experiences involved adopting a process of *constructing compatibility by adapting focus*. This basic social process will be addressed in Chapter Five.

Factors Influencing Mothers' Expectations

As already noted, participants became aware of the emergence of expectations when faced with significant mothering tasks such as breastfeeding and weaning. Firstly, mothers acknowledged their own personal expectations in their performance of

breastfeeding and weaning. Secondly, mothers also noted that expectations were placed upon them from external sources such as their children, partners, family, friends, health professionals, and society. Participants' beliefs and knowledge regarding breastfeeding and weaning influenced their personal expectations and subsequent goals for these experiences. Factors that affected mothers' beliefs and knowledge will now be discussed.

Beliefs and Knowledge

Participants' expectations and goals for breastfeeding, weaning, and mothering were influenced by their beliefs and knowledge about these subjects. All participants approached their mothering role swayed by their personal beliefs and knowledge. *"I had this idea in my mind about what I wanted to do" (M20)*. For example, a number of participants stated that they wanted to accomplish child-led weaning. This expectation was based upon beliefs regarding child development and child rearing strategies in accord with the following statement: *"when a child wants a feed I gave it to them ... I mean when a child comes to me I just don't like saying no" (M1)*. In order to honour this belief and achieve this goal, this participant ceased breastfeeding abruptly with two experiences as her partner consoled the weaned children and was content to wait until two weeks before last child's seventh birthday for the child to complete the weaning process.

Participants' expectations were influenced by their exposure to ideas and information about breastfeeding and weaning from a variety of sources. Interview data revealed that participants' beliefs and knowledge were shaped by their exposure to recognised expert sources on these subjects such as health professionals, official support groups such as Nursing Mothers' Association of Australia (NMMA), television, newspapers, books, web sites, and magazines. In addition, factors such as past experience as a mother, the current experience of mothering, the experience of others, and their partner's input also helped to mold each individual woman's belief system and knowledge level regarding breastfeeding and weaning.

Experts. -

Participants revealed that their expectations and goals for breastfeeding and weaning were based upon beliefs influenced by information provided by expert sources. Sources were regarded as expert when they involved written publications such as books, magazines, and newspapers, media such as television and radio, or people with recognised qualifications such as general practitioners, child health nurses, or midwives:

That's I think why I do like I guess professionals as such [for their knowledge], I mean providing I feel comfortable with them too but the clinic sister was great. She was just lovely and I would be on the phone to her ... just for a quick phone call just a quick check up [that I was doing the right thing according to expert knowledge]. (M33)

I rang my clinic sister to ask what am I going to do because I had no idea, I thought it's 9 ½ - 10 months, maybe I can just go to like soya milk straight away but then they need all the vitamins and minerals up to 12 months and she said "no, go out and buy a tin of formula and feed him from there" so that's what I did. (M17)

Participants approached health professionals and sought references to provide them with knowledge they felt necessary to develop and adapt their expectations and goals for breastfeeding and weaning. "He [GP] just told me well look, basically at this stage your milk won't come back after this period of time and it's no use persisting" (M9).

First-time mothers, particularly, relied upon health professionals to assist them to reach a sufficient knowledge level to deal with these new mothering tasks. "I called the clinic sister a lot, I had books, read my books called my girlfriend you know just sort of things like that" (M33). For example, some participants believed they needed to plan their weaning and sought information from the perceived experts:

So I actually went to my health nurse and said "look I'm going to wean, not happy about weaning but it really just too much for me to do". And she said "well I'll support you" ... I remember the day ... [we] wrote out or worked out how many feeds ... "What eight feeds [laughs] well okay let's cut out this one and that one" and then we worked out went home with my little prescription of what she did. (M32)

If health professionals were perceived to be unhelpful, participants still had the opportunity to consult other experts by changing their general practitioner or child health nurse or reading information from written sources:

I vaguely remember asking the clinic sister about how I should wean him ... I remember thinking that the clinic sister hadn't been all that helpful with the weaning because I did see that book, I had it already, I was pregnant when I bought that because I thought that book would be really handy to have. (M24)

Many expectations and goals were based upon attitudes of what constituted normal and accepted behaviours for breastfeeding and weaning. *“My goal [belief] was that I'd just be able to do it straight away. And that my baby would naturally want to be breastfed. I expect that was normal” (M5).* Participants used benchmarks of normal behaviour portrayed in the media and books or described by health professionals. For example, most first-time mothers attended antenatal classes where breastfeeding was discussed. Participants felt a disproportional amount of the information presented at antenatal classes focused upon the positive aspects of breastfeeding. They stated that a balance of positive and negative aspects of breastfeeding was not presented. This omission of possible negative aspects of breastfeeding resulted in many participants feeling that subsequent problems were their fault and contrary to the accepted, normal image of breastfeeding:

All the baby courses you went to it was all like you know breastfeeding is, showing pictures of this beautiful baby who would just be feeding in there and when I got my baby it was just fuss, fuss, fuss and it was a bit different to the baby in the video [laughs]. So you do tend to think well the video showed this beautiful baby sucking away on this big boob and then when you didn't do it the baby's fussing and you think what have I done. (M21)

Information from sources such as newspapers, books, and magazines also provided criteria that participants utilised to develop their breastfeeding and weaning expectations. *“I read a book at the library about allergies and about how it affects families and all the like preventative things to do [breastfeed]” (M21).* Again, anticipated outcomes based upon this knowledge did not always eventuate and these discrepancies resulted in undesirable consequences for participants:

... because all the breastfeeding books you read you know this “let down” and if you didn't feel “let down” it was related to you're being too tense and then of course you're a bad mummy because you're too tense and you're not being this nurturing warm person who's just sitting there lactating. (M32)

The information from books was particularly important for first-time mothers who did not have previous experience or regular contact with children. One participant who

chose the cold turkey method of abrupt weaning based that decision upon information she had read. *“I had read that weaning could take months and I wasn't willing to start months before and it would only stretch out that unpleasantness for that child rather than make it all this close together” (M1).*

Having accurate and complete information regarding breastfeeding and weaning gave participants choices when developing their expectations and goals. *“I wanted to hear lots of information ... then I've got more options” (M33).* Knowledge of options assisted participants to set expectations and goals that were congruent with their individual beliefs. If the resultant goals proved to be unrealistic or unattainable, participants were then able to use these options to modify goals and/or strategies that were still compatible with their beliefs and knowledge:

I used to read books and write notes. I know now when I look back that I most probably gained more information than I needed ... because I hadn't been exposed to a lot of babies ... I just wanted to have all this information to, heavens knows what for, but it all just went in. But I suppose it was the only way to do it because it gave me ... confidence if there had been problems. (M1)

Because I remember coming home and trying to find as much as I could from the books that I'd bought because I had a Penelope Leach one and that How to Stay Sane one and the Mother and Baby magazine so I remember distinctly looking through as much as I could. (M24)

As a reference, information from books, magazines, newspapers, and pamphlets was seen to be less threatening because it was not connected to a person in their life. Although written information or advice was interpreted as another expert opinion, it was easier to disregard printed material than ignore the ongoing influence of a partner, friend, mother, mother-in-law, or child health nurse. Books were viewed as non-judgemental and unbiased in that the information was generalised and offered with no consequences for accepting or not accepting advice. *“I don't remember a lot of mothers asking me about breastfeeding. I think most mothers seem to go and read books rather than ask each other” (M1).* Most mothers recognised written information as an option that complemented and verified other sources:

I tend to be the type of person who'll pick up a book and try sort it out myself or talk to other friends about what they did and then as a last resort I might go and talk to someone more professional. But that's how I've managed to get through most things ... other women talking about it or reading a book. (M24)

Many participants noted how they used expert sources for information at some time during their breastfeeding and weaning experiences. Although first-time mothers were most likely to utilise these sources due to their lack of experience, experienced mothers also expanded their knowledge by using these sources. This was especially so when knowledge gained from past experiences was not useful or relevant to a current experience. One mother of three children clarified how each experience was unique and she was confronted with a new problem with each child. Her source of expert information for all breastfeeding experiences was the Nursing Mothers' Association of Australia (NMAA): ... *"because I had been going to the Nursing Mothers maybe I had the confidence that if anything mucked up again I could ring them and say 'something else is happening I don't know what to do' "* (M21).

Participants' expectations and goals for duration of breastfeeding were influenced by their beliefs regarding appropriate breastfeeding behaviour. Breastfeeding an infant was regarded as acceptable by many family members and friends, but to breastfeed a toddler or preschool child often extended beyond the norm of acceptability. Recommendations by expert sources also indirectly reinforced the belief that breastfeeding was only acceptable for infants by promoting breastfeeding for 6 to 12 months (American Academy of Pediatrics, 1997; WHO, 1989a). Although these organisation encouraged breastfeeding beyond these minimal recommendations, the message that participants interpreted was that 6 to 12 months was an acceptable breastfeeding duration. *"I just sort of had in my mind that I wouldn't feed beyond six months. I thought that was well and truly long enough"* (M6). Recognition that infancy lasted for 12 months influenced many participants to set 12 months as an acceptable boundary for breastfeeding. *"I thought about a year. And I knew within myself that that was good, that I'd done well enough"* (M18).

Contemplating breastfeeding beyond that boundary was difficult for some participants because it was not considered to be compatible with normal, acceptable behaviour. *"Personally I didn't want to feed them for 12 months. I didn't want to do that at all"* (M6). Many participants considered long-term breastfeeding to be inconsistent with their beliefs of normal breastfeeding behaviour. *"I must admit maybe it was just a*

personal thing, I always cringe when I see kids that are about two years old still feeding because it just feels like this big thing and it just looks so gross” (M21). Participants that chose to go beyond this recognised norm for breastfeeding duration often did not receive ongoing support from family and friends and were faced with the challenge of being seen to be going beyond the range of normal. “I think he [partner] had more of a conventional ‘it’s abnormal to do it that long’ sort of thing, view inside [breastfed for 22 months]” (M31). Health professional’s advice and support also delivered messages of accepted practices for breastfeeding and weaning even though they were contrary to participants’ intentions:

I went to the clinic sister for her normal 12 month check and she asked all the normal questions, “are you still breastfeeding?” and I said “no, no she weaned herself off” and the clinic sister said “oh you lucky thing ... that’s great isn’t it. Well done”. And I walked out of there feeling really annoyed because I didn’t feel like it was well done at all [mother wanted to breastfeed until 18 months]. (M24)

What constituted normal, acceptable behaviour in relation to infant feeding was influenced by the individual circumstances for each participant. Participants surrounded by family and friends who advocated bottlefeeding felt alone and isolated because what the experts were advocating was outside the norm of their social reality. One child health nurse described seeing this lonely struggle with many women in her practice: *“if all their girlfriends are bottlefeeding and all those babies sleep all through the night, struggling along with three hourly feeds still ...” (CHN4). Participants involved with support groups like the Nursing Mothers Association of Australia (NMAA) received support based upon a different version of normal, acceptable breastfeeding behaviour. The benefits of breastfeeding beyond the first year of life were readily advocated from counsellors who encouraged and supported this practice. “I would phone the Nursing Mothers Association. And they were fantastic. I used to sit on that phone for hours talking to them and they, you know, they will be the ones to give me the encouragement to keep going” (M26).*

In summary, underlying beliefs and knowledge in relation to mothering, breastfeeding, and weaning were important and directly impacted upon personal expectations and goals for these tasks. Participants’ beliefs and knowledge level were influenced by

sources that women perceived to be expert such as health professionals, written material, media, and support counsellors in the NMMA.

Past experience.

Women's expectations regarding a current child's breastfeeding and weaning were influenced by their previous experiences. They used their first experience as a basis for managing subsequent breastfeeding experiences. *"I knew that I did have a problem with milk supply [with two previous children]. I knew as she got older and got hungrier, I knew she would want more. So I thought I would be ready for it [introduced supplemental bottle at four months]" (M2).* Participants considered issues encountered during past experiences when formulating current expectations in relation to examples such as managing sleeping difficulties, attachment problems, or how and when to introduce a bottle. *Bonnie* (cited in Owen, 1989, p. 8), an American mother of two children, made the following statement in a published collection of mothers' nursing and weaning experiences when reflecting upon her experiences: *"If I had to do it over again I would have less expectations about having a relaxed time with my second baby"*. Obviously, being an experienced parent did not guarantee that expectations carried over from one child to another child would be met.

Women acknowledged that what they had learnt from previous experiences influenced perceptions of their mothering abilities. If participants perceived they were successful with the first experience, their confidence in their mothering abilities increased.

Participants expected to be able to transfer the skills acquired from the past to future mothering experiences:

It's just the first parent thing, you just don't know what the baby wants and with the second one you've got some sort of idea and you think oh we'll change the nappy, we'll do this, we'll do that and you usually find the answer but with the first one you just have no idea. (M17)

Experienced mothers felt they had an advantage due to their past experience that allowed them to calmly use trial and error to unravel the needs of their child. Although it was acknowledged that each child is an individual, having coped with previous children allowed participants to feel that they had the skills to adapt. *"The situation*

may not be the same but I feel confident enough to be able to cope with whatever comes up” (M33).

For some participants specific expectations were based upon previous experiences and the desire to provide an equitable breastfeeding opportunity for each child:

I felt that if I didn't give him a go I would be sort of ... I don't know, it's like it's not fair that I don't try because I thought I did try with X [1st child girl] ... I've got this great complex that they've got to have the same. (M15)

I was sort of looking at 12 months, but that was the same goal I had with X [1st child] and I ended up feeding until 18 months so I was, I really hadn't made a plan of that, but deep down I suppose I was prepared to go to 18 months with X [2nd child]. (M24)

A further example of previous experience influencing current expectations was demonstrated in the management of breastfeeding in public. Experienced, confident participants armed with skills, such as feeling more relaxed and proficient to breastfeeding discretely, were able to modify their expectations of feeding in public. With time and experience with breastfeeding, some first-time mothers also developed confidence in their abilities and were able to modify their expectations:

I tried to feed at home but you know I wouldn't change my routine ... I was very home bound for the first couple of weeks, I was very scared to go out. But then when I did get to go out I was all right about it. I must admit I would go and sit in a corner somewhere, or I'd go to the mother's rooms to feed. I wouldn't stop in the middle of the shopping centre. (M11)

This increased confidence in breastfeeding in public was not encountered by all participants. If a woman had been exposed to past disapproving comments when breastfeeding in public, this made her more wary of the possibility of confronting similar situations with subsequent children. *“I did but I think I expected it [public comments] a lot more [with 2nd child] whereas the first-time I didn't expect people to say those things and I probably did [be influenced by those people] and I probably didn't breastfeed him [2nd child] in public” (M2).*

Many participants were more flexible with their expectations regarding subsequent children, having recognised the individuality of each child. *“Next time I won't have such a strong goal in my mind ... Next time someone says how long will you breastfeed,*

I'll say till we're ready" (M20). Having a smaller number of specific expectations as well as allowing themselves flexibility to adapt goals to the existing reality increased the possibility of achieving success with goals. A mother of three children expressed how she learned to adapt her weaning expectations with each individual child:

I just accepted that as part of it all and you tend to judge by the individual, the baby and yourself how you are at the time ... It wasn't "I have to breastfeed for a year and at 12 months on they go to a cup". It wasn't anything like that with me. It was all very much take it day by day and see how we feel. (M22)

If participants were experienced with breastfeeding, their expectations of the effort required to breastfeed were also more realistic. *"Well, it started off OK, but by the second day of breastfeeding my nipples were really sore and they started bleeding and cracking, and I knew that was normal anyway, that that happened" (M13). The issue of facing difficulties, especially during the initiation of breastfeeding, was anticipated for many experienced mothers. This realistic assessment was often due to breastfeeding problems encountered and resolved with a previous child:*

Learning how to keep my milk. Because I know sometimes I used to get a few days where I wouldn't be feeding as much and it would go down, whereas with X [1st child] I didn't pick that up and I kept losing it whereas with him [2nd child] I was in tune. (M21)

Past perceptions of success or failure based upon positive or negative experiences influenced participant's decisions with current and future expectations and goals. *"With [2nd child boy] I thought it's the easiest thing. I'm going to do it again, and yes 'let's start again' " (M7). In contrast, the following participant's disappointing first experience eroded her confidence in her ability to breastfeed subsequent children: "I didn't expect to be able to breastfeed. I expected to try [with 2nd child] ... Whereas I expected [with 1st child] that it would be normal for me to be able to breastfeed" (M7). Personal beliefs and knowledge observed with past experiences were often modified. For example, the expectation that breastfeeding was natural, convenient, and easy changed to breastfeeding being an onerous challenge. "It's probably ... one of the hardest, and it's been the most unnatural thing I think to start with, getting your baby to feed and how long it feeds for and when it wants it and when it doesn't" (M12).*

Past mothering experience did not always refer to participants' own children. A few women who had contact with children due to their job or from babysitting in their personal life felt more prepared in their knowledge of child-care. These experiences with children impacted upon current personal expectations regarding breastfeeding and weaning. *"I didn't have any influence from anyone ... it's because I've just grown up with that many kids and looked after that many ... (M10)*. Contact with children in the past through babysitting assisted these few participants with their knowledge and confidence regarding procedures such as bathing and formula feeding; however, breastfeeding and weaning were experiences that they could only observe from a care-taking role.

Current experience.

Current breastfeeding and weaning experiences were used by participants to assess, evaluate, and modify their expectations. *"My expectations were different to how things actually turned out" (M3)*. Achieving congruity with expectations and reality confirmed for participants that they were successful in their achievements. *"So it was nice breastfeeding her once I got the hang of it. It was really nice" (M20)*. Participants who felt successful in meeting expectations expressed a sense of pride. *"I was so proud that I could actually feed because I couldn't before. That's one thing that I will remember the most" (M5)*. Not achieving expectations resulted in participants feeling disappointment and failure. *"My God, I just didn't expect it to be the way it has [been]" (M23)*. The following quotation illustrated the distress some mothers felt when reality did not meet their expectations:

One mother ... wanted to breastfeed for as long as possible, her first child, and ... he was teething, rejected the breast because he didn't want any fluids in his mouth and she was absolutely devastated and she would cry, she would be here [at clinic] and he was going onto 13 maybe 14 months but she was hoping to breastfeed for two years. (CHN3)

For a few participants not meeting their expectations had a positive outcome, especially if they anticipated breastfeeding to be more difficult than the reality that eventuated. *"But it was just so easy and I thought 'this is not as bad as what I thought it was going to be' and it was a good thing so I kept breastfeeding" (M7)*. In addition, some participants who anticipated a struggle with weaning did not encounter that possibility.

“It was so easy I just couldn't believe it, I was really worried about the weaning process but she [child] made it easy” (M23).

Many participants used reality to determine whether expectations were being met and then decided how and if they could modify these expectations to be in harmony with reality:

There was no way I was going to feed my baby on a bottle ... And yes my expectations certainly changed ... I just gave up and she was on bottle full time and she was fine from then on and she slept through the night at six weeks.” (M5)

I thought I was going to breastfeed until he was one ... Because he wouldn't [accept an occasional bottle of formula]. I just found it too hard [child fully weaned onto formula by 9 months]. (M18)

Other participants continued to persist with their current strategies with breastfeeding and weaning in the hope that they could change reality to meet their goals. *“And like when I first started it was hard and I thought ‘no it's not worth it’ but now that I know, that I've done it [continued to breastfeed], I know what I did wrong” (M20).* Many participants demonstrated persistence with expectations in the face of a conflicting reality. Expectations were often regarded as the ideal situation, for example breastfeeding would be easy, natural, and convenient. Participants acknowledged that achieving expectations took time and patience:

Well, it started off OK, but by the second day of breastfeeding my nipples were really sore and they started bleeding and cracking, and I knew that was normal anyway, that that happened, but they were really sore. But I stuck with it because I, you know, I was told when that happens you've got to get past it. (M13)

The promised benefits of breastfeeding were used to develop expectations and were based upon these anticipated outcomes. When unexpected outcomes, such as loss of freedom, physical problems, ongoing pain, sleep deprivation, tiredness, or exhaustion eventuated, participants expressed frustration with their reality:

Everybody says “oh you know, breastfeed. It's good. The closeness. It's easy because you can just do it anywhere. You don't have to prepare bottles and all that” but it wasn't. I don't know why but it's hard because you are more or less on call all the time. You couldn't just give her to somebody else. You had to be there and do it. And especially being [every] 2½ hours you couldn't get anything done, go out or do housework. (M4)

In an Australian study of mothers' experiences with infant feeding, Cooke (1996) found that women could be separated into two groups according to their philosophical beliefs regarding breastfeeding. The 'idealists' would never consider accepting bottlefeeding as an acceptable alternative to breastfeeding and would demonstrate extraordinary perseverance to continue. In contrast, the 'pragmatists' had no difficulty accepting bottlefeeding as an acceptable alternative. Statements by participants in this study also confirmed these two potential philosophical differences but revealed how these beliefs could change depending upon current mothering experiences.

As already noted, expectations did not remain static but often changed as experiences evolved. Participants acknowledged the dynamic nature of their own personal expectations over the course of the breastfeeding experience. In addition, they faced changing expectations from other people. Advice and support from partners, family, and friends also changed as time progressed. For example, some partners, who were very supportive of breastfeeding for infants, became more reticent to support breastfeeding when their child became a toddler. *"I was also getting heaps of pressure from my husband by that stage [after 12 months] to stop"* (M31). Family and friends, who were previously supportive of breastfeeding, also changed their expectations. *"My best friend ... she said ... 'you've persisted long enough and it's not improving' "* (M9).

The context of individual circumstances during the breastfeeding experience also influenced how expectations and goals were modified. For example, one participant who separated from her partner while breastfeeding her toddler acknowledged how she continued to breastfeed to maintain a closeness that was important to her at that time:

I wanted to hang on to him as long as I could because I had actually split up with my boyfriend ... when we split up I was trying to hang on to him. I wanted to keep him as much as I could, a little baby ... So that was my way of holding on to him. (M26)

Another participant expressed how breastfeeding took on a special significance during her life due to postpartum depression. She believed that the ability to breastfeed was a redeeming factor in her perceptions of mothering because it was a *"link to a positive mothering side"* during a dark period she described as *"a black hole"* (M32):

I think breastfeeding helped that if anything. It certainly didn't do anything, that was no contributor factor in depression. That was a saviour if anything, because ... I felt that I was being a good mother. (M32)

Experiencing disappointment in unmet birthing expectations also was stated as an influence for subsequent expectations regarding breastfeeding and weaning. Whereas success with expectations in the pregnancy or birth enhanced participants' confidence, enduring a perceived failure meant participants were more vulnerable to further distress and guilt, having not achieved past expectations. *"I think the Caesarean [section] compounded that importance. So it was sort of a steam roll affect. I think if I hadn't felt so much guilt over the Caesar I might not, the guilt over the breastfeeding might not have been as severe"* (M8). Another participant who had a Caesarean birth also reinforced how the importance of breastfeeding reinforced her commitment to achieving this goal:

Choosing the breast? ... I think I did it mainly because I want that closeness and ... a combination of things, Caesarean birth ... But that made me I think very determined and committed to breastfeed because I wanted to have that closeness. I was going to have that closeness ... I don't know whether it's tied up to with drugs, Caesarean, all that sort of difficult birth and difficult start to feel so removed from your child. (M32)

The above examples were presented to illustrate how the context of individual circumstances during the breastfeeding experience influenced the development and adaptation of personal expectations. Adjusting to separation from a partner, postpartum depression, and unmet birthing expectations represented particular incidents experienced by some participants in this study. Due to the unique context of each woman's experience, the possibility of other types of examples not represented in this limited sample of thirty-three women, must be recognised.

Experience of others.

The experiences of significant others such as friends, family members, or acquaintances, impacted upon mothers' expectations. In addition, these support people also based their own expectations upon personal experiences, past and present, if they themselves were parents. The breastfeeding histories of family members or friends influenced how participants approached their own experience. *"I've seen other people, my sister-in-law,*

who had breastfed all the way until 12 months with nothing else except for waters and juices and then straight from then go on to cow's milk, so that's what my expectation was" (M19). For example, if a participant knew that a family member, such as her mother or sister, had experienced difficulties with breastfeeding she often anticipated these potential difficulties being passed on to her. "My mum couldn't breastfeed any of us kids, and I thought basically I'd probably be the same ... so it just seems strange that obviously it's something that could be in the family" (M15). These participants approached their breastfeeding with expectations biased with doubts about their potential abilities:

My sister had the problem. She had two children and I think she actually had probably had some kind of enzymatic deficiency. She certainly couldn't make milk. She made colostrum and then nothing else happened ... because of that ... I wondered whether I'd make any. In fact I was quite worried that I wouldn't because she hadn't been able to. (M31)

My mother had the same thing [laugh]. It sounds like it's hereditary doesn't it? But my mum lost her milk with me, because my parents actually separated for a while when I was born so that made my mum lose her milk, so she had to put me onto formula. (M9)

This awareness that other women's breastfeeding or weaning experiences were similar to their own assisted participants in accepting that they were not alone. "One of my girlfriends, she breastfed for a while then she bottle fed, but most of them ... they started off breastfeeding and then onto the bottle, the same situation as me" (M13).

Knowledge of others' breastfeeding and weaning circumstances was useful particularly when their own experiences conflicted with personal expectations. For example, this participant anticipated that her child would instinctively latch onto the breast; "I just felt that babies would have, they just went on (M3). When she stopped breastfeeding she found comfort in knowing that someone else experienced similar problems. "I've only got a sister-in-law who gave up for much the same reasons that that baby was just too wriggly" (M3).

Participants benefited when other people's past and current experiences reinforced their current breastfeeding or weaning experiences. Other people were often especially supportive of participants whose experiences were similar to their own. This situation

often resulted in a mutual benefit for both parties as both the mothers and support persons felt they were not alone in their experiences:

I mean my husband's mother the same thing happened to her so she was really good. She was really understanding. She was really supportive ... And another girl friend was the same, she just suggested ... "go on the bottle, don't worry about all these other people saying the breast is best, which it is, but if you can't do it you can't do it, you go on the bottle." (M9)

An awareness of other mothers' breastfeeding and weaning experiences allowed participants the opportunity to observe different strategies and options. Exposure to a diversity of situations provided a basis for evaluating expectations that were not currently attainable or likely to be successful. *"They [other mothers] are good for trying different things, what works for them may work for you but then it might not. So you've just got to keep trying until you find something that works" (M18).* Many participants found this sharing of experiences helpful in an emotional sense as well as an opportunity to increase their knowledge level. *"Nobody else had the same problem ... they all had their own individual ways of doing it and stuff and it was more of an opportunity just to talk" (M20).*

Exposure to other mothers' stories and examples assisted participants evaluate not only their own expectations but others as well. *"And mainly by seeing ... how they had done it wrong ... 'has it worked for them'? I mean these other mothers that I know that it hasn't worked for, they really wanted to wean but it's not working" (M12).* Other people's triumphs and struggles were observed and provided a basis for future decisions. *"I know friends who have found it a lot more difficult to wean them off once they get say beyond eight months. So I thought I'm not going to go beyond eight months" (M5).* Another participant also based her approach to weaning upon the stories she heard from other mothers. *"She [work colleague] breastfed both hers [children] till 12 months and she said ... that hers was very difficult to stop breastfeeding" (M20).* One participant who lived with her mother for several months after her child's birth was guarded with her own expectations due to her mother's disappointing past experiences:

I just thought I was just going to take it day by day and see how it went ... I didn't really know what was going to happen, I just sort of wanted to wait and see ... I think when she had her children and she would put them onto the bottle, I think she got a little bit of you know [negative comments from others]. (M13)

The level of support participants received from other women was often contingent upon their individual breastfeeding experiences. *“My husband’s an only child. His mother breastfed him for three months and then stopped, so once I got sort of to three months, everybody was like ‘when are you going to stop’ ” (M12).* If a participant’s persistence with breastfeeding was contrary to her support group’s expectations, she faced a lonely struggle. *“No one was really interested, or ‘you should stop feeding him by now’. Not one of them was interested in saying ‘you are doing a good job’ ” (M26).* Again some women had never breastfed and, of course, men never will, but they all still placed expectations upon breastfeeding mothers based upon their beliefs, knowledge, and exposure to other mothers. For example, the assumptions and subsequent support offered by partners was determined by their contact with other family members or friends who had children, as demonstrated by this father who was influenced to anticipate that all children are eventually put on a bottle: *“My husband just said ‘look, eventually he’s going to be on a bottle anyway so why don’t you just try a bottle once’ ” (M3).*

Many participants found support dwindled for continued breastfeeding over one year, as social acceptance of long-term breastfeeding beyond 12 months was the exception rather than the rule. Exceptions to this instance were found if participants associated with specific groups of mothers such as those in the Nursing Mothers Association of Australia (NMAA) which consisted of members who had breastfed for long periods and were supportive of this practice. NMAA provided information to Australian parents in written publications (NMAA, 1982, 1985, 1986), on line services (Gigacz, 1999a, 1999b, 1999c; Newbold, 1999), and also offered comprehensive telephone counselling. Although NMAA offered support to participants who wished to breastfeed, the organisation also had specific expectations regarding how women should manage their breastfeeding. For example, participants who had planned to breastfeed for less than six months were reluctant to approach NMAA as they anticipated opposition with the expectations of these counsellors:

I also belong to Nursing Mothers too which frowns upon weaning early ... there’s been some pressure there I guess to keep it up as well ... You do tend to see that people that have got the two year olds that are still feeding there, there seems to be a bit of a tendency for that, Nursing mothers is an organisation about breastfeeding. (M12)

The final factor that influenced participants' beliefs and knowledge and their subsequent expectations were the wishes and opinions of their partner or father of the child.

Partners' input.

Partners' beliefs and knowledge were influenced by the same sources as those of their spouse. They were exposed to expert sources such as the media, books, and health professionals. Partners of women who has breastfed previous children also had those experiences to reflect upon when they made their own expectations regarding the current breastfeeding and weaning experience. All participants in this study successfully breastfed their children for a mean time period of eleven months, with a minimum of six weeks and maximum of six years. Accordingly, all partners supported their spouse's decision to breastfeed as revealed by participants' overwhelming confirmation of their support.

Participants' partners also felt breastfeeding was the ideal choice for their infants.

" 'She has to do it, it's the best thing for the baby'. So he had it in his head, well this is what we have to do for this child because it's the best thing" (M15). Partners of these participants who had all breastfed were aware that breastfeeding was the best option for their infant and acknowledged the recognised benefits of breast milk. *"My husband was saying you know because it's his first child, 'please try and persist because it's our first child and breast milk is supposed to be better and we don't want anything to ever happen to her' "* (M5).

Fathers anticipated that breastfeeding would be natural and easy, in accordance with mothers' expectations. They expected breastfeeding to work. *"I wanted to continue breastfeeding he said 'well OK that's your choice and we'll give it more time to see if it works' "* (M9). Partners also expected breastfeeding would produce a happy healthy child. *"... he [partner] said to me it's not working is it, I can tell that he's [child] not happy" (M15).* As breastfeeding was assumed to be easier for mothers and children, these fathers anticipated that this convenience would enhance the management of infant feeding. Not having to deal with bottles and sterilising equipment was seen to be a positive outcome of breastfeeding:

He [partner] used to say whatever's best for her ... was OK and it was a lot more convenient too, you know. You didn't have to worry about warming a bottle or anything like that and when they're little and they sort of feed a lot more. (M22)

Because women were the ones who had to actually carry out the act of breastfeeding, they also based their management decisions upon their partner's willingness to be understanding and supportive:

Well basically I told my husband what I wanted. Because I was the one that had to do it and I said this is what I need from you to do it this way and he said "Well okay I can do that [provide help for weaning]". So that's how it worked. (M27)

Mother's anticipated support from their partners was not always available. Continual offers of advice and questioning of decisions were perceived by participants as signs of criticism and an indication that they were not meeting their partners' expectations.

"Hubby kept saying 'when are you going to wean him off ... you are doing something wrong, perhaps you are eating something that is affecting him. Perhaps you are feeding him wrong or something'" (M26). Another question perceived as disapproval was: "when are you going to stop?" (M31).

As breastfeeding progressed, some partners were forced to re-examine their expectations. If the child was not thriving on breast milk or sleeping long enough, and participants were struggling with physical problems or not enjoying the breastfeeding, partners often encouraged and supported mothers to do whatever they felt was necessary to improve the situation. *"I mean he didn't say 'oh, give it up or keep going' he just say 'it's just up to you just do what you whatever you want to do' " (M30). A few men were more adamant in their expectations, and rather than leave the decision solely to the women, they actively participated in the decisions around weaning:*

He [partner] went out and bought the bottles and everything [to start weaning] ... Because I thought "well, why"? It's working. I'm back at work now, as I was then, and I was breastfeeding him [child] three times a day. (M24)

Not only did some partners modify their expectations as the disappointing realities of breastfeeding unfolded, they worked with the mothers to change the circumstances.

Breastfeeding was not benefiting the family and the value of persisting with it was questioned:

Even my husband said, he said to me "it's not working, is it?" I can tell that he's not happy. And by this time we were both experienced [laughs] and I turned around to him and I said this is ridiculous. And he said I'll get the bottles out and sterilise them and that's when we started [child 10 weeks]. (M15)

Participants were also aware of their partner's feelings regarding how they should manage aspects of their breastfeeding. For example, many mothers were aware of their partner's feelings of embarrassment with the prospect of breastfeeding in public. "Because that was a bit embarrassing for me. And my husband gets embarrassed as well" (M5). These feelings were acknowledged in the way participants chose to manage their breastfeeding in the presence of others. "If I thought my husband would feel uncomfortable me feeding [child] while his friends were around then I would go into another room, I wouldn't make him feel uncomfortable" (M19). Choosing an appropriate place to breastfeed while out in public was an individual decision that participants made in consideration of their partner's expectations. Places deemed suitable to breastfeed varied from female toilets, parked cars, bedrooms, public transportation, mothers' rooms, and benches in parks and shopping centres:

He [partner] was ok, of course, initially there's that feeling of embarrassment because your breasts are out in public, he found that a little bit hard to deal with to start off with ... finding a comfortable place to breastfeed. And my husband could see that that was difficult, we'd always be hunting around the place trying to find someplace or juggling in the car to breastfeed. (M24)

Most participants acknowledged their partner's input in their decisions with breastfeeding and weaning. After all, he was the father of the child and had a vested interest in seeing the benefits of breastfeeding. Participants knew their partners' expectations and goals for breastfeeding and weaning: "I think the important part for him was the first couple of months but then he was not bothered (M20). Choosing not to accept or meet their partner's expectations had potential consequences for their ongoing relationship and was given serious consideration. Participants wanted acknowledgement for their mothering efforts and an important person able to offer that support was the father of the breastfeeding child.

To summarise, participants approached their breastfeeding and weaning experiences with specific expectations and goals. Mothers' beliefs and knowledge about these mothering tasks influenced their expectations. Beliefs and knowledge were dynamic in that they changed or were further developed with each child's breastfeeding and weaning experience. There were several factors identified in the data that influenced mothers' development and modification of their beliefs and knowledge level. These factors were: the participants' exposure to expert sources such as health professionals, media, and written publications; past experiences with previous children; current experiences of breastfeeding and weaning; the experiences of significant others such as friends and family members; and finally, input from their partners. As noted, the development of expectations involved a complex task of considering and balancing the influence of these factors. *"I don't know whether that was me because I wanted to and knowing that I wanted to, but I think it was also influenced by everything that you hear "oh no you have to breastfeed. You can't bottlefeed" (M5).* Resulting expectations were often derived from a complex personal negotiation and compromise between all of these influencing factors.

Summary

All participants revealed instances of incompatible expectations during their breastfeeding and weaning experiences. These expectations related to aspects of breastfeeding, weaning, and mothering. As noted earlier, expectations regarding weaning could not be disconnected from expectations regarding breastfeeding and mothering. Expectations were interrelated, as efforts accomplished in one area were a reflection on another. For instance, success with weaning was perceived as a positive outcome of the overall breastfeeding experience and reflected competency as a mother. *Incompatible expectations* occurred when mothers noted differing and often conflicting expectations between those held by themselves and by others. Participants' expectations regarding breastfeeding, weaning, and mothering were influenced by their personal beliefs and knowledge level. Participants' beliefs and knowledge level were modified in response to their exposure to perceived experts such as health professionals or the media, their past and current experiences, the experience of others, and their partners' input.

CHAPTER FOUR

Consequences of Incompatible Expectations

Introduction

It is not surprising that many women remain shy and mute when asked to speak honestly and openly about the experience of mothering ... To be found wanting as a mother is the worst crime most women feel they can commit ... The underlying meaning of this competitive spirit seemed to be the need to reassure themselves and others that they were not bad mothers; that they had done a good job raising their children (Swigart, 1998, p. 103).

This chapter addresses the impact of the basic social problem of *incompatible expectations* from the perspective of the mothers. As discussed in the previous chapter, participants faced a common dilemma of how to manage their breastfeeding and weaning experience when faced with conflicting expectations from others. Discussion of the impact of *incompatible expectations* includes the emotional consequences experienced by the participants and the conditions that influenced the impact of these consequences. Participants were acutely aware of situations where they were not meeting the expectations of others, as disapproving behaviours were obvious. “*People avert their eyes as if you are doing something absolutely disgusting [breastfeeding in public] but then it’s my mother’s response too*” (M32).

Consequences of Incompatible Expectations

Participants faced with sources whose expectations were incompatible with their own expectations expressed feelings of confusion, questioned and doubted their own abilities, and lastly, shared the guilt they felt when confronted with this dilemma.

Confusion

Participants were exposed to the opinions of many people during the course of their breastfeeding experience. Most people, including those who had never been parents, had opinions on the management of breastfeeding and weaning and they were very candid in sharing their views with the mothers. “*There was so much going [on] around*

me. Mother saying this and Auntie saying that and somebody else, a friend, saying this and it's just so confusing" (M21). Confusion was often the first emotion expressed by participants when they became aware of conflicting expectations. First-time mothers with no previous parenting experience were especially vulnerable because, as awareness of this conflict became a reality, they were often unsure of how to respond. *"Being a first mum like ... you want to go ahead and do the breastfeeding and you're not sure what to do because there's no manual ... she didn't come with instructions or neither did my body at the time" (M9).*

Participants did not anticipate the prospect of being faced with so much opposition and then to be expected to choose between meeting these expectations and their own. They clarified how their confusion resulted in unexpected emotional responses that, upon reflection, caused embarrassment:

Everybody seemed to have sort of different opinions though so it was very confusing especially being a first-time mum. You don't know what you're doing anyway so you don't know who to listen to and what to do and there were quite a few times there when I burst out crying and [nervous laugh] carry on a bit. (M4)

These findings were supported in the results of an English study that investigated how motherhood changed women's lives (Weaver & Ussher, 1997, p. 56). The impact of the "unexpectedness of the reality of motherhood" left these women feeling shock, surprise, and disillusionment. Media images of attractive, perfectly dressed women with their happy, smiling family resulted in these British women expressing feelings of inadequacy.

Participants in another Australian grounded theory study that examined the experience of 55 first-time mothers also experienced confusion and uncertainty in response to being "bombarded with advice and criticism" (Rogan, Schmied, Barclay, Everitt & Wyllie, 1997, p. 882). Confusion, in that study, was noted as a consequence of a major category entitled 'realising' with the core category of the study referred to as 'becoming a mother'. Realising involved the women acknowledging the impact their children's birth had on their life along with the overwhelming recognition of this responsibility. In an American grounded theory study that examined the breastfeeding experiences of low-income women, the researcher noted how women experienced confusion and frustration

due to “well meaning but often conflicting advice from friends or family” or from inadequate support from health professionals (Locklin, 1995, p. 286).

In this current study, the confusion participants experienced from the reality of facing many diverse viewpoints escalated when expectations placed upon them were in direct opposition to their own personal beliefs. Some participants expressed discomfort when they were pressured into doing something that did not feel right for them but, at this stage, they did not have the confidence to assert their own expectations and goals. The inner dialogue demonstrated in the following quotations highlight these participants confused and bewildered state:

Am I making the right decision? I'm only a first mother. I've got no experience. All I know is what these people were telling me: they were telling me to persist. I feel it's not right even though ... I felt like I was harming her because she wasn't getting enough to eat ... I'm not doing what's in her best interests. I was going ahead with what everyone said was the right thing to do and persisted breastfeeding but I didn't feel I was doing the best thing for my baby or by me, because I wasn't comfortable with what I was doing. (M9)

I remember feeling uncomfortable about it. And then going home having these mixed feelings about I should be able to breastfeed and you know, feeling annoyed with them that they made me feel uncomfortable. (M24)

Irene, an American mother whose story appears in a published collection of mothers' nursing and weaning experiences (cited in Owen, 1989, p. 13) shared her feelings when faced with the dilemma of encountering differing expectations:

I figured I had to stop nursing [breastfeeding] but she was such a wonderful kid I just didn't want to stop. I didn't want to do anything to hurt her even though everyone I knew had long since weaned their kid! Many of my friends' babies had weaned themselves at nine months but I knew X [child] wasn't going to stop by herself.

La Leche League International has a bimonthly magazine and corresponding web site that features articles from women sharing their experiences and viewpoints. A woman responding to this web site revealed the reactions she received from another women while breastfeeding her infant in public (Booksh, 1994):

... her little girl was pointing and smiled when she saw me and the baby. After looking at us for a few seconds, she [mother of little girl] realised X [baby] was breastfeeding. Her expression changed. She gasped and grabbed her daughter's hand, pushed her husband and son ahead of her, and whispered

loudly and furiously, "Don't look at her. She's breastfeeding." I felt humiliated, embarrassed, sad, angry, and misunderstood ... I wanted to cry out, "I am just feeding my baby. I am doing what I believe to be best for him. It is not a disgusting or perverted thing. He is getting the best possible food for him right now and we are forming a close bond in the process.

Health professionals were recognised by mothers in this study as being the experts on breastfeeding and weaning. When participants were confronted with opposing opinions from health professionals, they were especially perplexed. There were many debatable topics where right and wrong answers were not absolute, such as the best time to wean a child off the breast. When mothers realised this fact, they often were unsure of where to turn for advice and support:

But as a first-time mother, I mean there's a very good support group here in Australia, hospitals, doctors, nurses, and it was definitely, a whole lot of set ideas out there about the right and the wrong way and you really can, I found this, even now, you can get bogged ... what is right and what is wrong? (M12)

Some participants sought the support and guidance of their partners when dealing with contradictory expectations from many other sources:

X [child] used to scream and scream and scream during the night and I used to say to my then husband ... "look, he's just not getting enough and what do I do. I mean the sisters [child health nurses] were saying not to give him the bottle, but what do I do?" (M14)

Often the partners, especially first-time fathers, were reluctant to offer advice or opinions, as they also felt inexperienced with issues of childcare. Many fathers left final decisions with their breastfeeding partners while offering to lend support to their choice. *"He was as scared as I was and it was like whatever you think is best" (M11).*

The confusion over which expectation to accept or which piece of advice to follow left many participants in a precarious position. *"So I was left sort of not knowing what to do" (M5).* Many participants tried to base their decisions upon the perceived needs of their child, but this assessment was not always easy, especially for inexperienced mothers:

Just crying all the time which was, I don't know whether that was just being a baby or a bit of colic, and I didn't handle that very well like I said, X [partner] was working quite long hours and being tired and run down I just didn't know what to do. (M11)

Some participants stated that, while in this state of initial confusion, they were not objective or thinking clearly when reviewing their options. For example, one mother upon reflection expressed surprise at her actions when experiencing difficulties in the early stages of her breastfeeding. She did not consider approaching the child health nurse for advice and could only speculate that it must have been related to her confusion and vulnerability:

No I didn't [ask the child health nurse for assistance], it was silly really I never sort of went there and said "Oh I don't know what I'm doing". Maybe it was the fear of feeling that you're useless ... you can't do anything right. (M21)

The emotional drain of dealing with feelings of confusion was apparent in participants' statements. *"Hard for me emotionally and even giving up [breastfeeding] right at the end. I still was thinking 'should I or shouldn't I?' "* (M30). Another mother stated: *"I was a quivering mess. I was so confused, guilty at stopping this breastfeeding"* (M8).

In a Canadian study, phenomenological research into the experience of defining self as a mother was undertaken using in-depth interviews with seven women (Hartrick, 1997). For these women, the process of 'defining self' involved three themes: 'nonreflective doing', 'living in the shadows', and 'reclaiming and discovering self'. In 'nonreflective doing', participants took up roles that had been modeled by others without question. In the description of this theme, Hartrick also referred to the confusion and turmoil participants experienced when faced with contradictory scripts such as accepting prescribed traditional gender roles versus choosing to work and share household tasks. The reality that participants in this current study had choice in their parenting decisions challenged the concept of true 'nonreflective doing' because in choosing breastfeeding role models, they were in essence rejecting other roles such as bottlefeeding.

Self-Doubt

In addition to feelings of confusion, participants also revealed how being forced to deal with differing expectations resulted in them questioning and doubting their own competence in choosing options and making management decisions for their breastfeeding and weaning.

The resulting dissonance between expectations impacted upon participants' self-concept and self-esteem. *"I remember crying thinking it was just not fair, you know you set yourself up to be so perfect"* (M32). Perceptions of achievements in their mothering role were important to participants but this feedback was also provisional upon input from others. *"Sometimes you tend to listen like when your friends make comments and you think well maybe I'm a bad mother"* (M22). This perceived threat to their mothering self-concept resulted in women questioning their abilities to make decisions regarding breastfeeding and weaning. All participants had expectations regarding their breastfeeding and weaning experiences. When anticipated breastfeeding and weaning goals contradicted others' expectations, participants wanted to know 'why?': *"But why should I need this help? Why shouldn't I be able to feed all day and get two minutes sleep, cook the dinner and be all pleasant and lovely and be able to go out and things like that?"* (M31). Another participant, who felt she had not met her personal expectations, expressed doubts in her abilities by asking the following questions:

I should know everything you know I am a reasonably intelligent person "why don't I know all these? Why don't I know everything there is to know?"... You know, getting annoyed at yourself for that. "Why do I need help? Why do I need help with any of these?" (M32)

When differences between expectations could not be easily resolved some participants were susceptible to the critical and hurtful comments from others. *"Other people can be really critical and say, 'you only fed for so many weeks or so many months, oh what a shame' but there's more to it"* (M24). Because participants doubted themselves, they often perceived comments from others as being judgemental of their abilities and decisions, whether or not that was their intention.

Participants perceived many comments from health professionals as being critical. *"You're telling me I'm being a bad mother. She [CHN] said 'no I'm not'. I said 'yeah you are, basically that's how it's coming across'"* (M16). Health professionals' comments were often perceived as judgemental. *"It [breastfeeding] was having a detrimental effect on both of us but it was still 'oh why did you stop?' [participant questioned by child health nurse]"* (M9). Because health professionals were viewed as the experts due to their knowledge of breastfeeding and weaning, mothers were especially sensitive to their comments. For example, when health professionals asked

why breastfeeding had stopped, many mothers perceived this ‘why’ question as threatening. Heightened sensitivity to non-verbal aspects such as tone of voice, facial expression, or posture of the health professional were often interpreted as annoyance, disapproval, judging, or blaming and, consequently, a negative reflection of their mothering abilities. Health professionals often just wanted to know the reasons behind mothers’ decisions but by asking the question in such a way, mothers felt threatened and responded in a defensive manner: “*But I had my reasons, I didn't need to explain them to her [child health nurse]*” (M23). This defensive response was noted by one child health nurse who was interviewed for this study:

They [mothers] come this day [to the child health clinic] and they've weaned and I go 'oh, what happened? Why did you make the decision?' ... And usually they don't want to talk about it [feelings associated with weaning]. That's the impression I get, that they don't want to talk about it. I always ask them why they stopped or what happened. (CHN1)

Although health professionals felt they were diplomatic with their responses and questioning, they did not anticipate how their comments could be perceived as critical. Due to self-doubt, participants were sensitive to comments with any potential to be interpreted as critical of their breastfeeding efforts:

Initially when I told her I stopped breastfeeding. She... said 'oh, why did you do that?' ...She knew that X [baby] was losing weight and she knew because I'd told her about my expressing milk and realising I didn't have very much there. She knew all that, but it was still 'oh why did you stop?' (M9)

Family members and friends, however, were often more open and direct with comments. “*'He's not feeding properly' [says] my mother who came from the formula only generation. 'Why don't you just put him on the formula?'*” (M3). One child health nurse recounted a story told by one of her clients: “*His [partner] mother and his mother's mother are saying that I am starving the child and I should be giving him a bottle*” (CHN4). Not all family members were as direct with their comments, but even subtle comments were remembered by sensitive participants who were seeking support and encouragement for their efforts. “*My mother-in-law used to tease me a little bit. I don't think she breastfed at all, her five children, I don't know*” (M28).

Once an incompatibility with expectations between people became apparent and reality challenged their anticipated goals, participants looked within and began expressing

doubts about their abilities: *“you think ‘what have I done, you know what have I, it’s all me, I’m mucking something up’ ” (M21)*. Mothers wanted assistance and support during their breastfeeding and weaning experiences but when it became obvious that there were no easy solutions they would direct the questions and blame inward. *“It was hard because being your first baby you are thinking, why isn’t it working? [laugh] ‘Why can’t I breastfeed?’ It was hard because nobody really has any answers” (M4)*.

Not only did participants question their mothering abilities, but others also reinforced these doubts when they perceived the mother was not meeting their expectations. Comments from others indicating their concerns about the management of breastfeeding and weaning further eroded the mother’s confidence. *“And then it’s like well ‘have you got a problem, oh is he, oh has he got enough milk today?’ and all these old wives tale things that come out and you get really embarrassed ... sort of questions your ability I suppose” (M21)*. Unfulfilled expectations, reflected in an unhappy child, were also perceived as a negative reflection of mothering abilities and resulted in further self-doubt. *“I was having doubts then because he was so unsettled, and I was uncomfortable with what was happening with him, getting so upset” (M11)*.

Participants, especially first-time mothers, would observe and listen to other experienced mothers when formulating their own expectations. These expectations, realistic or not, became the basis for the participant evaluating her own efforts. A discrepancy between expectations added to the self-doubt. For example, new mothers often felt uncertain in evaluating their milk supply and looked for indicators to assess their abilities. *“And like I remember watching my sister-in-law take her kid off the boob and the stream would just go flying across the room, and I’m thinking well that never ever happened to me, not once ... and I just used to think well obviously there’s just nothing there” (M15)*. Another mother expressed similar doubts when she did not meet her expectations regarding milk supply:

But I always had these doubts as to whether I had enough milk. Because all these other mothers were saying “I just have to wear all these breast pads for leaking.” I did to start with but I settled down. And I was always worried as to whether he was getting enough. (M3)

Britton's (1998) study into the "embodied sensation" of the letdown reflex associated with breastfeeding revealed that although leaking could be an embarrassment, it confirmed the presence of breast milk and provided reassurance. British women from that study expected this letdown reflex to behave in a certain way based upon the advice or feedback of others and when it didn't, they became anxious and doubted whether they were able to nourish their children.

When comparisons with other breastfeeding mothers resulted in inconsistencies participants' confidence in their abilities was further threatened. With increasing doubts and inadequate knowledge, some mothers went to incredible lengths, as illustrated in the following participant's story, to accommodate their concerns:

And I was one of those very warped women and I'm sure some of them did it but never probably would admit to actually count the number of gulps that he had because I was convinced that I have not very much milk ... I used to convince myself that there was milk there because I didn't get much of a let down sensation but also that there's quite a bit there. Enough for him to lie comfortably and gulp what ever number and I used ... it ... [as] a timing device in that once he had his 180 gulps or whatever that I could start to say now ... it's time for bed. (M32)

The confusion and questioning of self occurred when participants realised that it was impossible to meet all of the expectations that they were being exposed to. Incompatibilities between these expectations ensured that they could not be met. Questioning of self often resulted in participants taking responsibility or blame for unmet expectations, "it's all me" (M21). They could not meet specific goals and expectations, felt it was their fault, and experienced guilt in not performing to expectations. Feelings of inadequacy occurred in many diverse situations where participants perceived they were doing something wrong. Although the interpretation of failure by participants varied in degrees, these findings are supported by a Canadian study that explored the experience of living with an incessantly crying infant (Hewat, 1992). These Canadian parents were found to have experienced considerable frustration, feelings of helplessness, anger, and guilt as they attempted to comfort their child in the context where their efforts were continually unsuccessful.

In her research into the experience of becoming a mother, Bergum (1989, 1997) identified relevant themes and challenged our thinking in her interpretation of resulting

themes. Concepts such as doubt and self-questioning, described by mothers in her research as guilt in their stories of motherhood, were discussed in relation to their positive potential of ‘decentering’ the mother for the sake of the other. In this process thinking moves from self to child and back to self, and the mother was able to create a positive, complex, relational experience of mothering. Bergum also discussed how women were fragmented and “caught in expectations” which resulted in feelings of ambivalence, sadness, and guilt (1997, p. 140).

Guilt

The final emotional consequence of *incompatible expectations* for participants, which emerged from the data, was guilt. “*I think I felt guilty and depressed about have I done the right thing*” (M19). The issue of guilt was a recurring feature in most interviews. Participants continually assessed their mothering abilities based upon their expectations and the expectations of others of significance to them. When an unforeseen incompatibility between expectations arose, participants could not ignore this fact. Because mothering was perceived to be their sole responsibility, the confusion, self-doubt, and questioning were directed inward resulting in feelings of guilt. “*I was feeling very guilty [for stopping breastfeeding] and I didn’t know what to do [about it]*” (M13).

The prevalence of mothers experiencing guilt was confirmed by comments from participants, their partners, and child health nurses. Most participants mentioned experiencing some degree of guilt during their breastfeeding or weaning experience. When breastfeeding or weaning expectations were not met, whether self-imposed or dictated by others, participants questioned their own abilities. All decisions were assessed and re-assessed for their outcomes. Decisions were often made but guilt lingered as participants reflected upon and re-evaluated their choice. “*I would have liked to [have] felt less guilty about making that choice*” (M3). This guilt reveals how questioning and doubting their abilities jeopardised the ultimate objective of being seen as a good mother; after all, would a competent mother feel the need to question her decisions? In reality, most mothers did question their decisions in the management of breastfeeding and weaning. Three child health nurses commented on this concept of

guilt based upon their exposure to numerous clients with diverse breastfeeding experiences:

A lot of mothers have brought up the idea of guilt, even mothers that have, by health professional's definitions, breastfed a long time, over six months and been happy with it. The issue of guilt, always questioning "am I doing the right thing? Am I a good mother?" That idea of guilt still comes through. (CHN1)

Guilt as in giving up because they wanted to continue and maybe the baby doesn't want to continue or guilt as in the partner wanted to continue ... [or] he [partner] decided that he didn't really want her to do it anymore. (CHN5)

A breastfeeding mother can be made to feel guilty by family ... the grandparent generation, fill them up with guilt for wanting to persevere with breastfeeding when maybe it's the mother-in-law who never breast-fed any of her children. And she wants the daughter-in-law to feel guilty because she's not giving her husband enough attention or other children or you know, there's all these pressures that can come from unexpected sources. (CHN2)

These child health nurses acknowledged the impact of family and friends in making mothers feel guilty. Interestingly, they did not comment upon their own potential in creating feelings of guilt in the breastfeeding women they were attempting to support.

Not only did participants need to re-affirm their decisions to themselves by evaluating the outcomes on their children, family, or self but participants who were confronted with people questioning their actions also felt obliged to justify their actions. "He [partner] often said to me 'why bother?' And I kept saying to him 'well you know it should be the best thing done' " (M15). In a society where breastfeeding is strongly promoted, mothers are often asked to defend their decision to introduce bottlefeeding (Gigliotti, 1995). Participants often provided a rationale for their decisions to others without being specifically asked:

I suppose when people asked me if I was breastfeeding or bottlefeeding I'd tell them that I'm bottlefeeding, and I'd explain why I was bottlefeeding. I don't know whether I was doing that because of guilt or whether I was doing that because of why I was bottlefeeding him. (M10)

The preceding participant's quote is not an uncommon occurrence according to Friedman (1996), who discussed the powerful influence peer pressure has had on women over the past decade. She suggested that this influence has resulted in women being "compelled to offer an explanation of their decision" should they not breastfeed.

The presence of *incompatible expectations* resulting in guilt for breastfeeding mothers was recognised by partners of the participants. One father wrote: *“women when at their most vulnerable are made to breastfeed by the ‘establishment’. If they can’t, they are made to feed like second class citizens {failures}. This is so wrong” (F12)*. This example also highlights how others used guilt to manipulate participants to comply with their expectations. One child health nurse commented upon the feedback non-supportive family members can give to women: *“Everything that’s ever been wrong with the baby ... it’s the fault of the mother breastfeeding. That’s another good one. He doesn’t sleep because you’re breastfeeding and you haven’t filled him up” (CHN1)*. Health professionals also used this strategy to coerce mothers to reconsider their decisions with breastfeeding or weaning:

And the information is incontrovertible that if you give your baby solids before he is four months, it will hurt his kidneys and he will get potentially high blood pressure when he is in his 30’s or 40’s. Do you want to do that to this baby? (CHN1)

Health professionals utilised strategies that focused upon mothers’ need to be acknowledged as doing the best for their children. Comments to promote continued breastfeeding or a preferred approach to weaning focused upon reinforcing the message that a good mother would meet these expectations and failure to do so will put your child at risk. The following response demonstrates this participant’s acceptance of that message: *“If I stop breastfeeding if something happens, I’ll never forgive myself because I’ll feel I’m responsible” (M5)*. The consequences of not accepting others’ expectations were graphically portrayed by some sources. For example, messages from health professionals who were the recognised experts had the potential to be remarkably effective, as revealed by the following participant’s interpretation of their message. *“They [health professionals] gave me an impression that X [child] must stay in your room [rooming-in] or it’s going to be an axe murderer. That’s what Mrs. Hitler did. That’s what she did” (M32)*. Another participant shared her interpretation of the consequences of not accepting health professional’s expectations:

I felt really guilty about it [stopping breastfeeding], and everybody kept saying to me, all the nurses, the clinic sister, everyone I spoke to said ‘breastfeeding is best, you should’ve breastfed, it’s better for your baby’, they tell you that your baby’s more... something about their brain development’s better if they’re

breastfed. So I was feeling so guilty, and I was thinking my child is going to be disabled, you know, I had it all in my head that this is what's going to happen. (M15)

The impact of guilt could have devastating consequences, as revealed by the following statements. *"Well everyone kept telling me it was me so I was stressed out. I can't ... that's why she wouldn't settle. And so I started to believe that maybe it is all my fault, and I ended up with postnatal depression" (M15).* Some participants dealt with their guilt more quickly than others, whereas certain mothers carried that guilt with them for long periods of time:

I kept persevering [giving expressed milk in a bottle], trying to get him to the magical three months mark because my guilt was enormous. I was just about breaking down with guilt and not feeding him was horrific. I'm still not over it [child now 8 months old]. (M8)

Other people were very aware of the issue of mothers' guilt and some attempted to assist participants in resolving these feelings. *"That reassurance and speaking to the clinic nurse last week she told me 'don't feel guilty', which I did in the beginning, because I thought well breast is best, I should be giving him breast milk" (M19).*

Family members or friends also tried to reduce the distress participants experienced in regards to guilt. *"She [participant's mother] sort of said to me, you know, 'well, it's your choice, don't let anyone make you feel bad because you're bottlefeeding' "(M13);* and:

She [participant's mother] kept trying to make the guilt go away, she was saying to me 'you've done 6 weeks and that's the most important time, and you know a lot of people only do a week'. So she was just trying to make the guilt go away. (M8)

Eunson's (1997) scholarly discussion of the impact of stress within roles was supported by the findings of this study. He suggested that taking on new roles was stressful particularly when one perceived they were not adequately prepared. Withdrawal and aggression were also identified as common responses to role induced stress. The consequences of *incompatible expectations* noted in this study, namely confusion, self-doubt, and guilt were expressed in participants' behaviours where they felt alone, isolated, and unsure of their expectations and options.

There were several conditions identified from the data that influenced the degree of confusion, self-doubt, and guilt that participants experienced. Each of these conditions will now be addressed.

Conditions Influencing Consequences of Incompatible Expectations

Consequences of *incompatible expectations*, previously discussed, were influenced by the presence of specific conditions. These conditions influenced the degree of confusion, self-doubt, and guilt experienced by participants. Two of the conditions were related to mothers' individual expectations such as the personal meaning they attached to their goals and expectations and the importance of their perceived control with decision making. Additional conditions were related to other sources of expectations such as the breastfeeding child, partners, family members, friends, health professionals, and society. The relationship of the source to the mother, the proximity and frequency of contact with the source, the extent of discrepancy between the expectations and, finally, the perceived credibility of the source all impacted upon participants' feelings when dealing with *incompatible expectations*. The remaining conditions involved the breastfeeding child's reaction, the impact upon the family, and the presence of some degree of compatible support.

Personal Meaning of Goals and Expectations

The meaning or significance of participants' goals and expectations was a major influence on how they dealt with the problem of incompatibility. The meaning participants attached to their expectations influenced the level of commitment they invested in accomplishing their goals. "*There's a sort of a fairy tale and then there's a reality, a harsh reality and it also comes back to ... 'what are you actually prepared to do?' "* (M33). The level of determination that participants felt toward honouring their goals of continuing or discontinuing breastfeeding, in the face of opposing expectations, affected how they responded to conflicting expectations. "*I was still determined that I wanted to breastfeed to at least 12 months. So I stuck to it*" (M24). Participants with very specific expectations and goals would put in added effort to meet their intentions. Breastfeeding intention has been positively correlated with breastfeeding duration in other research (Duckett et al., 1998; Lawson & Tulloch, 1995; Quarles et al., 1995).

However, another study did not find intention to be strongly predictive of breastfeeding duration to six weeks postpartum (Wambach, 1997). Women's intentions from that study were often affiliated with goals but the goal alone could not predict duration without consideration of the associated meaning.

Some women who had undergone previous unsatisfactory breastfeeding and/or weaning experiences were particularly determined to persist and achieve their goals with a subsequent child. *"I still wanted down deep to at least have breastfed one of my children"* (M5). One participant described the effort she went to in order to successfully breastfeed her second child:

It was at about three months it really set in and I fought and fought and fought to keep feeding him, I mean I tried all sorts of positions. My husband used to think I was weird but I was so desperate to feed him that I would do anything to keep him happy... at one time I was actually on the bed and I was on all fours feeding him ... just to keep him happy. He's just that kind of kid but I was so desperate. (M21)

Another participant expressed similar determination with her desire to achieve breastfeeding expectations for a second child. *"I thought, right I'm going to breastfeed, I thought I'm not going to give up this time. I'm going to persist and I'm going to breastfeed and if I have to sit there all day and feed this child, I will"* (M17).

The meaning associated with participants' expectations influenced not only the management of ongoing breastfeeding but their decisions and approach to weaning. Expectations with special significance motivated participants to maintain their determination. *"I was very determined to make it to 12 months, I thought 12 months would be just great. That was what I had in my mind. That was my goal and I didn't get there so it was upsetting"* (M17). Another participant explained her persistence with breastfeeding being associated with fear for her child's safety and the benefits of breastfeeding in protecting health. *"I really wanted to feed him, being a first child and being terrified of SIDS [Sudden Infant Death Syndrome] and being terrified of this that and the other and I really wanted to persist with that"* (M12).

The meaning that participants placed upon their breastfeeding and weaning experience was also influenced by the knowledge that a particular child was going to be the last

child. Participants recognised that this last opportunity to breastfeed represented an end to an important mothering phase:

I think maybe because I'm sure he's going to be my last baby, and you just want to keep him there forever type of thing. Yeah, I think that's the reason why I just kept thinking, no I'll just keep trying. (M14)

And particularly with the multiples [experienced mothers] with their last child. They'll often breastfeed a bit longer because it is something you will never ever do again. And you will never forget after 10 or 20 or 30 years. So it's an amazing tie. (CHN3)

Seven child health nurses during the focus group also noted that mothers who confirmed that this was their last child acknowledged the added significance of this breastfeeding experience. The reality that they would never breastfeed again influenced their expectations and goals. The significance of this passage was also demonstrated by the intensity of feeling experienced when the final weaning was complete. Participants progressed to being mothers of toddlers and preschool children rather than mothers of infants. Participants acknowledged that they would never have the opportunity to breastfeed a child again and would miss that experience. *"I often get mums who are very upset especially if it's the last one. They are going to miss it"* (CHN1).

Susan, another American mother who shared her experiences in a published collection of mothers' nursing and weaning experiences (cited in Owen, 1989, p. 25), described how her behaviour changed due to the knowledge that this child was to be her last: *"With X [child] I was more patient. Maybe because we are not going to have more children and if he has to nurse [breastfeed], he comes first"*. Huggins and Ziedrich (1994) in their advice to weaning mothers also noted the significance of knowing this last child marks the end of a woman's reproductive years and acknowledges a passage to the next stage of life (p. 176).

Being able to reach specific goals and achieve a sense of satisfaction further fostered participants' determination to persist with their ambitions. *"I wanted to go as long as she wanted to go. I wanted her to be the one to stop. That's mainly why I was so satisfied with the whole thing because I felt that that had happened"* (M29). Not reaching goals that were particularly important to participants accentuated the distress experienced. *"Because I was crying all day, every day. And not because I felt unhappy"*

about anything else but because I couldn't breastfeed" (M5). Other participants whose goals and expectations did not have significant meaning for them did not express the same degree of distress when their goals were not achieved:

I thought I'm not going to fall into that same hole and get myself so much into a dither. So it didn't worry me this time and when I finally stopped I thought it's obvious. I thought ... I can't breastfeed ... it's not worth the hassle and having them starve while you're trying to wait to see if it'll work. (M15)

If goals did not have significant meaning, participants were more able to feel less attachment to the goals and had more flexibility in modifying these goals. *"I hadn't made any strict rules on how long I was going to feed for anyway, so it didn't worry me at all (M16).* Another participant clarified her approach to personal expectations as follows:

I wanted to go as long as I could but I didn't also want it to become, I don't know. It's just my own personal thing you know ... I tend to think "go with the flow" and whatever suits the situation you do and it just suited us better to do it this way. (M22)

In the current study, flexibility was particularly important when it became obvious that certain goals were not going to be achieved:

I really wanted to stay breastfeeding for a year, just the year was poignant to me ... But when it came to eleven months I realised that she had all the nutrients from foods, I could accept it you know. It's not that I was emotionally attached to the one year, it's just the one year, the milestone, that's it. So it wasn't any big emotions underneath it. (M23)

...because she was my third I was far more flexible. Nothing was hard and fast. What had to be, had to be, sort of thing. I sort of changed goals quite easily. Don't be too hard on myself if you like, you know. (M2)

Mothers' perception of their flexibility with infant care has been associated with later weaning (Vandiver, 1997). This American study of 50 first-time mothers examined the relationship between breastfeeding duration in the first 12 weeks after birth and self-reported maternal characteristics. Questionnaire data revealed that mothers who rated themselves as less flexible caregivers weaned earlier than their more flexible counterparts.

A firm commitment to specific goals, coupled with personality traits, such as self-determination, assisted participants in this study to disregard expectations that opposed their personal beliefs. *“And you know, I’ll give it up when I’m ready, not you know when I’m told to give it up” (M12)*. Strong convictions to accomplish personal expectations allowed some participants to remain faithful to their goals and ignore pressures and comments from others. *“And she [child] just kept on coming back more and more for milk and the mother-in-law was saying ‘oh no, no, no more, no more this’. Just teasing. I wouldn’t give in to pressure anyway; it’s what I’m comfortable with” (M28)*. Participants mentioned how this aspect of their personality, described as stubbornness or a strong will to accomplish a personal goal, allowed them to respect their own beliefs when confronted with opposing expectations:

Well no one influenced me to stop, and my family didn’t encourage me, it was just my own will to keep on going and my own will to stop because I think that’s what it should be, it should be up to the mum what happens, not everyone around you. (M10)

I’m quite strong minded, strong willed, but they couldn’t make me more determined to do it. I’m a bit like that. If you tell me not to do something I’ll, or if you tell me to do something else, I’ll do the opposite, so I’ve always been quite strong willed, so it probably made me hold on longer [persist with breastfeeding to overcome many difficulties] [laugh]. (M12)

Possessing a *“strong will and stubborn personality” (M12)* gave some participants an advantage in maintaining their resolve to accomplish their own expectations in a hostile environment. *“There was no way I was going to feed my baby on a bottle. They were my views. I was very stubborn and very tunnel visioned” (M5)*. One child health nurse characterised these determined women as strong: *“Well stronger mums will just say ‘tough, this is what I want to do’ ” (CHN5)*.

Some participants believed that weaning was a negative and painful experience for both mother and child. Due to these expectations they felt that a swift process of weaning, such as cold turkey [stopping breastfeeding abruptly], would decrease the duration of that *“unpleasantness” (M1)*. *“He literally had to scream for a day while my milk supply dried up. She [sister] kept giving him the bottle ... We just had to let him cry until he took the bottle” (M2)*. These participants felt this approach was the best option to minimise the damaging effects of weaning for the child and mother. They believed that,

although there would be discomfort for both the mother and child, reducing the time period of that discomfort was seen to be compatible with the belief of minimising harm. One participant explained her reasoning for using the cold turkey strategy, as she felt gradual weaning was not a practical option for their circumstances. She felt the prospect of gradually denying her child was contrary to her personal beliefs about weaning:

I just had decided that that wasn't how we wanted to do it [gradual weaning] or how I wanted to do it. I couldn't see how I could have said no and keep cutting it down ... Because I just didn't want to say no to a child because I could see that that was what I would have had to do and I just didn't want to do that over a length of time. (M1)

This participant's goal was to accomplish child-led weaning but due to circumstances of another pregnancy and a toddler who was not interested in weaning, she chose a strategy that was most compatible with her beliefs.

The personal meaning of goals and expectations influenced the degree of confusion, self-doubt, and guilt participants experienced when dealing with *incompatible expectations*. These meanings explain the degree of commitment and determination some participants demonstrated in the management of breastfeeding decisions.

Control over Decision Making

Participants expected to have some degree of control over their breastfeeding and weaning. When they felt that the timing of the weaning was right, it often reflected recognition of readiness in both the mother and child. If mutual readiness was achieved, weaning progressed relatively easily. Some participants expressed satisfaction when they were able to assess this readiness and respond accordingly. *"And I gave up because I wanted to and I did it over about a month ... I always enjoyed the second one because of that, because I was able to decide when I wanted to"* (M21). This same mother frankly shared her long-term feelings towards her two children as a result of comparing the success of achieving readiness versus being forced into making unwanted decisions:

I look back and I think that I much more enjoyed feeding X [2nd child] and how it was sort of a happy occasion to not feed him. I suppose it was like an agreeable decision, it was a happy decision. X [1st child] was like a forced,

sometimes I look back and I wonder if I hold it against him now ... he was such a fussy ... baby ... I know it did disappoint [me]. (M21)

Another participant expressed her sense of accomplishment when the timing for weaning met the needs of herself and her child. *“The second one was my choice ... He was quite happy to keep going or happy to go on the bottle because he’s a very easy going little baby so that suited me as well and it seemed to suit him” (M22).*

The ease of weaning represented sensitivity to timing. Situations where mutual readiness of mother and child could be achieved resulted in easier weaning. Certain psycho-analytical authors would not agree with this finding. Lubbe (1996) suggested that weaning was a struggle and “creates considerable emotional turbulence in the mother child relationship” (p. 195). Weaning according to Lubbe was viewed as the first opportunity to experience the struggle of simultaneous love and hate in realistic relationships at a time when “letting go of the old” and “moving on to the new” occur together.

Participants discussed particular unanticipated instances where they felt their control with decision making was at risk. *“You don’t picture all those sorts of things you’ve been out of touch or control with, epidurals and Caesareans” (M32).* When participants felt pushed to make decisions before they were ready, they found this difficult to accept. *“Because they haven’t actually come to terms with it like being induced [in relation to labour] and things like that ... it’s not their time (CHN5).*

There were several situations when participants felt forced to wean before they were ready. Examples of life events that necessitated prompt or undesired weaning were work commitments, another pregnancy, irreconcilable physical problems, maternal illness, medications that were contraindicated for breastfeeding, or unanticipated travel requirements:

I felt like I was sort of lumped into a corner and I was doing something that I deep down didn’t really want to do but I knew I had to ... I remember sitting in the chair thinking. I had the bottle in my hand and I thought this is the last time. If I go cold turkey, this is the last time I’m going to feed her and I felt like crying. I felt like saying “bugger it” and chuck the bottle. It just seemed so harsh ... I had to because if we bought this business we had no option, I just had to do it and then what really annoyed me more was that the business didn’t go ahead

and I'm still at home and I could've been feeding her all this time, so I gave up for nothing. (M21)

Many participants had a difficult time coming to terms with their perceived loss of choice. Feelings of confusion, self-doubt, guilt, and sadness were accentuated.

Although these participants initiated and managed the weaning process, they felt that the decision to stop breastfeeding was not what they wanted. The following participant expressed her distress with initiating weaning. After her child would not attach to the breast over six weeks of persisting, she continued to offer bottled expressed breast milk for a further eight weeks while struggling with several episodes of mastitis:

And that weaning was one of the hardest things I've ever done because when you wean your baby... that Caesarean I had no control over, but when you wean a baby you've got control over it and it's very hard to physically do something that your brain's telling you "I don't want to do this" ... I'm used to being a professional person ... And when you have a baby and things start going wrong, ... you have your Caesar [caesarean section] ... then you can't breastfeed ... my whole world was crumbling. And I couldn't get any sort of control. I wasn't doing anything right and that was very foreign to me. (M8)

Life events and irreconcilable difficulties were not the only situations when participants felt choice was taken from them. A number of children weaned themselves abruptly over a day or two. The participants in these situations were shocked and bewildered by their powerlessness over the weaning process:

I breastfed him in the morning, bought the cup. For lunch I gave him his lunch and the cup and he drank it and then refused to breastfeed from there on in. He wouldn't take it, he screamed, he bit me, he scratched me, he threw himself on the floor, he just howled and wouldn't take it ... He weaned himself and I did nothing, absolutely nothing and I was so upset ... I just felt really horrible and I was really upset. (M17)

These mothers often made attempts to continue breastfeeding, sometimes for several days, but were confronted with determined resistance from their child. *"I tried [to continue breastfeeding] during the week. No ... she was determined. She just didn't want it and that was it ... I was so disappointed ... I felt really flat for a long time"* (M24). This woman's partner also acknowledged the effect of this perceived loss of choice upon his wife, reinforcing the significance of this event for this family. *"X [mother] was quite put out that it was X's [child] choice to stop feeding from the breast, not hers"* (F24). Participants were more able to promptly resolve issues of loss of

control and choice if they felt their child's expectations and needs were being met, first and foremost. For example, with abrupt child-led weaning, mothers often resolved their disappointment and guilt by acknowledging weaning was the children's choice and met their needs even though they did not like it. *"I tried as much as I could to breastfeed this baby and he didn't want it. That was his decision, not mine; that was taken away from me. There was nothing I could do about it, so I just accepted it"* (M17).

When participants perceived specific expectations were too strongly advocated, they expressed feelings of powerlessness and loss of choice. This loss of choice applied to the paternalistic relationship between participants and particular health professionals. *"I don't think you have a lot of choice to be honest. The doctors and the nurses more or less assumed that you were going to do it ... I think they sort of push you to breastfeed"* (M6). The following quote illustrates how one participant endeavoured to maintain control and reclaim ownership of her decisions:

I decided that if I was going to stop I was going to stop before I went back to my next clinic appointment, so that I would say that I'd been on probably three to four days all bottles and no ill effects ... I didn't want to waste my time having a clinic sister trying to influence me to persevere for longer when I knew that the time was right, it just felt right within. I knew that if I went there and I say "I'm going to stop" she would have tried to influence me so I took the decision out of her hands. (M16)

A number of child health nurses interviewed recognised the dilemma faced by mothers with *incompatible expectations*. A few child health nurses interviewed advocated that women maintain control over their decisions. They presented information as options and encouraged mothers to make choices based upon their beliefs and goals. *"I'll say this is how it could be, there are different options and they'll say 'yes this is what I want'. They feel more control of it then, their lives"* (CHN3). Another child health nurse shared her thoughts on this issue:

They [mothers] have a choice with whether they want to breastfeed or not. I thought that was quite important that they are not doing it for anybody else but for themselves ... I say it is their choice and I'll support them whichever way they want to do it. (CHN5)

Participants acknowledged that many aspects of parenting were challenging and often beyond their control. Mothers wanted to assume control where possible as the ultimate

responsibility for their children resided with them. Participants appreciated knowing that choices were available when decisions were being made. When control of decisions was taken away from them, many participants had to deal with resulting feelings of confusion, dissatisfaction, self-doubt, and guilt.

Relationship with Source of Expectation

The relationship between the source of expectations and the participant influenced the degree of confusion, questioning, and guilt that eventuated. The importance of this relationship to the participant influenced the impact of these consequences. A long-term close relationship with a partner or family member, such as the grandmother or mother-in-law, was often more meaningful to participants, compared to the temporary relationship with a health professional or the transient encounter with a stranger at a supermarket or restaurant. The support of a woman's intimate partner has been also recognised in the literature as being more salient than the support of others in relation to the maternal process of achieving maternal identity (Mercer, 1995).

All participants stated that their partners were very supportive of their initial decision to breastfeed. Many participants stated how expectations evolved as the breastfeeding experience progressed and new expectations in relation to weaning became apparent. A number of participants described circumstances that revealed how their partners influenced their decisions with weaning. If there was agreement or compatibility between the expectations of mothers and fathers, no problem resulted. However, if there were discrepancies between expectations, participants assessed possible outcomes. If participants felt that continuing to breastfeed was jeopardising their relationship with the child's father, they often compromised their expectations for the sake of the relationship:

I had to wean him off. Hubby started coming around and he wanted to come back into our lives [separated for several months]. So he stayed one night and he said "well, you're still feeding him that's not right". I said "well, I feel close to him and he still wants it". But in the end I thought no, perhaps I should just let go. So I did, I let go. (M26)

Comments from partners that reflected differing expectations from the participants were not always immediately acted upon. Some participants chose to evade opposing

expectations if they felt their relationship with their partner was not being compromised. “So he [partner] was always telling me every couple of months, ‘give him the bottle’ ... and I said ‘no’ that I wanted to keep on going until twelve months” (M19). Participants assessed how adamant their partners were about having their expectations respected:

Because I enjoyed it [breastfeeding] and I felt ... he [partner] waxed and waned ... He, but I didn’t think had conviction. He thought it was too long but he didn’t have sufficient conviction to really stamp his foot about it. (M31)

I was so upset about not feeding him and he used to say ... “just put him on the bottle” and ... I have seen other husbands that really make their wives [stop breastfeeding] and go on and on and on. He didn’t go on and on and on about it. (M21)

If participants were determined with their goals for breastfeeding or weaning, and their partners were perceived to be not seriously demanding of their expectations, mothers chose to ignore or resist their remarks. “I did feel a little bit of pressure although I sort of resisted it from him to put her on the bottle so he could feed her” (M2). If their partners’ comments continued as time progressed, participants re-assessed the ongoing potential impact upon the relationship, and chose the best balance for their family:

I think he had this thing that you really shouldn’t be breastfeeding a baby after 12 months anyway. So ... he helped me actually. I think I probably would have still kept breastfeeding X [1st child boy] just out of that niceness but my husband really had quite a bit to do with influencing me and encouraging me to wean him off ... He went out and bought the bottles and everything. He was that determined but that’s his nature. He just thinks something has to be done; we’ll do it. (24)

Due to the perceived significance of the relationship, extended family members and friends often did not have the same degree of influence upon the participant’s decisions as the child or partner. “Mother-in-law and ... a few friends [pressured mother to stop breastfeeding] and I said ‘no, when I am ready I will wean him off’, but I wasn’t ready” (M26). The following example also illustrates the greater influence of the partner over the mother’s decisions with breastfeeding in comparison to an extended family member:

[Mother-in-law] was a nurse and she was really into breastfeeding, so it was mainly X [partner] who said to me that I had to do something with the baby [stop breastfeeding because the child was unsettled]. And it was hard because they [in-laws] were here; I had only just met them ... So that ... made me give up. (M17)

The participants' perceived expectations of their child took precedence over all other people, after all the children's wellbeing was the primary factor for choosing to breastfeed. As stated by participants, the perceived benefits for the child was the reason for breastfeeding. *"The reason why I chose breastfeeding was because it's the best for them [her children]" (M11)*. This assertion that the needs of the child were the main motivating factor in the decision to initiate and continue breastfeeding was confirmed by all participants:

It makes sense that it would be too ... we would be best able to concoct the right you know drink for a child than a cow's milk modified basically. Doesn't make sense for that to be the case so ... it's obvious that it would be and I thought basically just wanted to give her the very best. (M31)

When the dilemma of conflicting expectations occurred between participants and their extended families, partners were placed in an uncomfortable situation due to their relationship with these family members. *"I think his [partner] is more pressure from picking up on the teasing from his mum and things, the fact that his sisters didn't breastfeed" (M28)*. Partners were placed in a difficult position of wanting to support their breastfeeding spouse, but also acknowledge their extended family members' opinions.

The closer or more sentimental the relationship was with the dissenting party, the more difficult it was for the participant to ignore their input. *"Being mum I mean I'm closer to her than my mother-in-law" (M4)*. Dealing with a close family member's conflicting expectations and advice was not easy. Women determined to breastfeed were put in a difficult position when they were confronted with conflicting opinions from their own mother or mother-in-law. Many of these mature people came from a generation where breastfeeding was not as accepted, the *"formula only generation" (M3)*:

My mother-in-law ... she just said to me "well you know, her son was brought up on a bottle and she can't see what difference that has made. I mean there was one that was breastfed and the other one was bottlefed and she, there's no difference." (M14)

And my mother would say "keep her on the breast ... with colic, she'll get worse on the bottle". So I persevered and especially my mother-in-law and that side of the family ... they said "put her on the bottle, she'll be much happier. She'll fill up". I said "no, I want to breastfeed" and I persevered and I'm glad I did. (M25)

Stark (1995) referred to the generation gap with breastfeeding where today's mothers often have parents who came from an era where bottles and formula were the norm. As a lactation consultant she saw women who had received comments from their own parents such as: "stop fooling around with this breastfeeding nonsense and just give the baby a bottle" or "how can you be sure that she's getting enough" (p. 1).

In summary, the participant's relationship with the source of differing expectations influenced the impact of *incompatible expectations* upon the mother. The more value the participant placed upon the relationship, the greater impact that person had upon the mother. This finding is consistent with the literature on conflict resolution which states that when dealing with conflict, two issues must be considered: the achievement of personal goals versus the importance of maintaining a good relationship with the other person (Johnson, 1997, p. 240). Participants approached this issue by considering their personal commitment to their goals and expectations, previously discussed in this chapter, against their desire to maintain a positive relationship with the dissenting person.

Proximity and Frequency of Contact with Source

Although participants noted conflicting expectations from many people, the proximity of these persons and the frequency of contact influenced their impact upon the participants. Close, constant interaction with someone whose expectations contradicted their own caused some participants particular distress. "*She [mother] came over [from another state] for the birth but that's another story. That was a nightmare, but I found that her help [with breastfeeding] was more a hindrance than help*" (M20).

Participants generally interacted with their partners on a daily basis. Partners were in the best position to assess the impact of breastfeeding and weaning upon the family. "*'Stop breastfeeding' because he [partner] could see how exhausted I was. He wasn't encouraging me to breastfeed if X [child] wasn't going to take the milk*" (M10). This frequent contact may explain why it was more difficult to ignore a partner's comments in comparison to those statements made by an extended family member, friend, or acquaintance seen on an occasional basis. Participants were better able to deal with an

occasional disagreeable comment from a distant source than from a close, persistent source:

Mum's of the opinion that they should be off the breast by four months anyway and when we went to [visit parents in another state] ... that's what she said "are you still breastfeeding her" and it's like thanks Mum ... If they'd been here every day it would've been harder for me I think because then I would've ... wanted to breastfeed her then until she was 15 just to prove I could, so I would've felt ... extra pressure to do it and be good at it with them there. (M20)

A few participants, especially first-time mothers, stated that extended family members, such as mothers or mothers-in-law, moved in to their home temporarily to assist them with the adaptation to parenthood. *"I stayed there [mother's home] for four months ... that was unreal because I had a lot of help from my mum because she's had seven kids, so ... that was really good. She ... gave me a bit of advice" (M13).* During these periods of intense contact, the extended family members were able to see the effects breastfeeding and/or weaning were having upon the mother, child, and family. This opportunity encouraged family members to feel more justified in offering their opinions or advice:

I mean, no, she's [mother-in-law] never said "why don't you give up?", she just said ... "you've done incredibly well to last as long as you have" ... my mother-in-law was a lot closer, she could see my weight loss and that I was getting sick, I was picking up every infection. It was just like two or three months that I was constantly a wreck, and I was picking up bugs and I was losing weight and it's ... "why don't you give this up, it might help?" (M12)

Some participants' mothers did not actually live with their daughters but maintained frequent contact either over the phone or by visiting. The following participant stated that her mother phoned her every second day to see how she was managing with her breastfeeding and subsequent weaning:

They [mother and sister] were saying give up because they could see what I was going through ... so I think my mum, being a mum, just wanted to see me not crying anymore ... she was saying to me you've done six weeks and that's the most important time, and you know a lot of people only do a week. (M8)

Having that frequent contact with extended family, particularly female members, was important for many participants. *"The big thing was support from family and friends that was really good" (M9).* This support was particularly helpful when the person listened and respected the participant's wishes:

She [participant's mother] was concerned for me ... "let me just hold her while you go and have a sleep or something and I mean some times she'd say "should we give her the bottle so you can have some rest"? And I say "look mum I know but I really want to do this" ... so she was very supportive. (M33)

My mother-in-law was pretty good too even though she never breastfed hers. She just said "keep going". So that was good. I think that's all I needed was someone to say "you know just keep going you'll be right." (M20)

A number of participants, who did not have that close contact with family during this transition period but desired that support, expressed a sense of being alone. *"It was hard not having someone close. I mean sisters-in-law and mother-in-law are there, but they are not the same. You're not as close to them as your family. So I probably did feel a little bit alone" (M4).* Receiving support and reassurance from a person one respected and with whom one had a meaningful relationship was important for many participants. *"She'd [child] be up for five or six hours just crying. So I just thought in the end it was my fault. You see my mother wasn't living here, she lives in [another state] so I didn't have her backup to tell me 'it's not you' " (M15).*

The proximity and frequency of contact with people whose expectations conflicted with their own, had an impact on how participants interpreted and dealt with this inconsistency. Close, frequent interaction with someone whose expectations coincided with their own supported and reassured participants, whereas constant exposure to people whose expectations contradicted their own accentuated the confusion, self-doubt, and guilt experienced.

Perceived Credibility of Source

Certain people exerted greater influence over participants than others in relation to breastfeeding and weaning decisions. The perceived credibility of the dissenting person influenced how the participant dealt with their advice and expectations. Participants assessed the person's credibility based upon their knowledge of breastfeeding compared with their practical experience:

I always used to think people [who hadn't breastfed] who said that [friends who asked if she was still breastfeeding after six or nine months] were ignorant because I think there's so much research that shows it's good for the babies and things like this so I always used to think to myself well they just don't know. (M30)

Many participants anticipated that health professionals would have the greatest knowledge on breastfeeding and weaning. *"I looked to the clinic nurse to see what I was doing right. They stipulate everything and once hearing from them that I had done the right thing, 'don't feel guilty, you've given him the best' "* (M19). Health professionals were generally regarded as having the most up-to-date information but their credibility was lost if participants felt that they were giving inaccurate or outdated advice. *"I can't be specific [concerns with outdated advice], I just wouldn't go to her [child health nurse] for advice, I'd join the Nursing Mothers Association "* (M18). Because participants were exposed to many sources of information, both personal and in written form, they were often able to determine when advice was outdated. *"She [grandmother] would say things ... I'll just actually run that by the clinic sister which I know that book discusses too ... it was like things have changed, babies still come out the same way ... but ideology has changed hasn't it?"*(M33). If advice from one source conflicted with many sources, mothers became confused but could verify the suitability of advice from numerous sources. The prospect of losing confidence with health professionals was demonstrated by another participant's statement when she questioned the information given based upon her own reading. She then became discriminating in accepting advice:

I just started going to the other health clinic ... she's really good. She'll let you sit there and talk to her but some of the advice she came out with ... I mean at six weeks of age she said "he should be on a bit of solid food now". I said "no", eight weeks I think it was but I said "he just can't handle it." (M26)

The interpretation of whether the information on breastfeeding and weaning was up-to-date was a factor that participants considered when evaluating the source of expectations. *"It's not that I didn't disbelieve her, 'sure mum that's what you did but also it was a long time ago when you had kids' "* (M33). Accepted practice for one generation was not always perceived as desirable by the subsequent generation. *"My mother-in-law, I mean she's sixty, my Mum's forty five, she's [mother-in-law] nearly sixty, I just think that her advice is even more antiquated than my own mother's, so I really know when to shut off"* (M23). Participants noted that people's expectations and advice were biased by their own parenting experiences. *"I started going to this ... support group. That was a really good help. So I sort of learnt, but you've got like*

seven mothers telling you seven different stories” (M11). Participants anticipated that information offered would be biased by the parenting trends from the time period they had dealt with breastfeeding and weaning. “And I sort of expected that from my parents so it didn’t really worry me but that’s their ideas because that’s what they did so they think that’s right you know” (M20).

Age and recent personal experience with breastfeeding were considered by participants when assessing credibility of the source. Other women, family, or friends who had recent experience with breastfeeding and weaning were often regarded as credible sources. Participants also regarded other mothers in similar situations to their own as credible sources of information and support:

There were other mums in my age group [at parenting class] and ... there was one girl there that had already ... weaned her baby at two months because she had such bad problems as well. And she was very good ... it’s [parenting class] a great help going to it because I could meet other mums who were in the same boat with first-time babies. (M3)

Although other mothers’ advice was often biased by their personal experience, their knowledge base was assumed to reflect current trends. Although older mothers were not always perceived to possess current practical information, their wisdom was acknowledged in a more general sense. They had successfully raised their children and were able to reflect upon motherhood in a different light:

They’re mothers. And they probably knew in context the importance of it. In the overall 20 years that you’ve got this child at home, it’s not a do or die situation and that’s what I was seeing it as ... so you know if that meant not breastfeeding him she said you know she had seven kids and “it’s not that important.” (M8)

Many participants relied upon family and friends for advice, and this reliance was accentuated if a participant questioned the credibility of her chosen health professionals. *“I have got my sister who’s got five kids and I’ve got friends with kids and I’ve kind of been around children a lot and whenever I needed information or help I went to my friends or family before I went to X [child health nurse]” (M22).* In contrast, family or friends who were significantly older than the participant, had teenage children, or had no children were not regarded as credible sources and participants were more likely to disregard their expectations. *“My sister who is terrible, I mean she’s older than me.*

She's got no children. She'll never have children and she's a bit funny about everything so I just like she'll call me a cow and stuff like this" (M30).

Participants also considered the age and personal experience of their health professionals when assessing their credibility:

This is going to make me sound terrible, but she's [child health nurse] not married and she doesn't have any children and she's I can't even guess how old she is, I don't know, just say forty so in my own mind I thought you know it on paper but you don't have the experience. (M23)

The following participant had expected to wean her child around 14 months old. When asked how she chose that time frame, she indicated that her friend's previous experience coupled with advice from her general practitioner (G. P.) had influenced her:

I guess it's because I've got friends that have got 14, 15 month old children that are now walking and talking and are just constantly demanding that [breastfeeding at will] ... So I wanted to start with X [child] quite young ... before he got to that stage that he could dictate to me himself ... [later in the interview] I said "when do people stop breastfeeding" and he [G. P.] said "well, everybody's different, but from 14 months you really can't offer the child the nutrition after that 14 months, I mean, you're not able to supply enough iron and the rest of it ... And he said his wife fed their kids till they were 14 months old. (M12)

Not only did participants associate antiquated information with different generations and changes in attitudes, but they also screened advice that was influenced by cultural background or attitudes that did not place a value on breastfeeding congruent with their beliefs:

It was virtually my dad right from day one telling me to give him a bottle. If it was up to my dad, X [child] would have been on a bottle since the day he was born. That's because he's an old Italian from the old fashioned ways. (M3)

It was actually my father because he's Italian, he was the one who would always say to me when X [child] had a stomach ache, "it's your milk giving him stomach ache because you give him everything and because he was colicky, give him a bottle it will stop, it will stop." (M19)

An exploratory, correlational study that examined the sources and perceived helpfulness of weaning advice from 76 first-time mothers was conducted in Britain (Walker, 1995). Although weaning in the British study referred to practices such as the introduction of foods, rationale for decisions, sources of advice, helpfulness of advice and benefits, and

difficulties with weaning, the findings have interesting implications for all weaning experiences. Conflicting advice and infants being ready to wean before the recommended age were the most frequently cited difficulties resulting in parental anxiety, guilt, and animosity toward health visitors. The British health visitor's role in supporting parents in the community is similar to the Australian child health nurse. If advice was regarded as unrealistic by parents, it reduced the professional's credibility and doubts were then transferred to all advice given. Ultimately, many parents chose to not use that resource again. The findings from that British research strongly support those of this study. Walker's (1995) conclusions suggested that "official guidelines may be too rigid to reflect the diversity of individual infant's needs ... and a more flexible approach may be needed if professionals' credibility is not to suffer" (p. 109).

The perceived credibility of the source of advice was a condition that influenced how participants interpreted and resolved *incompatible expectations*. The age, personal experience, and knowledge level were all used as criteria to assess this credibility.

Extent of Discrepancy between Expectations

A further condition that influenced the amount of confusion, self-doubt, and guilt experienced by participants was the degree of discrepancy between differing expectations. A smaller degree of discrepancy did not cause the same amount of distress to participants as a larger degree. For example, one participant whose goal was to breastfeed for twelve months but decided to wean at ten months in response to her child's behaviours shared her feelings in relation to being faced with this situation:

I think I was just a bit depressed because I felt like he [child] didn't need me anymore and now he's a big boy. Now I know that I gave him the best ten months that I could, there are a lot of people who can't breastfeed and who don't want to breastfeed, so I know that I gave him the best ten months that I could.
(M19)

However, this same participant also had to deal with her partner's *incompatible expectations* of wanting to put the child onto the bottle right from the early months to allow him to be involved with feeding. "So he was always telling me every couple of months 'give him the bottle, give him the bottle', trying to get him on to the bottle and I said 'no' that I wanted to keep on going until twelve months" (M19). In this situation,

the meaning attached to this goal allowed the participant to maintain her commitment and disregard her partner's requests. However, once the child indicated his desire to wean, she conceded her goal of persisting with breastfeeding for the sake of the child's expectations.

All partners of the participants were initially supportive of breastfeeding so no one experienced a wide discrepancy of breastfeeding between their partners' wishes and their own. As time progressed though, *incompatible expectations* did become apparent for some couples. The following example illustrated different expectations between parents in relation to the initiation of weaning:

I was also getting heaps of pressure from my husband by that stage to stop [pressure intensified at 18 months]. He I think had a bit of a hang-up basically with her breast-feeding when she was an older child [20 months] which I didn't really have. And so he was kind of pressuring me, not hugely but subtly. I was starting to feel mildly irritated about it myself, I thought I'll give it a go now [weaning]. (M31)

The extent of discrepancy between these parent's expectations was only a few months. The partner intensified pressure upon his wife to wean at 18 months but by 20 months the mother also felt the time to wean was right for her.

One of the widest discrepancies with expectations participants faced was dealing with comments from others suggesting they should not have made the decision to breastfeed in the first place. Society, generally, and health professionals strongly advocated breastfeeding and rarely provided this type of message. In contrast, sources such as extended family members or friends were more likely to suggest that breastfeeding was not worth considering. *"Even my mother-in-law had to sit in another room [laughs] and she was always enforcing that bottle was best"* (M18). One participant who had decided to wean at six weeks but changed her mind felt the need to *"confess"* her decision to her mother who had been non-supportive of her breastfeeding from the start. *"'Look Mum I know you're not going to be happy about it but I'm still breastfeeding', so she wasn't happy about it"* (M32). As discussed previously, these sources often based their expectations upon their own parenting experiences:

My sister was great but unfortunately ... she bottlefed her two babies from about ten weeks old. Breastfeeding and her didn't quite mix so any hint of too many

feeds or whatever "the bottle, the bottle. Shouldn't want to be feeding that often." So that was a little bit you know that got my back up a little bit. (M33)

Examples of wide discrepancies were most often apparent in relation to the acceptable time to stop breastfeeding and begin weaning:

She [participant's mother] had very strict regimental ideas on how it should be done and of course we were sort of a bit more laid back ... So we had different ideas altogether. And she was saying stop her at four months is enough, she doesn't need it after four months [participant's goal was to reach 12 months]. (M20)

I had a friend who really loved babies and she'll come around to see the baby all the time. And I remember her saying that (are you still breastfeeding). I was so surprised because I thought somebody who liked babies so much would expect me to breastfeed. (M30)

Participants listened to other people's expectations and then assessed how consistent they were with their own goals and beliefs. *"I know some people find it very comfortable to be feeding a 1 or 1½ year old. I know a girlfriend who still feeds her 2 year old every now and then ... I wouldn't feel comfortable doing that" (M5).* When participants attempted to disregard other people's expectations, they stated how difficult it was to be put in that situation. Numerous examples were provided where participants felt caught in a struggle of wills with the other source of expectations. *They [midwives in hospital] just kept saying you've got to keep doing it. They kept forcing her on me. I'm saying 'they're really sore [nipples]' ... and they said 'no you've got to persist, persist' " (M5).* Two further examples clarify struggles participants had with health professionals, when they wanted to initiate a strategy in opposition to the other person's advice:

So I was going back to this doctor and he was just saying just persist with it, persist with it, which I was ... And after six weeks I was just sort of way beyond zombie mode and I thought this is not good and she just wasn't putting on weight. Like she'd put on 25 grams and lose 50 ... I wasn't happy with how she was going. (M9)

She [child health nurse] wasn't very supportive of me weaning. So I mean I was bugged and that and couldn't carry on and here she was saying 'no don't give a bottle'. I mean I suppose it's good to keep trying but after a while. (M4)

Discrepancies did not only exist for breastfeeding and weaning expectations, but were apparent for other expectations of mothering behaviour such as the management of crying or sleeping arrangements. The following example between a participant and her mother demonstrated irreconcilable differences in expectations of how to manage a crying child:

Which Mum [participant's mother] was very good at, "just put him in there he can cry", but "he'll cry for 45 minutes Mum and I'll get half an hours sleep out of him". "He'll only do that a couple of times" but I don't know that. I'm not prepared for it to have the three days of this terrible child because he's had no sleep so I don't know ... I just appreciate that Mum and I had different opinions on that. (M32)

The second example illustrated a significant discrepancy between a participant and her parents on the opinion of appropriate sleeping arrangements:

My parents are going "what a rod you're making for your own back." I had her in the bed with me. She was virtually a self-serve feeder and that's what happened ... And I've always been ... some people would say weak, but I simply don't believe it's an issue like a lot of people do. And I think there are a lot of other cultures let their children close to them for a much longer period than we do and they don't all end up fruitcakes. (M31)

Incompatibility by definition implies that certain expectations could not be respected or met concurrently. A choice had to be made. The extent of the discrepancy between expectations influenced the amount of distress participants experienced when faced with this dilemma. The smaller the discrepancy between expectations, the smaller the amount of distress experienced by the mother. Conversely, wide discrepancies between expectations resulted in the potential for greater emotional distress for the mother and the existence of greater animosity with the opposing source.

The Child's Reaction

Participants' assessments of their child's reaction to breastfeeding and weaning were based upon expectations. These expectations which originated from the mother and other sources were also modified due to the reality that emerged. Nevertheless, participants' primary concern was in meeting the needs and expectations of their child. As children, especially infants, were not always able to clearly state their needs, mothers based decisions upon their assessment and interpretation of their child's behaviour.

Findings from Walker's (1995) study into the weaning practice of first-time British mothers, discussed earlier in this chapter, also revealed that the infant's behaviour was the major influence upon parents' decisions regarding weaning. Children's cues were followed first and foremost, and parents were aware that their practice was "not in line with official guidelines and professional recommendations" (Walker, 1995, p. 110).

Participants focused upon two concerns when deciding how to address *incompatible expectations*. Firstly, they considered their child's reaction to continuing with breastfeeding. Was the child obtaining the anticipated benefits of breastfeeding? A happy, thriving child together with a mother satisfied in achieving her personal expectations fostered continuing breastfeeding even in the presence of conflicting expectations from others. "*I'm just happy to continue that ... I'm happy so long so she wants a feed. And she falls asleep easily*" (M1). If there were any concerns that the child's reaction indicated that their needs were not being met, mothers began to question the value of continuing with breastfeeding. "*He was never upset, but he was never ever settled after a feed. Like he always looked like he wanted more*" (M15). Participants interpreted their child's behaviour based upon their own expectations and perceptions of their needs. A child who was unsettled was interpreted as not having his/her needs or expectations met. "*I was having doubts then because he was so unsettled, and I was uncomfortable with what was happening with him, getting so upset*" (M11).

Secondly, participants assessed their child's reaction to attempts to cease breastfeeding. How were they adapting to the process of stopping? Were they ready for this change? "*We had tried for months and months and months when she started eating to like give her a little drink with the meal but no [refused bottle], straight on the boob after [child insisted on breastfeeding]*" (M25). If the child indicated that he/she was not ready for these changes, participants had to balance personal expectations to wean with the child's expectations of wanting to breastfeed. "*No, if he had been really upset about it that I think I would have said 'OK it's just not time for it yet' and I'll just breastfeed another month*" (M3). Many participants were prepared to temporarily forgo their needs for the sake of their child:

Started weaning at 12 [months] but I planned on feeding for about 14 months, the same as X [1st child], but she just didn't want to let those last three go. And

she was getting really quite upset at some stages so I slowed it down a lot.
(M28) -

While many participants utilised cues from their child to indicate readiness, there were many occasions where the child indicated a readiness to wean prior to the mother feeling willing to cease the breastfeeding. During these instances, participants assessed their child's determination to stop breastfeeding:

I kept trying to put her on probably about four days ... I'd keep giving her the breast first and I'd fight her and put her on first and then if she wouldn't have any at all, didn't want to upset her and I'd give her a bottle. (M20)

So I knew he was ready to go off. He was quite happy but I was getting more and more disappointed, the more distracted he was and the longer it took to breastfeed, the more it occurred to me that this is it. He doesn't want the breast anymore and I was getting disappointed because of that. Because I thought I've only got a few more weeks left and I'm going to make the most of it. (M24)

The child may have been physically ready to accept other food due to their developmental age, but if they wanted to continue breastfeeding for intimacy or closeness, participants allowed and often encouraged this. *"At night when he woke up in the night, he seemed to want that comfort ... he wanted me ... so I kept persisting [with breastfeeding] and trying it with different feeds, feeding him with me first" (M5).*

Therefore, participants' assessment of their children's needs involved interpretation of their physical and emotional readiness to change. *"By 7 ½ months she was walking around furniture and eating heaps ... that probably meant that she was taking less but she still had it on demand but mostly associated with comfort and sleep and mostly at night" (M29).*

If participants were enjoying breastfeeding and wanted to continue, they looked to cues from the child to justify the need to continue, especially if they were exposed to expectations from others to stop breastfeeding:

If he'd been very eager to keep breastfeeding then I would have continued even though my husband would have said "oh come on ... this week's the week," sort of thing. I would have said "look, look at him, he [child] really needs it." (M24)

It was difficult for sources of expectations such as partners to pursue their opposing opinions when it was obvious that the advice was not in the best interest of the child:

There was a time she [child] got gastro [gastro-enteritis]. We could both see that it [breastfeeding] was a real life saver, wasn't a life saver, it was a Godsent thing. And so I think that also weakened his [father] own conviction that I should stop [breastfeeding].” (M31)

The degree of distress displayed by the child in response to change was significant in how participants interpreted this behaviour. *“He just sort of was looking at me as if to say this is, what's happening, what's going on. He just sort of, curiosity, I suppose and he'd suck ... when I gave it to him that second time he was more at ease” (M7)*. If the child was reluctant to accept a bottle of formula initially, but did eventually accept the formula without expressing significant signs of distress, participants perceived that the child was receptive to the changes and his/her needs were not being compromised. Behaviours such as intense crying, biting, head shaking, spitting out the teat of the bottle, refusing to suck, or screaming were interpreted as significant distress. Initial reluctance to accept the bottle, confusion, or transitory crying were interpreted as minor signs of distress:

At first his initial reaction when I gave him the bottle, he was looking at me with his big eyes. That made me feel a bit guilty. But after a couple of days of having the bottle straight, he seemed really content and I think that's what made me feel that he was ready. (M19)

The time it took the child to adapt to changes being implemented with breastfeeding was also considered by participants when interpreting behaviours. If the child settled in to the weaning strategies over a period of days or even hours, participants interpreted this response as a positive adaptation to the changes. *“He was happy after the second attempt so it turned into cold turkey rather than it had to be that way” (M27)*. The duration of weaning evolved in response to the child's reaction to the strategies. *“His [child] was a faster weaning because he just had enough as well and he was just too busy. He'll have a drink and a little nip to tell me he's finished and off he'd get and play” (M28)*. Even a longer settling in period to wean was viewed as positive if the degree of distress was perceived to be minor:

... for a couple of days it was a struggle between us and then she just kind of accepted and gradually stepped back from it ... I always let her put her hands on my breast and even today she will still do that now and again. (M31)

Both factors, degree of distress and time to adapt, were considered by participants in assessing whether their child's expectations and needs were met. Although the child's overt reaction to weaning may have been of short duration, the intensity of a distressing reaction could negatively compensate for any swift compliance to accept a bottle of formula:

I look back and I think when I stopped feeding her, that was hard too because ... she hung on for that 24 hour period and got hungry [refused a bottle for 24 hours]. She'd be screaming at me and grabbing at me wanting to have a drink and that was hard too because it was like, it was almost like I was letting her down. [Mother's interpretation of child's thoughts] "I want a drink and ... for all this time the only time I scream at you, you give me a drink and now I'm asking you for a drink and you're letting me down." (M21)

The resultant guilt and distress experienced by this participant is evident in her words: *"I almost felt like I, what's the word, I was hurting because I felt, she felt was that she was being hurt by the situation"* (M21). To contemplate having caused harm to her child was disturbing to this participant who perceived that the child's expectations were not met.

Although some children were compliant and readily accepted a bottle of formula, the perceived benefits of bottlefeeding were not always immediately realised. The opportunity to receive immediate assistance from other people was not always available. Although weaned from the breast, some children would not allow anyone but their mother to give them the bottle. *"[I thought] everyone could sort of give him a bottle, but he wasn't like that at all, he still would not, it's only been the past four weeks that he's let my husband give him the bottle"* (M19). This reluctance by some children to allow other people to offer them the bottle was a comfort for some participants who were still resolving their feelings of sadness and loss. The continued dependency on being the sole nurturer enabled them to maintain that special intimacy with their children for a short time longer:

Even though I'm not feeding her she still wants Mum. So in a way, I've never said it to my husband but in a way it gave me a bit of satisfaction that even though I wasn't still feeding her, you know, she still saw me as her caregiver and the person who she could source for her food. (M21)

While assessing the reaction of their child to breastfeeding or weaning in the face of differing expectations, participants also considered the individual personality of their child:

I remember with X [1st child], he used to get up from his sleep and he'd need a cuddle for about 15 minutes. He'd need a good cuddle and he loved cuddles and closeness but X [2nd child] is quite happy to get out of the cot and go and play. As much as I try to cuddle her, she's not really that cuddly. (M24)

Specific decisions and strategies were made with individual children's personality or responses in mind. *"The major decision to take him off the breast was probably because he was unsettled at night and because X [child] was the way he was, you sort of had to do it cold turkey" (M2).* Some mothers chose to use the cold turkey method of weaning, where breastfeeding is abruptly ceased usually over one day, with a particular child although they had not attempted this strategy with previous children:

She'd just hold out. And in the end after a few days I said to my husband "the only way we're going to do this is just go cold turkey because if, I just can't get her to take the bottle in the first place" so I think I went cold turkey. (M21)

Some children were considered to need breastfeeding more than others. Attributes like: having allergies or colic; being born early: *"she came 6 ½ weeks early ... because my daughter was apart from me for the first month ... it was only natural that we should spend so much time together [through breastfeeding], you can't make up for that month but I think we probably both needed to be together" (M33);* being a "soft hearted" child (M26); or needing more closeness and intimacy were considered by participants when assessing their child's individual needs:

I think you could also feel the difference between the two children. It was total different personality. One really enjoyed it and one, it's a food supply ... He used it as a food supply rather than a bonding process. (M27)

Although some mothers noted how their current expectations were based upon past experiences, expectations for one child were not always appropriate or possible for another child. *"Because I knew for him being a more sensitive child, I knew that he wouldn't just go cold turkey. He needed that gradual weaning so and it worked" (M24).* Participants with a number of children often recounted the need to be flexible with expectations for different children. *"Like with all three, it was all different times and just sort of take it from there" (M22).* One participant expressed her frustration

with her third child's weaning circumstances as she based her expectations upon her two previous experiences. *"I sort of thought every other kid takes the bottle and you just can't even make the transition being a little brat, you know, you're just making me go cold turkey and I didn't want to go cold turkey"* (M21).

The temperament of the children affected the complexity of challenges participants encountered with decisions about breastfeeding and weaning. Some children were *"happy and easy-going"*. Their response to approaches undertaken to modify the feeding method confirmed that expectations and needs were being met. *"She's such a happy baby. She's happy with everything so like I said that no matter what I would have done to her she would have been happy doing it"* (M23). Other children were more firm and intolerant to changes in their feeding patterns:

He'd arch his back and throw his head back and he'd scream and he'd be throwing his arms around and pushing at me. You'd try and put him on the breast and he'd just be so distressed. (M5)

In summary, participants faced with *incompatible expectations* monitored their children's reaction to how breastfeeding and weaning was being managed. Children who were happy, thriving, and contented were interpreted as having their needs met. These criteria reassured participants that their judgement in choosing specific decisions was appropriate for their child and reflected good mothering skills:

He was happy and you could see his personality change, he wasn't as hungry all the time and from the bottle he started eating a lot more solids, so he was a lot better in himself and I think that's what made me feel reassured as well. (M19)

Participants who felt that their child's needs and expectations were not being met faced the dilemma of deciding what changes to make to reach this goal. Unfortunately, the amount of *incompatible expectations* placed upon the mother during this time often increased. Family, friends, and health professionals who were aware that the child was not contented or thriving as anticipated offered more advice, information, and opinions such as *"your milk's getting too thin, obviously your milk's dying out or your not eating well enough"* (M21) to *"help"* mothers resolve this situation. The underlying message interpreted by participants was that they were doing something wrong, *"what I'm doing ... maybe it was the fear of feeling that you're useless ... you can't do anything right"* (M21) which contributed to their self-doubts and guilt:

And nanny said “no, there’s something wrong with this child ... it’s not normal for her to be screaming like this ... especially if you’re trying to breastfeed her, and she’s had a feed and she’s still not settled.” (M15)

Impact upon the Family

The impact of the consequences of *incompatible expectations* upon participants was influenced by how these expectations were affecting their immediate family. The reaction of the child to decisions on breastfeeding and weaning were identified as a major category and discussed in the preceding section. The impact upon the immediate family relates directly to the recognised outcomes of breastfeeding and weaning decisions upon other family members, such as the partner and siblings of the breastfed child.

If mothers perceived their partner or other children were being harmed or disadvantaged in any way due to their decisions, it put them in a dilemma. Participants then had to weigh the advantages or disadvantages of their breastfeeding and weaning decisions upon the family as a whole. *“I felt very guilty [stopping breastfeeding] but it was just the point that I couldn’t, I was physically drained. It was affecting the relationship with my husband because I was always cranky” (M19)*. Participants shared stories of how they were concerned with the impact of their breastfeeding or weaning goals upon their other children. *“As she [child] got older, it [breastfeeding] was more, putting him out more [older sibling]” (M28)*. Some mothers rationalised their decision to wean by clarifying how continued breastfeeding negatively affected their partner or other children:

With having the boys [two older children] it [weaning] did give me time, more time or X [father] could feed her ... or we could just prop feed her. So it did give me hands free to give the older boys a little bit more attention. (M2)

He [father] wanted to be involved, but he couldn’t be involved and he liked to bottlefeed, so he thought this is something I can do with the baby, so by me breastfeeding he couldn’t do that. (M17)

If the partner and siblings benefited from breastfeeding or weaning decisions, it was easier for the mother to justify her choices in the face of opposition. For example, achieving the promised expectations of convenience and reduced expenses with

breastfeeding had positive outcomes for the entire family even though other sources may have strongly advocated bottlefeeding:

We [mother and father] can just sit down on a lounge all together and watch tele [television] and feed. There's no bottles, you know I guess he didn't have to make up bottles at night you things like that sort of convenience. (M32)

He wanted me to breastfeed because ... he wanted X [child] to have the best and all that sort of stuff. Now he says "I'm glad you're breastfeeding. It's so expensive to buy formula [during the breastfeeding period] ... I think the important part for him was the first couple of months but then he was not bothered and he liked to be able to give a bottle to her, he liked that so that suited him [after weaning had occurred]. (M20)

There were many issues relating to breastfeeding and weaning decisions that were assessed specifically in relation to their impact upon the partner or other children. These issues focused upon emotional, sexual, and financial concerns. If partners were upset or distressed, participants were aware of this. *"I was getting sort of emotional and stressed and everything, so that was sort of upsetting him as well" (M9)*. Participants acknowledged that their own distress was often transferred to their partners. *"He [father] would've been finding it very difficult because I was crying a lot" (M8)*. There were situations where partners were upset due to other factors not directly related to distress experienced by their wives. The following example highlights a case where a child, after being weaned, continually refused to let his father feed him:

He thought that he would be able to get more involved [after child weaned to a bottle], but it wasn't the case, so he sort of felt a bit ... "now I should be able to get involved in giving him milk while you're not around" ... I think when it first happened he really wanted to get involved and he just couldn't [child refused to accept bottle from the father] so he felt a bit upset as well and I think a bit rejected but now he's fine. (M19)

Many participants noted how their feelings and their partners' attitude towards their breasts changed during the breastfeeding experience. The role of the breasts became more nurturing rather than sexual to many mothers. *"I didn't care if I was dressed attractively because that wasn't what was happening right now. What's happening now is we're mothering" (M33)*. If participants' feelings toward the sexual image of their breasts during this mothering stage were compatible with those of their partners, acceptance and tolerance of this temporary change occurred:

Because my husband and I discussed it and he actually felt the same way too like he didn't particularly want to, you know, be in that area [breasts] anyway because his daughter was ... Even the sex thing or whatever I know it was obviously an issue for him because it was and we discussed it but there was never any amount of pressure ... "I wish you'd stop feeding so that" you know. (M33)

However, a dilemma resulted when differing expectations emerged between participants and their partners in relation to the role of the breast during motherhood. One participant expressed her dilemma in addressing this issue:

I suppose it [breastfeeding] did have a down side to it because he [partner] tended to feel they were the baby's now and he looked at me differently ... As far as sex and everything came he'd tend to think that they [breasts] were the baby's and you keep away from them because that's baby food and ... that always made me feel a bit awful in that respect. (M22)

Another participant expressed her interpretation of her partner's feelings toward the changed sexual role of the breast during this time. *"My husband, I think he had a little bit of jealousy you know sort of the male jealousy thing of being surplanted" (M31).*

Although parents resolved their expectations on the changing role of the breast during breastfeeding, the fact that society still regarded the breasts as sexual objects influenced both parents:

[Mother of participant stating] "You're doing it unnecessarily [long-term breastfeeding] ... so you must be getting some pleasure out of it in some way". And I think a lot of people can't draw it away from sexual pleasure and even if it is there's that intimacy. (M32)

You got dirty looks from some of the older ladies ... You can understand from where they came from but I think I've heard muttered comments in the background. She shouldn't do that in public, wasn't allowed in my time ... they've been brought up that way, they weren't allowed to expose themselves. (M27)

Sensitivity to their partners' feelings was acknowledged as being important by a number of participants. One such example concerned partners feeling "out of place" (M19) when they were not encouraged or allowed to be involved in the care of their child. Some children preferred to be fed by their mothers, whether it was breastfeeding or bottlefeeding feeding. *"X [partner] every now and then [can feed him the bottle], if he is really really hungry, he'll take it. But quite often he'll cry until I give it to him" (M5).*

Many participants recognised the special closeness and intimacy breastfeeding afforded them but not their partners:

Being that nurturing person and in that nurturing position, as a very powerful position too in that no male can breastfeed and no male is going to get that look of adoration from the child when it attached to their flesh. (M32)

Sensitivity to possible embarrassment for their partners influenced how some participants managed their breastfeeding in public. Although there may have been an initial embarrassment, many couples overcame these feelings over time:

Initially there's that feeling of embarrassment because your breasts are out in public, he [partner] found that a little bit hard to deal with to start off with. But after awhile he got used to it and he could understand that X [child] needed that milk and that was it. (M24)

Breastfeeding also had a potential impact upon intimacy with partners where altered sleeping patterns took mothers out of the bed to feed during the night. One participant described a dilemma, where she attempted to juggle the needs of her child who wanted to be breastfed to sleep and her partner's needs for intimacy:

For some sleep I'll just go and crawl in his bed when he woke up and that way we both sleep for the rest of the night. But that wasn't the solution because it caused big problems with my husband ... because he thought that was a huge mistake, and I was just trying to get some sleep and keep some peace. (M28)

Issues with breastfeeding and sleeping were not only associated with intimacy. A number of partners wanted to be involved with settling their child at night. If circumstances did not allow this expectation to be met, partners expressed their disappointment. *"So the breastfeed ... became associated with sleep and, that's when I had the mixed reactions from my husband. Because it made it difficult for him to get her [child] to sleep"* (M29). Participants noted the effect of breastfeeding or weaning decisions upon their partners regardless of their involvement in these decisions. For instance, the following participant weaned her child without input from her partner but still assessed the outcomes of her decision on her partner. *"He [partner] thought putting him [child] on the bottle was the ants pants virtually ... Now that X [child] does let my husband give him the bottle he's virtually taken over at night time putting him to bed"* (M19).

The final issue considered by participants in relation to the impact of their decisions upon the immediate family dealt with financial concerns. One participant shared an example of how the cost of formula and its impact upon her family was considered when faced with balancing differing expectations:

I thought I really wanted to breastfeed until they could go straight onto cow's milk ... if I couldn't breastfeed, fair enough, I'll do formula but I won't do both. I thought that's a bit pointless, and money wise ... so I did as long as I could until they were ready to take cow's milk. (M25)

Other participants' need to return to paid employment for the sake of their family influenced how they interpreted *incompatible expectations*. “When he [child] was six months old I think I had to go back to work” (M14). Some participants saw this act as a measure of self-sacrifice as they decided to put the needs of their family ahead of their own needs and desires. “I stopped the day time feeds, before I was ready because I had to go back to work and that sort of upset me a bit” (M30). Some partners encouraged weaning in the belief that by doing so, they were being supportive of the entire family by fostering that second, necessary financial income. “So X [husband] could really see that practical side that if I didn't start weaning him then I wouldn't want to go back to work” (M24).

In summary, when assessing the influence of *incompatible expectations* related to breastfeeding and weaning, not only did participants appraise the impact upon themselves and the breastfeeding children, they also considered how their decisions would impact their partners and other children. They considered whether their partner or other children were being positively or negatively affected by their choices in balancing different expectations. The impact of decisions was assessed in consideration of emotional, sexual, and financial concerns within the family.

Presence of Compatible Support

Participants who had a supportive network of people with congruent expectations were better able to deal with comments from persons with conflicting views. Some people were especially understanding to participants because they felt their expressed expectations were acknowledged and respected. Participants stated how they benefited from this compatible support. “I was quite happy that no one else sort of said ... ‘at

least you could've tried a bit more or whatever'. So I was happy that everyone was supportive of what I'd done" (M9). Compatibility meant there was no conflict present in the relationship and the mother and other source were working toward similar expectations and goals. "But he [father] was really supportive, he said 'I know breastfeeding is the right thing to do, you want to do that' ... so he was really supportive. He just wanted the same thing, for X [baby]" (M9).

Some people were flexible and supportive of whatever expectations and goals participants chose to pursue. *"I'd just tell him [father] 'I'm just ... putting her on the bottle and I'm gradually doing that' ... you'd tell him and he just agrees with you" (M13). Shelton (1994) asserted that when others demonstrate respect and support mothers in the choices they make, they are empowered to breastfeed successfully. The tension described by participants who were dealing with incompatible expectations was not present when the atmosphere was perceived to be supportive:*

They [grandparents] had a lot of involvement with the children and ... they'd support whatever I did. They came into the house as grandparents and did everything that needed to be done and whatever happened that's what was going to happen. No one ever questioned it or thought it shouldn't be done or not at all. (M1)

The presence of family and friends did not necessarily represent a supportive network. For some participants their supportive network was one or two people, out of a large circle of family or friends, who agreed with their expectations and assisted them in whatever way they could. *"She [sister-in-law] was actually very supportive and I asked her a lot of questions" (M3). Assistance provided was not always in the form of advice or information but sometimes just being there to share the experience with the participant was important:*

She [grandmother] would sit with me and she just loved watching my baby suckle but that's with the three of us and that's the most beautiful experience having my Mum there and plus she's forty five, she's very young and it was almost like, because she lost her milk early in the piece, it was like re-living it, so I loved having my Mum there. (M23)

For some participants the reality of having someone available for support was not possible. *"She [mother-in-law] always said to me 'Look I'm happy to look after him' but every time I rang, I mean it wasn't her fault, they really weren't making excuses but*

they always had something else on” (M3). Due to distances or other commitments, the availability of support could not be taken for granted. *“You see my mother wasn’t living here, she lives in X [another state], so I didn’t have her backup” (M15).* Even having friends around that were mothers did not mean they were available or accessible for support:

I was actually a hermit, I stayed inside, I had no visitors because most of my friends were in the same boat, they were at home or with their mothers or whatever, and would just stay home, that was it, I wouldn’t go anywhere. (M15)

Other participants had numerous family and friends around them, but their expectations were so incompatible that the mother felt unsupported in their presence. *“Not one of them [family members] was interested in saying you are doing a good job” (M26).*

Having a small number of supportive people around was more helpful to participants than having a large number of people who were perceived to be not supportive:

I really would have appreciated more support ... I didn’t feel I had any support from my family. I don’t mean that in a negative sense ... They didn’t, they still don’t realise ... how because he was so active I’m just exhausted by the end of the day. That as I say coloured my weaning decision as well. I just didn’t get a break and I thought I couldn’t keep going on like that, struggling much longer ... Everybody rushed to the house, everybody rushed to the hospital and really I just didn’t want to see anybody. Which sounds very unfriendly but with this child that I couldn’t get on [breastfeeding attachment problems], and all these people that were avidly watching and trying to offer suggestions ... It was just too much ... one great big merry go round. (M3)

Participants expressed a need to have their goals and expectations acknowledged by others. The partner of the participant was often the person in the best position to acknowledge success or disappointment in achieving goals:

Even though I didn’t really say anything my husband could see that I was disappointed ... he could understand that but he was actually giving her the bottle because he could see that I was just so disappointed in giving her the bottle. So he would give her [the bottle] as often as he could. (M24)

If partners had no previous knowledge or experience with breastfeeding, they relied upon the participants to clearly indicate what support they felt they needed. Partners often went to great lengths to give the desired support:

I mean he sat up with me as I was expressing, because I didn’t want to give up feeding, he could see that. He did everything that he could to help me express. He would sit up with me every feed and feed him the bottle so that I could

express and we could both be back in bed at the same time. Every feed, every night. And never complained once, just was prepared to do it for as long as I felt I needed to do it. (M8)

If partners did not or could not offer participants the acknowledgment they needed, they sought it from others, often female friends, family members, or health professionals:

All my sisters have got young children so they told me that when they went through that weaning process they felt ... even my mother-in-law whose youngest is twenty four, my husband is twenty four, she said I could remember weaning him and how I felt. That felt like I'm not alone. (M19)

A number of participants, particularly first-time mothers, expressed feelings of being alone during their breastfeeding and weaning experience. These feelings of isolation were not always anticipated. *“And I don't have any friends to help who have babies so socially I've been very isolated. Which wasn't something I expected” (M3)*. Many experienced mothers had developed their supportive network with previous children, but participants who had recently left the workforce due to the birth of their first child did not initially have the knowledge, time, or resources to build up a supportive network:

I didn't have any other compatriots who had children. All our friends at that stage were sort of non child-bearing couples and my parents are relatively old so it was a long time ago. My mother actually had trouble remembering what she did sometimes, it was that long ago. (M31)

The theory of early motherhood developed from a grounded theory analysis on the experiences of first-time mothers discussed earlier in this chapter (Rogan et al., 1997) also identified feelings of isolation and aloneness as consequences of two major categories. In that study, isolation and loneliness were revealed during ‘realising’, when the impact of motherhood was initially recognised, and also when they were ‘working it out’ by actively problem solving and performing in their new role.

One child health nurse who was interviewed mentioned the importance of her role in acknowledging and supporting mothers. *“We [child health nurses] can be listeners and pick up where the mother is now” (CHN2)*. Participants also clarified their expectations of the role of the child health nurse. *“You [child health nurses] should be here to advise us but support us in whichever direction we take ... you should just help and support us (M16)*. Gigliotti (1995) suggested that health professionals must clarify their

own values and increase awareness of their own personal expectations so they are able to respect the client's choices in infant feeding decisions. The realities of receiving support that respected mothers' expectations was not always achieved by participants in this study:

I went to the clinic sister for her normal 12 month check and she asked all the normal questions, "are you still breastfeeding" and I said "no, no she weaned herself off" and the clinic sister said "you lucky thing ... that's great isn't it. Well done". And I walked out of there feeling really annoyed because I didn't feel like it was well done at all and I didn't feel like I should be happy about it, I was really annoyed. I thought that she would show a bit more empathy. (M24)

She [child health nurse] still sounded disappointed that I was giving up breastfeeding ... I thought well surely that's not the right attitude if the baby's not doing well and the mother's not doing well, you don't ... when they've taken a positive step about doing something towards it, you don't ... give a negative to that. (M9)

Participants experienced less confusion, self-doubt, and guilt in the face of *incompatible expectations* if they had a supportive network of people around them whose expectations were in agreement with the mothers. Support was not dependent upon the number of people accessible to the participant. Support referred to the comfort and reassurance offered by a single person or group of people who agreed with the participant's expectations or who were at least willing to acknowledge and respect the mothers' wishes should they differ from their own.

Summary

Exposure to *incompatible expectations* resulted in notable consequences for participants in this Western Australian study. These consequences involved feelings of confusion, self-doubt, and guilt. Numerous conditions were identified from the data that influenced the degree of confusion, self-doubt, and guilt that mothers experienced when faced with the dilemma of *incompatible expectations* (Figure 9). These conditions were: the personal meaning of goals and expectations; the degree of control over decision making; the significance of the relationship with the source of expectation; the proximity and frequency of contact with the source; the perceived credibility of the source; the extent of discrepancy between expectations; the child's reaction; the impact upon the family; and the presence of some degree of compatible support.

BASIC SOCIAL PROBLEM
Incompatible Expectations

Expectations of others
 (child, partner, family, friends,
 health professionals, society)



INCOMPATIBILITY

Expectations of mother

**Consequences of
 Incompatible Expectations
 on Mothers**

- Confusion
- Self-doubt
- Guilt

Conditions Influencing Consequences

- Personal meaning of goals & expectations
- Control over decision making
- Relationship with source of expectation
- Proximity & frequency of contact with source
- Perceived credibility of source
- Extent of discrepancy between expectations
- The child's reaction
- Impact upon the family
- Presence of compatible support

Figure 9: Consequences of incompatible expectations.

CHAPTER FIVE

Findings

Basic Social Process: Constructing Compatibility By Adapting Focus

Introduction

The ethical stance of the interpretive researcher is one of respect for the voice and experience described in the text. The guiding ethos is to be true to the text (Benner, 1994, p. 101).

This chapter outlines the basic social process that participants adopted to contend with the dilemma of *incompatible expectations*. This process entitled *constructing compatibility by adapting focus* involved participants moving through three phases. The phases of *shifting focus*, *selective focusing*, and *confirming focus* are described and extracts from the data presented to illustrate and support this interpretation.

Constructing Compatibility by Adapting Focus

All participants adopted a process of *constructing compatibility by adapting focus* to deal with the presence of *incompatible expectations*. *Constructing compatibility by adapting focus* was the process participants implemented to create congruency between self and others in relation to breastfeeding and weaning expectations and decisions. This process did not ensure that all participants achieved a total state of compatibility between self and others. However, most participants were able to construct a degree of compatibility by employing the following three phases of this process: *shifting focus*, *selective focusing*, and *confirming focus*.

During the first phase of *shifting focus* participants re-assessed the relative importance of specific aspects of their breastfeeding and weaning management. Readiness to enter the phase of *shifting focus* was triggered by participants reaching their individual level of tolerance. Each participant reached a turning point and decided when something had to be done as they were no longer prepared to endure the confusion, self-doubt, and guilt they felt due to *incompatible expectations*. By re-assessing and modifying the relative

importance of specific aspects of their breastfeeding and weaning, participants clarified what they wanted to achieve and were able to take charge of their experience.

The second phase of *constructing compatibility by adapting focus* was entitled *selective focusing*. During this phase, participants chose to attend to certain expectations and pursue specific goals at the exclusion of others. Two concurrent strategies were employed during the phase of *selective focusing*: ‘embracing’ and ‘distancing’. ‘Embracing’ allowed the participants to actively seek or welcome agreement and support with their expectations and decisions. While utilising the strategy of ‘distancing’, participants consciously avoided or dismissed disagreement or opposition to their expectations and decisions.

Participants moved back and forth from *shifting focus* and *selective focusing* as they made ongoing decisions regarding their breastfeeding. As new *incompatible expectations* arose during the management of their experience, participants moved back to *shifting focus* to re-examine, clarify, and modify expectations that were being challenged. Clarification of what was important to them assisted these mothers to again take charge of ongoing decisions. Having clarified what option they would choose from those available, participants then moved back to the phase of *selective focusing* and utilised the strategies of ‘embracing’ and ‘distancing’ to cultivate a network that accepted and supported their choices.

The final phase of the process of *constructing compatibility by adapting focus* was titled *confirming focus*. During this last phase, participants resolved decisions made in the management of their breastfeeding and weaning and justified how their chosen focus had achieved the compatibility they desired. Two concurrent strategies were also employed to accomplish this verification. Firstly, participants ‘rationalised their decisions by focusing upon the positive outcomes’ of the weaning process, and secondly, they ‘acknowledged feelings’ that were often a mixture of sadness, relief, and pride, at the end of this significant event.

Shifting Focus

Shifting focus was the first phase of the process of *constructing compatibility by adapting focus*. *Shifting focus* referred to participants modifying their mental view of the relative importance of aspects related to the management of breastfeeding and weaning. Participants took charge of their experience by clarifying and reinforcing their own expectations and goals within the context of their individual experience. The consequence of taking charge resulted in an increase in self-confidence for these mothers. Confidence developed and grew as participants began to recognise, acknowledge, and trust their own judgement and ability.

Turning point.

This first phase of *shifting focus* was triggered when individuals reached their tolerance level of confusion, self-doubt, and guilt. As noted, both first-time and experienced mothers in this study expressed a degree of confusion, self-doubt, and guilt due to their exposure to *incompatible expectations*. Reaching this tolerance level acted as a catalyst for change. Participants became increasingly frustrated and overwhelmed with these feelings, to the point where they felt compelled to do something:

It [breastfeeding] really started to affect me socially. I got to the stage where I was embarrassed to try and feed him because he was just so wriggly and other mothers or older people would comment on "are you feeding him right" or "are you sure he's getting enough" ... And that ... coloured my weaning decision as well. I just didn't get a break and I thought I couldn't keep going on like that, struggling much longer. (M3)

Another participant, who had been persisting with breastfeeding for several weeks due to pressure from her partner, friends, and child health nurse, described the circumstances that culminated in her reaching this turning point:

I said because I'm getting to the point where I think ... "Oh no she's crying, what am I going to do." I just wanted out. As soon as I heard her cry, I just felt like fleeing for the front door. You know because this is going to be so painful. It's going to be a fight. (M5)

Experienced mothers generally reached this turning point earlier than first-time mothers. One possible explanation for this was the fact that they had experienced confusion, self-doubt, and guilt with previous experiences and were often not prepared to allow these

feelings to reach the same level again. “*I thought I’m not going to fall into that same hole and get myself so much into a tether*” (M15). Strategies from the phase of *shifting focus*, such as clarifying expectations and goals, were quickly implemented to acknowledge past mothering abilities and reaffirm self-trust and confidence.

Additionally, participants who had just completed breastfeeding their first child also stated how they would not allow the presence of *incompatible expectations* to influence them to the same degree with subsequent children. As experienced mothers, they could now anticipate and plan for future conflicts:

Next time if we're lucky enough to have another baby, I'll still go to them [child health nurses] once a month and get the baby weighed, but I'll be a lot quicker just to make my own decisions. If they start judging me I'll tell them and I think next time I would just change clinics and see if another clinic would be better.
(M16)

Another difference noted by experienced mothers in relation to *incompatible expectations* was the decreased input they received from health professionals. “... *by the third child [health professionals] don't make much comment on anything, they let you go*” (M23). Health professionals such as general practitioners and child health nurses tended to concentrate their attention upon first-time mothers whom they perceive needed more support in their new role. Research has shown that first-time mothers, compared to experienced mothers, are more likely to be influenced by advice given by health professionals and therefore higher priority is given where it is more likely to make a difference (Fetherston, 1995; Humenick et al., 1998). Although the presence of *incompatible expectations* from health professionals tended to diminish for many experienced mothers, other potential sources such as individual children, partners, family, friends, and society still continued to exert their influence.

For some participants, the trigger to enter the phase of *shifting focus* occurred when the confusion, self-doubt, and guilt escalated into anger. Anger that was turned inward resulted in more guilt but once anger was turned outward, it assisted many participants to examine why they were having these feelings and to clarify whose influence they were responding to. One mother clearly expressed her anger at other people’s influence but also acknowledged her own role in allowing herself to be influenced:

“Why am I letting people get to me with their opinions? I don’t want to take them on board but am I? Why am I letting it bug me?” You know, getting annoyed at yourself for that ... Maybe it’s okay for things to bother you ... better not to take it on board too much but then it’s hard because I did take it on board. (M33)

For many participants, arriving at their tolerance level of confusion, self-doubt, and guilt occurred gradually over days, weeks, or even months. Other participants reached their individual tolerance level suddenly due to a particular unexpected but significant incident. For example, one mother discussed her encounter with an elderly gentleman in a restaurant while breastfeeding her two-week-old infant and how “*surviving this nightmare*” quickly assisted her to resolve the issue of breastfeeding in public:

One guy came up to me and called me a slut and how dare I expose myself in public and how dare women do this and that and the other. “That’s fine” I said “that’s your opinion ... I happen to find this very natural. It’s good for me and good for my baby. If you don’t like it you can remove yourself from the café instead of me. My child has to eat somewhere ... I’m damn sure he’s not going to eat in the toilet.” (M27)

This mother changed her perspective on the issue of embarrassment with breastfeeding in public. The focus was shifted from being personal and internal for the mother to becoming the other person’s concern: “*their problem rather than my own*” (M27).

For some participants acknowledging that they had reached their tolerance level was facilitated by partners or other support people. Because partners were aware of the day by day difficulties faced by mothers in dealing with *incompatible expectations*, they were often the first to support strategies to foster change:

He [partner] said, “look, I know breastfeeding is the right thing to do. You want to do that, but it’s not working. We’ve got to do something and the baby’s suffering and you’re suffering” ... I was also at the end of my tether. I was sort of just worn to a frazzle. He said, “you can’t go on like this. It’s just not healthy.” (M9)

The tolerance level for some participants eventuated due to physical factors such as exhaustion or pain: “*I was physically drained*” (M19). Often these physical factors had an emotional impact as well: “*It was affecting the relationship with my husband because I was always cranky. I wasn’t eating properly when I knew I had to be and I just got to the point where I needed a break from him [child]*” (M19). Another

participant discussed how her physical difficulties reached a point where she lost her anticipated enjoyment of breastfeeding. *“So I leaked constantly, I dripped constantly, I’m sitting down the beach and it’s running down my top and I thought no, enough’s enough ... and it was getting to the point where it was, it wasn’t enjoyable to breastfeed anymore” (M25).*

Once participants had reached their tolerance level and felt enough was enough they were able to move into the phase of *shifting focus* and take charge of their breastfeeding and weaning management. The term *“enough was enough”* was literally used by thirteen participants whereas other participants used terms like *“reached a point”* or *“got to that stage”* to describe their readiness to enter the phase of *shifting focus* and take charge.

Taking charge.

Participants began the task of *shifting focus* and modified their image of the relative importance of specific aspects of breastfeeding and weaning. Taking charge involved clarifying and reinforcing their own expectations and goals within the context of their experience. One participant clearly identified her thoughts when she began clarifying what she wanted with her breastfeeding experience. *“... sit and think now what do I really want?” (M33).* Once participants had clarified their expectations and goals, they were better able to assert their own opinion in the face of opposing views. One major theme that emerged in an American study of women’s experiences with long-term breastfeeding beyond 12 months was the importance of being strong in the face of social unacceptability (Hills-Bonczyk et al., 1994). This strength assisted women to breastfeed to the duration they wanted even though it went against the social norm.

Clarification of expectations meant some participants chose to stay with their plans and reinforce those, whereas others modified their expectations in consideration of the context of their current situation. If reality contradicted their anticipated plans, an incompatibility between mothers’ expectations and their child’s was often the reason. For example, one participant had planned to wean at 18 months and decided to stay with that goal although the child would have been happy to continue breastfeeding. *“Then it got to a point where I really didn’t want to breastfeed him past 18 months, for me that*

was my personal limit. I really didn't want him to go further than that because he was so active and so *sō boyie*" (M24). She reinforced her goal, made a decision, and trusted herself in making a choice that was right for her individual circumstances.

Many participants were able to be flexible, change their expectations, and feel comfortable with this decision. "*I thought I'm just going to do whatever works*" (M9). Another participant modified her expectations of weaning in consideration of her child's reaction and her own preferences. "*I thought it would probably take me three or four months to stop altogether. I didn't think she would be as attached to it as she was*" (M28). Although she initiated weaning at 12 months, this mother did not complete the process until 19 months, when she was confident both the child and herself were ready to stop breastfeeding.

Once participants had clarified and reinforced their expectations as being either definite or flexible, they were more confident in considering their thoughts and feelings when approaching choices and making decisions. Participants often referred to this self-trust and increased confidence by acknowledging the importance of their own comfort level with decisions. The focus of being concerned with others' opinions changed to a focus of concern for oneself. Comments such as "*I was going ahead with what everyone said was the right thing to do ... I wasn't comfortable with what I was doing*" (M9) changed to confident statements of "*thanks for your advice but this is what I've decided I want to do*" (M9). Another participant's comments demonstrate her development of confidence and an ability to listen to self as "*you do what you in yourself think might be right*" (M11).

Essentially, they began to acknowledge their own thoughts and feelings when examining options for their breastfeeding and weaning. This led to the establishment of trust in their judgements. A growing recognition and confidence in their parenting abilities also reinforced the development of this trust in self. Britton (1998) suggested medicalisation of childbirth has occurred since the 1950's but that, simultaneously, interest in holistic discourses has also evolved which encourage women to "listen to their bodies, be guided by their own intuition, and have faith in their abilities as a woman" (p. 78). The participants in that British study that explored women's

experiences with the letdown reflex during breastfeeding began to demonstrate these characteristics of holistic thinking.

Many experienced mothers did not dwell in the phase of *shifting focus* because of the self-trust and confidence developed from past experiences. In short, these participants did not have to develop trust and confidence but were able to re-establish or rekindle this trust and confidence by acknowledging their abilities and efforts with previous children:

I felt a little bit more confident with X [2nd child]. I felt like I'm the mother of 2 ... But having more experience with other women as well with babies, having other friends with babies and being more involved with women with babies in between X [1st child] and X [2nd child]. (M24)

With time and experience, first-time mothers were also able to establish trust and confidence in their mothering abilities. *"Well I feel confident now after a year, I feel like I've been mothering for ages"* (M23). The following participant's story demonstrates her journey in developing trust and confidence in her own judgements. She struggled with breastfeeding for 12 weeks, visited a lactation consultant, and talked to another *"... 15 people ... ringing up the milk Mafia and getting them to say 'just try one more time' and I'm going 'but I don't want to try one more time' "*(M32). The participant's own mother had encouraged her to bottlefeed from the beginning and was delighted when she decided to wean. That evening she re-examined her expectations and goals, considered her options, decided to oppose her mother's wishes, and began the momentous task of learning to trust her own judgement:

The only person who knows [about the decision to wean] basically apart from my husband and my health nurse and my mother ... my mother will be the one who will be very unhappy, if she finds out I can't [wean] after one day. I've decided I'm not going to wean him. So I decided well no one is forcing me. It was so nice a decision and he actually woke up soon after. It was such a relief to go; look we'll try just a few more weeks [she breastfed for two years]. (M32)

This example also illustrates how this participant took charge of her situation by clarifying expectations and goals. As a consequence, her confidence and self-trust grew to the level required to assist her manage her breastfeeding experience the way she wanted rather than how her mother wanted.

Although it was more common for people to express their expectations through specific advice rather than general encouragement, some people did foster the development of trust in mothers by encouraging participants to listen to themselves. One child health nurse gave an example of her approach to mothers' questions and requests for advice: *"I'll often mention early on ... it's your baby and you must do exactly what you want to. I'll tell you things and you can say 'yes X [nurse's name] I can relate to that. No X, I don't' "* (CHN3). Partners were another group who frequently encouraged mothers to trust themselves to do what they wanted: *[partner stated] ... "Let's do whatever you want to do"* (M7). Interestingly, participants' comments about family tended to highlight mothers being allowed to do what they wanted with breastfeeding rather than being encouraged to do what they themselves wanted: *"The other day I was out with my mother-in-law and her mother are both telling me how to do things. My mum is okay, my mum allows me to do what I want with my baby [story told by child health nurse] (CHN4). Corinne, (cited in Gorgas, 1997) a women who replied to the La Leche League web site, regarding the issue of criticism from relatives, encouraged other women to trust themselves and "go with your gut feelings and put aside what everyone else has to say".*

Participants commented on how this development of trust and the ability to listen to their own thoughts and feelings evolved over time:

[With her second child] I just sort of decided ok, I'll listen to people but my decision was that I would go with how I felt rather than listening to everyone else. Try and go with my instincts ... [in comparison to her first child] because I suppose down deep I knew what I should have done with her but I didn't listen. I listened to everybody else rather than listening to my instincts and how I knew she was feeling. (M5)

Another participant who was an experienced mother also commented on the shift to being able to listen to herself in comparison to her first breastfeeding experience where she relied completely on the input of others: *"I've been here. I've done this before. I'm not going to listen to anybody else's opinions ... I think I got stronger this time around"* (M15).

A grounded theory study which explored the breastfeeding experiences of 17 educated, low-income, culturally diverse American women revealed five major themes (Locklin,

1995). The theme entitled 'becoming empowered' related to mothers relying upon their own intuitive and critical judgement and being able to assert themselves as needed. This theme closely parallels behaviours in the phase of *shifting focus* where participants in this study began to take charge of their own experience by clarifying and reinforcing their own expectations and goals. Although Locklin's (1995) study focused upon women who were currently breastfeeding, participants from this study took charge of both breastfeeding and weaning decisions during the phase of *shifting focus*.

Selective Focusing

Selective focusing was the second phase of the process of *constructing compatibility by adapting focus*. In this phase, participants had the self-trust and confidence to actively pay attention or selectively focus upon aspects of breastfeeding or weaning that were compatible with their clarified expectations and goals. A network of people with compatible expectations was constructed to provide participants with the social support they desired. The importance of social support for women was also confirmed in an American study that examined the experiences of women who breastfed longer than 12 months (Hills-Bonczyk et al., 1994).

In this second phase, participants in the current study continued the process of constructing a supportive environment that was compatible with their own goals and expectations. *Selective focusing* enabled participants to employ a strategy entitled 'embracing' that involved seeking and welcoming agreement or compatible support. A second strategy entitled 'distancing', which was employed simultaneously with 'embracing', allowed participants to avoid and/or dismiss disagreement and opposition to their expectations and decisions. The focus upon specific compatible sources negated and inactivated the impact or influence of the incompatible sources. The terms selective attention and filtering used by Keane (1989) to describe ineffective listening skills in clinical counseling have similarities to the strategies of 'embracing' and 'distancing'. Health professionals were cautioned by Keane to be aware of this judgemental listening as it can interfere with counselling skills by limiting focus. Participants in the current study actively sought to limit focus to the sources they perceived as compatible. One child health nurse from the current study commented upon mothers' abilities to selectively see what they wanted and dismiss what they didn't want. Her experience

with mothers supports the phase of *selective focusing*. “... it’s like they [mothers] are in denial. There is like a glass perspex [clear plastic barrier] thing in front of them, they don’t want to see it” (CHN1).

Embracing.

‘Embracing’ involved seeking and welcoming agreement and support from sources of expectations that were compatible with participants’ expectations and decisions in relation to breastfeeding and weaning. By aligning themselves with people or resources that reaffirmed their decisions, participants were able to cultivate a supportive network tailored to their personal expectations, goals, and choices. “I’m able to do it and I’m putting the effort in and I’m not letting anybody put me off and I’m finding the right sources around me to do this” (M21).

The number of compatible support people or resources was not as important as the fact that participants felt their decisions were accepted and endorsed by someone, whether that was a friend, partner, health professional, or author of a resource book:

So it was good that someone else [doctor] said to me “look, you’ve got to [formula feed] for your baby’s sake and the weight you have to go on the bottle”. So it was good that someone reaffirmed what I thought. (M9)

I called the clinic sister a lot, I had books, read my books, called my girlfriend, just things like that ... I would call places [NMAA] ... I guess just to confirm I think in yourself, well in myself, I knew what I was doing was right for us but I also needed to know that someone else sat on their couch all day, everyday as well. I wasn’t the only one like there wasn’t some easier way. (M33)

When I saw the paediatrician, he was the first specialist actually I’d spoke to that said, “don’t worry about it, why are you worrying about it, bottlefeeding feed the baby if she’s going to be happier”. And so that’s when I started to really comp feed properly, because everybody I spoke to just kept telling me, “keep trying, keep trying.” (M15)

It was just funny because I’d never normally look at a book like that but I was having problems at the time and I thought “oh” and I flicked through it and there was quite a bit of writing in it and that was very helpful. It’s a lot older and it had some very sort of, I don’t know, very strict ideas in some areas but in other areas it was very helpful ... now I skip past that, that doesn’t suit me. I just read the bits that I wanted to hear. (M20)

Many participants struggled on with their breastfeeding and/or weaning decisions in the face of many opposing sources. Some mothers' own convictions and self-trust, coupled with the knowledge that their child was contented and thriving, formed a pivotal foundation for the minimal support these women received. For these mothers, finding a compatible support person or resource was invaluable in assisting them to continue their struggle in the face of considerable opposition:

Everybody's got their opinions but I just felt like I do what he was happy with and just battle on and that's what I did I battled on ... only every now and then I would phone the Nursing Mothers Association. And they were fantastic. I used to sit on that phone for hours talking to them and they will be the only ones to give me the encouragement to keep going ... It's always just the phone call [contact with Nursing Mothers Association] and that was all I needed. (M26)

Participants, who adjusted their focus in phase one by developing self-trust and reinforcing clarified goals and expectations, chose to embrace the influence of specific sources over others. For example, one mother who persisted with breastfeeding on the advice of her child health nurse decided to embrace her own feelings and the wishes of her child and change to formula feeding:

I thought I'd give it a go your way [child health nurse], but I don't think it was working. I probably would have given up a bit sooner, but they kept telling me it would come back after the mastitis and it didn't. So I thought "no [child] was happy on that bottle, just let her have it." (M16)

Another participant cited a further situation where her priority in considering her own needs and her child's were embraced to make life easier due to becoming pregnant while breastfeeding:

But I was kind of determined to do whatever I felt she wanted to do just because it was easier for me to. I was feeling revolting [pregnant while breastfeeding] so you know whatever was easiest to get her off to sleep or to make life easier for me I would tend to do. (M29)

Although some sources had expectations that were not directly compatible, participants chose to embrace those sources who were adaptable enough to support whatever decision the mothers chose to make. "They'd [friends] give me their opinion, but then it would be 'do whatever you think is best for you and the baby' " (M11). Some participants assessed other sources as supportive, not by what was said but more on what was not said. Silence was regarded as agreement with participants' actions. One

mother described the perceived support she received breastfeeding her four-year-old child during a primary school assembly because no one said anything against her actions. She assumed other parents would be supportive of her behaviour. *“Because I used to feed her at assembly time. I never felt uncomfortable here because you know all the other people around you” (M1)*. She assumed that an environment with other parents would be supportive of public breastfeeding no matter what age the child was. *“If I was in an environment with other men or single men or men who hadn’t had children or even women who weren’t in that role of having had children I think then you would feel that pressure [not to breastfeed in public]” (M1)*.

Participants embraced the support from a variety of compatible sources. For example, mothers groups were often mentioned as a source of expectations that were consistent with those of the participant. This compatibility depended upon the dynamics within the group and the individual’s expectations. Participants who found what they perceived was a supportive group often benefited significantly from their involvement with these mothers:

Because there were other mums in my age group and as I say there was one girl there that had already ... she had weaned her baby at 2 months because she had such bad problems as well. And she was very good and there was another girl that had lots of problems as well and she could at least relate to me because we both had boys. Whereas the other one was a girl ... we got plenty of opportunity to talk about problems within ourselves and all of the women said we really should get together again in a couple of months which we will do. We all exchanged phone numbers and I found that was psychologically, a great help. (M3)

Unfortunately, not all mothers groups were perceived to be supportive and compatible. The following example demonstrates a participant using the strategy of ‘embracing’ with the midwife who attended her mothers group. She embraced the midwife’s input but chose not to embrace advice provided by the other mothers. This participant continued to attend the group for a social outing but did not rely on these mothers for support with her breastfeeding or weaning decisions:

You’ve got like seven mothers telling you seven different stories, and then the only person I would really listen to was the midwife at my group. But even then I found that the midwife at my group and the child care nurse conflicted a lot [laugh]. (M11)

Another incident demonstrated how a participant chose to utilise her mother and partner as her support network. She embraced their input while also distancing herself from the influence of the mothers group she briefly attended. The thoughts and advice offered by these other mothers were not in agreement with what this participant wanted for her breastfeeding or weaning experience. Her statements demonstrate how she focused upon the desired support while, at the same time, rejecting those sources whose expectations conflicted with hers:

I've got a good relationship with my Mum talking to her all the time and she fulfils my needs you know ... I had two important people in my life and I didn't need all these other women who I didn't know from a bar of soap and plus I'd always come away feeling "[child] doesn't do that". There was this one mother they had regimented programs for her baby, it went down at two o'clock, three o'clock whatever and I thought "my God I don't do that for [child]", so I always left there feeling inadequate. I don't like being put in an inadequate position, so I think that was another reason why I left. Just the comparisons, the competition, comparisons I don't need that. (M23)

As well as seeking and welcoming agreement with sources such as their children, families, friends, health professionals, and other mothers through mothers groups or organisations such as Nursing Mothers Association of Australia (NMAA) or Le Leche League (LLL), participants embraced the support of partners with similar expectations. Participants were aware of their partner's expectations and receiving support from important persons like partners reinforced that their expectations and subsequent decisions were accepted. *"I think he was pleased that I put him on to the bottle when I did because I just said 'it's not worth the battling with them', and I think he was quite happy enough" (M20).*

The parenting magazine *New Beginnings* published by the La Leche League International (LLL) had a corresponding web site where women directed questions or discussed problems they were experiencing. Other women then responded to their concerns by sharing information and advice based upon their own experiences. Numerous examples were noted where women offered advice that supported the strategy of 'embracing'. *"I started going to La Leche League meetings and was surprised and overjoyed to meet women who supported my decision to put off weaning ... I was at peace again" (LaCour, 1994).* Another women stated *"I was so relieved to hear LLL mothers and fathers talk about doing the same things I believed in. I no*

longer felt guilty about nursing [breastfeeding] on demand ... I had found my home”
(Bunce, 1997) and:

I found that my ideas about parents (breastfeeding, baby-led weaning, loving guidance) were not necessarily the same as my friends’ ideas. There are several places you can find support, though! ... You will also find others in your community, outside the La Leche League (LLL) who have similar parenting values. Even if all your parenting ideas aren’t the same, you can find support for those that are ... I also think the on-line work is potentially a great place to network with other mothers and find support for your parenting style. (Marilyn cited in Rich, 1996)

An interesting ethnographic study into the lived experience of American women in playgroups examined the impact of informal, interpersonal networks in health care decision-making (Tardy & Hale, 1998). Conversations were found to serve a practical function of ‘cracking the code’ and a ‘bonding’ function through sharing narratives about pregnancy, birth, and breastfeeding. Women recognised their vulnerability and the playgroup assisted in their development of connections and friendships. The findings revealed that women actively solicited assistance and then followed their advice. This activity had similar characteristics to the strategy of ‘embracing’ whereby participants sought and welcomed expectations that were in agreement or compatible to their own. In his scholarly discussion of conflict resolution strategies, Johnson (1997) suggested an effective method to manage stress was to “seek out friends and sympathetic acquaintances” (p. 295), which again supports the strategy of ‘embracing’ utilised by the participants in this study.

In summary, the strategy of ‘embracing’ involved participants pursuing and selectively paying attention to those sources of expectations that they perceived supported and agreed with their own decisions to manage their breastfeeding and weaning experiences. Although ‘embracing’ has been discussed first, the two strategies of ‘embracing’ and ‘distancing’ occurred simultaneously during the process of *constructing compatibility by adapting focus*. The second strategy of ‘distancing’, which also occurred during the second phase of *selective focusing*, will now be discussed.

Distancing.

Participants chose to distance themselves from disagreement and opposition to their breastfeeding and weaning decisions by either avoiding situations where this conflict could occur or accepting the fact that incompatibilities would occur and dismissing or ignoring the influence of that source. *“I knew what I wanted to do and I did it. So whatever people said, it went in one ear and out the other” (M25).*

As demonstrated in the next two quotes, participants trusted themselves enough to embrace the sources compatible with their expectations while, at the same time, ‘distancing’ themselves from disagreement and opposition:

I just really took the information that I had read, and made a plan for myself out of that ... I did adapt it [the information] of course because our weaning was a lot more gradual than most weanings would be but that’s what I wanted so that suited us and everybody was happy ... We put in a few modifications ... because some of the information was conflicting as well so we had to work out what suited us and then work on a base that these people were saying this. “what’s good for us and go by that.” (M24)

I really do like them [health professionals] and if I don’t like what they say I just won’t take them on board. That’s okay because some, because the next person might like it you know ... But that’s your choice, you can choose too, you know. Because I also believe that at the end of the day take the information ... What do I feel comfortable with?” (M33)

Kneidel (1990) presented an article in the La Leche League (LLL) web site regarding her breastfeeding experiences beyond one year. Her story also demonstrated similar strategies of embracing and distancing occurring together: *“I was able to ignore the advice [from her pediatrician] only because my best friend was still nursing her two year old with tenderness and affection and apparently no ill effects”.*

Janet, an American woman, (cited in Gorgas, 1997) while interacting with the La Leche League web site gave the following response in reply to women’s concerns regarding criticism from relatives while breastfeeding: *“there was no way I was going to win them [mother and sister] over to my way of thinking or get their support and agreement, so I had to let go of the idea of wanting or needing their support”.* Another woman, also named *Janet* responded to the same issue by stating *“while family approval would be wonderful, it is not necessary”* (cited in Gorgas, 1997).

Participants employed the strategy ‘distancing’ by either avoiding the source of opposition or dismissing their expectations. Specific examples to illustrate these two approaches will be presented.

Avoiding.

Participants utilised many strategies to avoid putting themselves in situations where *incompatible expectations* would be present. First-time mothers were more likely to utilise an avoiding approach, particularly vulnerable participants who were still developing trust and confidence in their mothering abilities. For example, many mothers chose not to breastfeed in public to avoid being confronted with opposing views. *“I wouldn’t go out if I didn’t have to. I wouldn’t go down to the shops because he might have to feed or if I did I would take a bottle with me” (M3)*. This practice was more common amongst first-time mothers and some experienced mothers who didn’t feel confident dealing with people’s stares or comments. *“So I started just giving him a bottle when we went shopping or something, I’d sit down and give him a bottle rather than the breast and then when I got home I’d breastfeed him” (M5)*. Participants commented how this practice was restricting and required them to plan their day around feeding:

Putting her on the bottle was sort of getting away from that as well I think [breastfeeding in front of other people] ... But I never really put myself in that situation. I mean I didn’t hardly step out of the house for the first six weeks. If I did it was to go to the shops which is just down the street from my mum’s, and I planned it, you know, I planned it... she’s just had a feed I’ll just go down to the shops. (M13)

If I was out I thought that I wasn’t going to sit somewhere and try and persevere having a baby who might get anxious if she was hungry, so I might as well give her the bottle when we’re out, so that is what I ended up doing ... I don’t [breastfeed in public]. I didn’t. I’d either go to a room or I’d make sure I was home at feed times. (M16)

I tried to avoid it unless he was screaming. I was quite surprised at people’s attitudes in this day and age ... Shopping centres. I tried to avoid it if I could. Things like that. If I had to do it I would do it in a car, because sometimes if he was not going on properly and there was a big fountain coming out it was embarrassing. (M18)

The issue of mothers needing to adopt approaches to avoid opposition to expectations associated with breastfeeding in public has been noted and publicly debated in the media:

Some people do find it offensive to have babies being breastfed in very obvious public places. There are, in many cases, facilities available for people to breastfeed elsewhere and it's a matter of choice. It's a matter of taste. It's also a matter of just common decency (Premiere of Victoria Jeff Kennett on ABC 7.40 am radio programme April 6, 1998).

Participants, from this study, were left with a number of choices in how to deal with *incompatible expectations* when breastfeeding was encouraged in private circumstance, such as a friend's home, but not advocated in public situations. As already noted, some participants consciously chose not to breastfeed in public. Others did breastfeed but were careful about being discrete with exposing their breasts in public. *"But they [general public] couldn't see anything. I mean, I always wear T-shirts like this and there's ways to do it and there's no way they could see it anyway"* (M26). Again these strategies sought to avoid confrontation with opposing sources. These tactics were more common with strangers in public places rather than in participants' homes with friends or family:

Yes actually when I have been on a train I do make a point there of covering myself up more only because I feel someone might be looking. Not that I'm embarrassed but I think I wouldn't want to incite some other You know, if someone keeps staring at me I might sort of feel that I'm making it uncomfortable for them and just could be a situation that might get out of hand. (M1)

The ability to be discrete with breastfeeding in public in order to avoid criticism required not only skill but a cooperative child. *"I couldn't feed him in a room even with a couple of other mothers because he'd just get too distracted"* (M3). Some participants were not able to achieve the degree of discreteness they wanted during breastfeeding. *"If I was in a shopping centre I'd go to one with a decent mothers room, because I'm so big and I had trouble at first latching on"* (M16). Participants saw the skill of being discrete with breastfeeding in public as important and were praised by others for doing so:

I would never expose my breasts so I always had a scarf mainly because a lot of people are very embarrassed too, so I'm thinking about the general population, they don't like to see my breasts and in the same token I don't think that I need to

expose it ... A lot of people appreciated it, like I'd be at a shopping centre and someone would be sitting next to me saying "Oh that's a really good idea" you know, so I think a lot of people appreciate the effort. (M23)

The issue of breastfeeding in public was one example where participants used the approach of avoiding conflict and criticism to address *incompatible expectations*. On the other hand, other participants chose to deal with this dilemma by dismissing the influence of the opposing source. The following story told by one of the participants demonstrates examples of two mothers she observed at a shopping centre. Each mother employed a different approach, with one choosing to avoid conflict by breastfeeding discretely and the second exposing her breasts while feeding but being prepared to dismiss antagonistic comments should they occur:

This mother [first mother avoiding criticism by being discrete] was desperate and she sat on a shelf and there she is feeding ... But you couldn't tell she was doing it just looked like she was cuddling. So I think it depends on the mother. Some mothers [second mother dismissing opposition] just hang it out as I put it, whereas other mothers do it very discreetly and you can't see anything anyway. (M26)

The likelihood of choosing to avoid an opposing source of expectations rather than dismiss their influence tended to occur with people who participants had a better chance of avoiding. The feasibility of using the avoiding approach was more suitable for people with whom participants did not have a close relationship, such as strangers in public, acquaintances, or health professionals. To illustrate, no participant shared a situation where they utilised avoiding with their partner due to closer living arrangements. However, there were many examples where participants utilised the approach of avoiding with friends and extended family. *"I guess it's sort of made me not tell people I was still breastfeeding, rather than be open about it" (M30)*. Another example involved the participant who informed her mother that she was weaning at 12 weeks then changed her mind and decided to continue with the breastfeeding. Her plan to deal with her mother's anticipated disappointment was to decrease her visits plus ensure that she did not breastfeed in her presence:

Then I avoided my mother for a long time because I knew she'd know, somehow most mothers do. "You're still breastfeeding aren't you?" [laughing] even though I didn't do it in front of her. So I avoided her when she actually found out or I think I told her, it was like a confession. "Look mum I know you're not

going to be happy about it but I'm still breastfeeding", so she wasn't happy about it. (M32)

This avoidance approach continued throughout her experience to the point where the participant chose not to inform her mother of any decisions regarding breastfeeding or weaning. *"I don't think I've even told her [mother] that I had weaned now. But I neglected to tell her that I was still feeding too because she's so against breastfeeding past any stage that it was necessary" (M32).*

As noted earlier, participants often chose to avoid further contact with a health professional whom they perceived had *incompatible expectations* to their own. *"I didn't like going [to see the child health nurse], I don't go for the monthly checks, I used to" (M18).* While some participants chose not to return to a health professional: *"He [doctor] told me not to worry ... just to continue breastfeeding as that's the best thing which I thought "that's really good but she's not putting on weight" and I was starting to worry so we changed doctors" (M9),* other participants changed the focus of their contact to a weighing and measuring service rather than to seek information or advice: *"I only take him there [child health clinic] just to have his annual check ups, I don't listen to anything she says. I don't think most of us do" (M26).* A further example illustrated how a participant lied to avoid conflict in her relationship with her child health nurse. The nurse had insisted that the child be breastfed at least six times a day but the participant was satisfied that her child was thriving on four:

I lied [to child health nurse]. If the weight wasn't going on I would have woken her up for more feeds, but she was thriving. She was above the middle line anyway. And so I lied. And the next time I went I told her six again [when the child was feeding four times a day]. (M16)

Stearns's (1999) qualitative study of 51 American women that explored the experience of breastfeeding in public presented strong evidence to support this avoiding approach found in this study. One of the categories identified in her study was entitled 'location'. The tactics of 'avoiding some places' and 'claiming other spaces' were adopted to assist women to deal with the potential stigma of breastfeeding in public. Anecdotal statements from her interviews clearly parallel experiences shared by the current study participants whereby mothers went to great lengths to make sure they were invisible

breastfeeders such as feeding in store dressing rooms, cars, or staying at home and timing their outings according to anticipated feeds.

Another final component of distancing entitled dismissing, which has been briefly mentioned, will be further discussed.

Dismissing.

In choosing to dismiss incompatible expectations, participants did not physically separate themselves from the opposing source but instead chose to dismiss their influence. Those participants who had developed enough self-trust and confidence in their mothering abilities were better able to withstand any opposition to their expectations and decisions. Personal expectations and goals were given the priority that participants wanted. The following quotes illustrate two participants' ability to dismiss comments perceived to be incompatible to their own: "*Isn't that toddler old enough to be off the breast now. And I say 'well he enjoys it, I enjoy it, what's the problem?' ... I thought comments like that ... I just passed over*" (M27) and:

I actually recalled thinking "I don't care what other people think". I really didn't care and if they look and thought of it I didn't care. It wasn't the issue. My child was hungry and that's all there was to it. So I didn't care whether ... people agreed or not agreed or thought it was this or that or the other. (M33)

This degree of confidence did not only come from experienced mothers although it was more common for participants with previous experience to demonstrate more confidence in asserting their breastfeeding and weaning intentions:

By the time you got to number three [third child] it was like it didn't really matter at all but no I never minded. I always fed her when I was out and I always kind of dared anyone to say anything. You often hear of people making comments ... it never worried me. (M22)

If they [general public] can't handle seeing [breastfeeding], I'm not the sort of person just to hang a boob out, I was very discreet about it, [not] flop it out or let anybody have a look at it either but, and I found my second one, that was so much better not being stressed out about it and just saying "Oh well I'm in the middle of a shopping centre in the mall, I'm going to sit down and feed", rather than get wound up and I've got to rush home and ... I'd just sit down and do it there ... I used to just sit there and just do it as casually as anything and I'd notice other people getting really embarrassed and I just used to gloss over. I'd never sort of look at them as if to say "What's up with you, can't you handle a boob?" [mother of three children] (M21)

As their breastfeeding experience evolved and self-trust developed into increased confidence, some first-time mothers were also able to use dismissing when confronted with sources of *incompatible expectations*:

You're telling me I'm being a bad mother. She said "no I'm not". I said "yeah you are, basically that's how it's coming across and anyone younger would think they were being a bad mother". I said, "I know I'm not so I don't really care what you say." (M16)

Additionally, participants possessed other characteristics that assisted them in developing the confidence to dismiss opposition, such as maturity, previous contact with children, or work experience. *"I've worked with men, used to be in the airforce, worked with men all my life so I don't care what they think anyway [laughs]. So no I didn't have a problem at all, no I didn't care [breastfeeding in front of men]" (M20).*

Whereas participants who used avoiding tended to change health professionals who had opposing expectations, participants who were able to dismiss opposition continued seeing their health professionals but were able to selectively take what they wanted from the relationship:

She [child health nurse] was an older lady and she was saying "you must cut back on the breastfeeding if you want her to eat more" and she was prescribing what I think was older ideas and I basically ignored them all. Did my own thing. (M31)

Dismissing others' expectations occurred across the range of all sources of expectations. Partners' opinions and wishes were dismissed on many occasions. *"He [partner] said that the longer I leave it the harder it will get. But with my first child he gave me lots of information, which wasn't necessarily true, so I sort of listen but did what I feel comfortable with" (M28).* This dismissal applied to all decisions in the management of breastfeeding and weaning. *"Hubby kept saying when are you going to wean him off; he is getting too big for this now. I say I'll wean him off when he is ready" (M26).*

Some participants also attempted to dismiss the opposing wishes of the breastfeeding child. This dismissal often manifested itself in persistence on the mother's part with decisions such as introducing the bottle, initiating weaning, or persisting with breastfeeding, although the child resolutely protested. *"No, I just persevered with the*

bottle and he just took it” (M19). Participants weighed the costs of persisting against their child’s wishes and would put limits, often days, on how long they would dismiss their opposition. “I kept trying to put her on probably about four days before I’d keep giving her the breast first and I’d fight her and put her on first” (M20). Other examples where participants attempted to use this approach was if weaning was child-initiated against the mothers’ wishes. The mother had the option of using techniques, such as breastfeeding in the bath or when the child was half awake, to entice the child back to accepting the breast:

This baby here doesn’t want to breastfeed for some reason and I have to give it up. Well then I’m going to have to look at the strategies to see if there is any way I could continue if the child just won’t take to it whatsoever. (M27)

Some participants were successful in their persistence to modify their child’s behaviour whereas others were not.

Participants also dismissed *incompatible expectations* from friends and extended family members. “I went back into work and one lady said ‘oh you’re breastfeeding?’ and I said ‘oh no she’s on the bottle’ and her face dropped a bit [laughs] but I sort of thought I’m not going to let that bother me” (M13). Once differences in expectations between extended family members became apparent, some participants were able to anticipate opposition and were prepared for these predictable disputes:

I didn’t want to hear that [to stop breastfeeding] because I wanted to do it ... so after that then I didn’t involve Mum that much in what I was doing ... Mum said “oh you’re still feeding that child” ... I expected it so it was not a shock. I expected mum to say something like that ... And I sort of expected that from my parents so it didn’t really worry me. (M20)

Women corresponding through the La Leche League web site also shared similar experiences and offered suggestions on how they dealt with opposing expectations. “Even so, I would get comments about how ridiculous it was that I was nursing my child so long. I often would ask, ‘why does it bother you?’ No one ever came up with a good answer and invariably would back off” (Margie cited in Rich, 1995). Another woman, Stephanie, offered these words of wisdom “To those verbal few, I reply ‘I respect your opinion and while you may not agree, I’m sure you will respect mine’”. The Nursing Mothers’ Association of Australia also has a web site that provided information and articles on breastfeeding. Newbold (1999) addressed the issue of breastfeeding in

public in this Australian web site for mothers and encouraged women to feel comfortable in how they chose to handle this dilemma. In similar international web sites, women have openly offered practical advice to other mothers to breastfeed discreetly and build confidence with breastfeeding in public (Booksh, 1994; Wight & Johnson, 1995). Martin (1995) offered her opinion in another international parenting web site and suggested that “the simple act of breastfeeding in public will also go a long way towards making it more normal in our society.” Finally, Newbold (1999), from the Australian perspective, asserted that:

breastfeeding will never be seen as the norm while children see only bottlefeeding and mothers hesitate to breastfeed outside the home. Those of use who feel confident about breastfeeding while out and about are helping to make it easier for others to do the same (p. 4).

Duckett et al. (1998) proposed a Theory of Planned Behaviour (TPB) which was a structural model for explaining variability in breastfeeding intention and duration. The model addressed the complex relationships between antecedents such as age and formal education, knowledge level, beliefs, subjective variables such as attitude, intentions, and early modifiers upon breastfeeding behaviour. The authors concluded that knowledge about the predictors of intentions, attitudes, and perceived control can be used to assist with effective practices toward improving breastfeeding outcomes (Duckett et al., 1998, p. 334). For example, in relation to this study when women perceived their support network was not actually supportive of their breastfeeding, they used ‘embracing’ and ‘distancing’ to establish relationships with people they felt were truly supportive of their decisions.

In summary, the strategy of ‘distancing’ was implemented by either avoiding or dismissing disagreement from sources whose expectations opposed those of the mothers. Avoiding disagreement meant that participants physically ceased contact with an opposing source by changing health professionals or using techniques such as not breastfeeding in public or being discrete to avoid being noticed and incite conflict. Dismissing others disagreement and opposition allowed participants to continue contact with the dissenting person while discounting their opinions and diminishing their influence. Participants were still able to capitalise on these sources for valuable information and advice but were able to selectively dismiss what they did not want.

Being able to maintain contact with sources of expectations meant participants were exposed to a wider range of possible options from which to choose. *“I’ll do what I want to do ... Because still people gave me advice and I think ‘well no not right now I’d rather not do that I’d rather try something else’ ” (M5).*

Once the weaning process was complete, participants then progressed to resolve their decisions in relation to their breastfeeding experience in phase three of the process of *constructing compatibility by adapting focus* entitled *confirming focus*.

Confirming Focus

In the final phase of the process of *constructing compatibility by adapting focus*, participants reflected upon their experience and resolved how their adapted focus assisted them to achieve the agreement, support, and acknowledgement that they desired. Firstly, adjusting their focus to encourage self-trust and confidence had allowed them to clarify and reinforce what was important to them during their breastfeeding experience. Secondly, participants selectively focused upon sources whose expectations were compatible with their own. Employing strategies from the first two phases of *shifting focus* and *selective focusing* had enabled participants to create a supportive environment with expectations and goals compatible to their own.

Having weaned their children from the breast, participants in the third phase of *confirming focus* reflected back upon their experience using their adapted focus. They rationalised their breastfeeding experience by focusing upon the positive outcomes of their decisions in relation to their child, other immediate family members, and themselves. At the same time and to varying degrees, participants acknowledged a range of emotions in response to weaning. These emotions involved mixed reactions of loss and sadness to relief, pride, and a sense of accomplishment. Having constructed a support network of compatible sources ensured that participants received affirmation for their sanctioned efforts with breastfeeding, weaning, and most importantly, mothering. The importance of this acknowledgement to women was also noted in Schmied and Barclay’s (1999) Australian study as their participants, first-time mothers, felt that mothering and breastfeeding efforts received little reward or recognition.

Reflecting upon positive outcomes for decisions and recognising the emotional impact of the weaning process allowed participants to accomplish three significant outcomes. Firstly, participants sought to reinforce a positive mothering image of themselves and their breastfeeding efforts. *“I look at him and he’s twice the size and healthy and so I don’t think he’s missed out on anything” (M11)*. Reviewing their expectations of motherhood and breastfeeding in particular provided the opportunity to confirm that they did their best. *“I gave her the start that I wanted” (M16)*. Achieving their expectations and goals, albeit modified, reassured participants that they were good mothers. *“And I knew within myself that that was good, that I’d done well enough. Like I thought the first six months were probably pretty important” (M18)*. For some participants, the notion of doing the best for their children was adjusted to doing the best they could considering the context of their individual circumstances:

Now I know that I gave him the best ten months that I could, there are a lot of people who can’t breastfeed and who don’t want to breastfeed, so I know that I gave him the best ten months that I could. (M19)

Secondly, once participants were able to positively acknowledge their mothering efforts, they were better able to let go of the breastfeeding role. Being a breastfeeding mother for a particular child had ended and new challenges lay ahead. Participants had to accept the end of breastfeeding and weaning for this child and move on:

But it all turned out for the best I suppose. He’s happy and growing up too quick ... I thought well you know, I tried as much as I could to breastfeed this baby and he didn’t want it, that was his decision not mine that was taken away from me and there was nothing I could do about it, so I just accepted it and got on with it. That’s all you can do. (M17)

Just my baby had grown up, that’s it, I guess that was it, already she’d grown up, so I don’t know how I’m going to be when she starts going to school, well I think I’ll be devastated then. But that’s it, just the fact that she’s grown up and she doesn’t need my milk anymore, sort of just like a process, a growing process I guess, that’s how I saw it ... just an acceptance, that’s it, I guess that’s the word, just acceptance. This is what happens. (M23)

Thirdly, establishing a positive mothering image and being able to let go of their breastfeeding role encouraged readiness to move on to the next stage of mothering. All participants had to resolve the completion of their current breastfeeding experience before they could move on to what lay ahead. *“Time to move on to the next stage, she*

had grown up that little bit more” (M16). For some participants this process was relatively easy because of their perceived readiness. Other participants found the process more difficult, especially those who admitted they were not ready to relinquish their breastfeeding experience. “It’s hard ... I don’t know, I didn’t want to let go that’s for sure, so I prolonged the weaning process more than necessary I see now in hindsight” (M8).

To successfully resolve breastfeeding and weaning decisions, participants utilised the strategies of ‘rationalising decisions’ and ‘acknowledging feelings’. By concurrently focusing upon positive outcomes of the weaning process for themselves, their child, and family members and acknowledging mixed feelings of loss, sadness, and pride, participants completed their weaning process and were able to welcome future mothering challenges:

But I had enjoyed it so much but it’s drawn its own conclusion too. It was time and it was time then for me to say okay ... So it was sort of like well it’s finished so there are good things about it being finished ... this [breastfeeding] was a great time, but we’re going to move on now. (M33)

Rationalising decisions by focusing upon positive outcomes.

Although many weaning experiences had been a struggle for both mother and child, once this transition had been completed, participants focused upon the positive outcomes of their decisions. *“But once I had done it and she was on the bottle, and much more settled baby, I was quite relieved in a way thinking that this was best for her” (M2).* There may have been both positive and negative outcomes with the decisions to wean but participants, whether deliberately or unintentionally, tended to focus upon the positive outcomes. *“Once I gave him the supplement bottle and realised how content it made him, that’s what made me make up my mind really” (M11).* They were able to justify compatibility between their child’s and their own expectations with their weaning decisions by confirming that their actions were appropriate as demonstrated by the perceived benefits:

He [child] was happy and you could see his personality change, he wasn’t as hungry all the time and from the bottle he started eating a lot more solids, so he was a lot better in himself and I think that’s what made me feel reassured as well. (M19)

As the reasons for choosing to breastfeed focused upon its benefits for the child, participants always assessed the outcome of their breastfeeding and weaning decisions in relation to their impact upon their child. Mothers reflected upon their child's current behaviour now that weaning was complete and compared it to past behaviours while breastfeeding. *"I think he is a lot happier now [weaned on to bottle]. I think he was getting very frustrated ... he was a lot happier on the bottle. And I am too. I think it was the right time"* (M3).

If the change revealed a happier, healthier child, it reinforced for the mothers that their decisions were right for their child, that their expectations of being a good mother and providing what was best for their child had been fulfilled. *"But then on the other side of that I was happy that she was gaining weight, she was healthier, she wasn't crying, she was actually sleeping you know for three or four hours or whatever between feeds which was excellent"* (M9). An improvement in the child's behaviour after weaning, or at minimum, no obvious detrimental changes, was used as a benchmark that the chosen timing and strategies for weaning were appropriate for that child.

When assessing the impact of weaning upon their child, participants specifically focused upon behaviours after the process rather than during, as some children were initially reluctant to accept weaning. Therefore, it was the long-term effects of weaning that mothers used to evaluate their decisions rather than the responses demonstrated during weaning strategies:

He needed that gradual weaning so and it worked. It worked really well for us ... He didn't mention anything about it. Even when he saw other babies being breastfed, he didn't say anything so I think he was ready. He was just definitely ready to be weaned off. (M24)

Even participants who experienced particularly difficult weaning situations, where the child was overtly distressed, were able to find positive outcomes for their decisions. Often participants allowed time for the child to adapt to the change before assessing its long-term impact. For example, one participant used the cold turkey method to abruptly wean her nine-month-old daughter due to starting a family business. The child refused to drink anything for 24 hours and *"every time I went to give it [bottle] to her she would scream at me and try and go for my boob"* (M21). This struggle went on for over two

weeks and it wasn't until six weeks later that this mother decided to evaluate her child's response to weaning:

It's helped with the relationship with her and my husband because it's really nice to see now because now she'll go to my husband and hug him and put her head on his chest ... now that she's been on the bottle and she's not as clingy to me I can see that he's really enjoying coming home at night and saying "hello darling" and giving her a cuddle and she goes ooohhh [laughs]. (M21)

Once participants could affirm that their decisions were right for their child, they were able to acknowledge the benefits for themselves and their immediate family members.

"But as soon as we gave up the whole family was a lot happier and more relaxed"

(M5). Positive outcomes for the partners, such as the ability to increase their involvement with their child, were often cited as benefits for the family:

And I mean her being happier made me happier too. And I wasn't tired. Like breastfeeding every 2½ hours on your breasts at night time too, so my husband couldn't help. So once I put her on the bottle he could feed and help out a little bit ... She was just happier in herself. Her mood, her personality. Before I couldn't give her to anybody. It was just me she'd go to. Even X, my husband, he couldn't feed her. She'd just throw a wobbly. Yes so she became better socially as well. (M4)

Although the impact of the weaning was always initially assessed from the perspective of the child, mothers also commented on the benefits for themselves. For example, the mothers' improved physical well being promoted an improved home environment for all family members. *"I think he [partner] was happier [when child weaned] ... I suppose maybe in my own self I wasn't so tired, it wasn't so draining. So maybe it was happier all around"* (M6). Although contented with having breastfed, participants were also happy once the experience ended and they were able to reclaim their bodies. *"I just wanted myself back"* (M18). Because the act of breastfeeding is such an unselfish, demanding, and giving act, participants appreciated regaining what they had sacrificed to breastfeed. *"Not long after that [weaning] I don't know whether it's psychological, hormonal the whole bit, I started to feel like I was myself again, my body was my body"* (M33). Participants noted that it was time to indulge themselves:

You kind of feel like you're constantly having to live for the baby and the other kids and whereas time for you and your own body ... I felt like my body was back to normal. Finally over that whole pregnancy and child birth effect that your body changes completely and I felt like I was back to me, back to normal ... I quite liked that feeling. (M22)

In addition, having more time for other children was another positive example cited by mothers with more than one child. *“And he [older child] wanted some attention and that breastfeeding [younger child] was sort of getting, taking his time away as well” (M28).*

The strategy of ‘rationalising decisions by focusing upon the positive outcomes’ has been identified in other research. DeMeis and Perkins’s (1996) study examined homemaker and employed American mothers’ performance and perceptions of the motherhood role. Each group was found to redefine mothering to maintain their desired image. Homemaker mothers had higher expectations that legitimised their need to stay in the home, whereas, employed mothers’ expectations were found to be lower and reaffirmed their commitment to employment. These coping strategies were also supported by earlier studies (Elman & Gilbert, 1984; Emmons, Biernat, Tiedje, Lang & Wortman, 1990) that identified how employed women restructured their thinking about mothering by emphasising positive aspects of their situation while minimising the negative.

Reflecting on the positive outcomes of the weaning process for their child, family, and themselves assisted participants to rationalise their decisions, acknowledge their mothering efforts, and reinforce a mothering image consistent with their own expectations.

Acknowledging feelings.

The strategy of ‘acknowledging feelings’, whether sadness, loss, or relief and joy, allowed participants to reflect upon their entire breastfeeding experience. Symbolically, breastfeeding was more than the act of providing physical nourishment to a child. Although the emotional meaning of breastfeeding varied for each mother and with each experience, they needed to acknowledge that meaning before letting it go. One partner acknowledged this separation as *“a feeling of loss or letting go” (F23)*. *“I don’t know, I felt really emotional about giving up breastfeeding with him. I don’t know why I did, it seems like a life’s attachment to him and that was it” (M30).*

Swigart (1998) recognised that weaning was idiosyncratic and uniquely executed but also described it as the beginning of an end, a rite of passage, and a symbolic event in the relationship between mother and child where the child was not longer a passive, recipient of the mother's care. The experiences of the participants of this study support these assumptions. Letting go was also noted in the work of the poet Adrienne Rich (cited in Swigart, 1998, p. 56) who felt that mothers must "work to wean their children and the passionate intensity that accompanies the different phases of mothering". Weaning a child from the breast was said to be one of the earliest stages of mothering that women faced.

The degree of emotional involvement with letting go varied for mothers depending upon their perceived readiness. If participants felt ready to wean their child and symbolically let go, the emotional transition from being a breastfeeding mother to a non-breastfeeding mother was smoother. To illustrate, the following mother's comparison of her feelings after two weaning experiences highlighted how her readiness with the second child resulted in different feelings following the event. *"I was pleased that everything went well. I wasn't forced to stop before I wanted to. I didn't go through an emotional thing like I did with X [1st child] at all. Quite happy"* (M30). Furthermore, another experienced mother expressed her relief that the weaning process had finished and had been desirable due to the readiness of herself and her child. *"I was ready and whether she was or not, I think I was going to put her on to the bottle anyway and I was quite relieved [that she was ready] and it was finished"* (M22).

Letting go was a mutual process for both the mother and child. When this readiness to let go occurred simultaneously participants expressed relief. Furman (1995) in her conceptual approach to weaning noted that weaning was also a developmental step that children must take to develop their own person, separate from their mothers. According to Bergum (1997, p. 154) "as the child grows and moves away from the mother, and the mother lets the child go, both mother and child recognise more clearly the selfhood of each other." At the same time, participants who did not feel ready to stop breastfeeding but did so for a variety of reasons experienced a longer period of adjustment in accepting the next stage of mothering. *"Yes because emotionally I wasn't quite ready to give up and I must admit I did for a long time physically held him next to me"* (M3).

The emotions expressed by most participants during this phase varied from feelings of loss and sadness to relief, pride, and a sense of accomplishment. In presenting their guidelines to weaning mothers, Huggins and Ziedrich (1994) advised women that feelings after weaning can include grief, relief, anger, rejection, anxiety, guilt, sadness, and regret. In reality, most participants expressed many of these feelings at the same time, where they felt relief to be finished but also sadness that they were no longer needed to the same degree by their independent non-breastfeeding children:

I just didn't feel like a mum or I didn't feel like I had a baby anymore because to me I always imagined a baby was to be breastfed and cuddled when they're feeding and I didn't have that closeness anymore. And anyone could bottlefeed but I knew I could breastfeed my son or my daughter ... So it doesn't feel as close then but then he's very very cuddly when he's finished his bottle ... I just thoroughly enjoyed it and I was so proud that I could actually feed because I couldn't before. (M5)

As well as experiencing relief that the process of weaning progressed smoothly or relatively smoothly, many participants were relieved to “*feel like I was myself again, my body was my body*” (M33). Breastfeeding involved significant physical and emotional effort and sacrifices on the part of the participants. “*I just felt relieved actually because I thought to myself... it felt like I had a weight off my shoulders*” (M15). Having acknowledged their accomplishments with breastfeeding, participants could regain what was lost or changed during breastfeeding. “*Some of them [mothers] are relieved ... [having experienced] hair loss and lack of energy and the closeness with partners. That all changes there as well*” (CHN5). Some participants were relieved that the constant giving was over and they could think of themselves and their needs again. “*I wasn't constantly feeling like a cow, I felt like I was a deli, everyone coming in for a snack*” (M19). Another mother of three children expressed her relief as follows:

I think I was kind of relieved actually that the breastfeeding was finished I mean I enjoyed it at the time but it does drain you a lot. You kind of feel like you're constantly having to live for the baby and the other kids and whereas time for you and your own body ... it was over and that was good and I felt like my body was back to normal. (M22)

Not only did participants acknowledge the physical relief once breastfeeding had stopped, but they commented upon the benefits to their relationship with their partner. “*My partner was immensely relieved. How did that affect me? It just made things*

easier" (M31). Increased freedom after weaning meant that others could care for their child and participants and their partners were able to spend more time together. "Because she stays at Grandma's once a week and that was good you know it's only one night a week but it's a nice night [laughs]" (M20). As noted previously, participants' perceptions of their sexuality changed during breastfeeding but once they had weaned, their sexuality reverted back to pre-pregnant attitudes and behaviours. "I finally wouldn't have any milk left and wouldn't have to be wearing breast pads 24 hours a day and maternity bras to bed [laughs] and all those beautiful sexy lingerie" (M5). Participants regarded changes due to breastfeeding as temporary and accepted them as part of the experience. "So we both kind of knew that once it [breastfeeding] stopped things [sex] may or may not get back to normal or whatever normal was" (M33).

Maternal feelings of relief associated with weaning have also been noted in the literature. An Australian study examined the effect of breastfeeding cessation on mood and sexuality for first-time mothers (Forster, Abraham, Taylor & Llewellyn-Jones, 1994). Nineteen women, recruited from a parent's magazine, provided data two months before and after weaning. The study concluded that stopping breastfeeding was associated with an improvement in mood, fatigue level, and sexuality. Findings from other research on sexuality during the postpartum period also supported the impact that breastfeeding has upon sexual patterns. Breastfeeding women revealed significantly less sexual activity and satisfaction compared with non-breastfeeding women (Hyde, DeLamater, Plant & Byrd, 1996; Visness & Kennedy, 1997). However, Hyde et al. (1996) found that by 12 months there were no differences between the two groups, which questions the long-term impact of breastfeeding upon sexual activity. Data from the current study suggested that sexual activities had been altered, especially in relation to how participants and their partners perceived the lactating breast.

Most participants, no matter how their breastfeeding and weaning experience had eventuated, expressed feelings of loss and sadness to varying degrees. "You feel like you are losing them [child]" (M26). Even mothers who were very happy with the management of their experience acknowledged how weaning their child from the breast represented an end to an important stage of life, the closing of that unique breastfeeding bond:

I went outside in the car and drove off and cried my eyes out you know. I was letting go my baby ... It was awful. It was awful. But I think it was worth it. Again it was the only way I could do it. I had to have somebody else that could take over at that point because I found that breaking the bond quite difficult. (M27)

This special bond was something that could never be recaptured with that child again. It was a loss of a particular closeness that could only be achieved during breastfeeding. “*I suppose you feel a bit sad when you give up even though I wanted to. I think you don’t feel that closeness that you do ... with a bottle than you do when you’re feeding them yourself*” (M6). It was suggested by mothers, that other children may come along but the uniqueness of the bond with that particular child would never be the same.

The end of breastfeeding also symbolically represented the end of babyhood, the loss of a dependent child who relied upon the mother for something only she could give. “*So all that period of nurturing, mothering was all going to end. So every time I thought about stopping it was, I’ll get upset ... no I couldn’t, I can’t bear the thought of her not needing me at all*” (M33). Another participant expressed her sense of loss as follows:

I felt like I lost something, I felt like he went from being a baby to being independent all on his own. He was also crawling at that stage, he just became independent. He wasn’t my little baby any more. He was just a big boy all of a sudden and it just happened so quick which was even worse, he went from being little to being I’m on my own, thanks mum I don’t need you any more. That’s what it was like. You know he didn’t need me anymore. (M17)

Women outside the context of this Australian study have also noted feelings of loss and sadness. Cyndy from Ireland (cited in Murad, 1994) and Missy from the United States (cited in Murad, 1994) shared their stories on the La Leche League web site:

My son, who is two years old, loves to nurse [breastfeed]. I remember the first night he chose to go to sleep without nursing. He was twenty months old. I cried so hard! My husband understood that I felt a loss, but also reminded me that our son was learning to meet some of his own needs without me. I realised then that I needed to celebrate my son’s growing independence, not mourn it.

I believe that the sense of anxiety and loss you describe is normal and natural, given the intensity and the intimacy of the breastfeeding relationship. Nursing [breastfeeding] is a special time of physical, emotional, and spiritual closeness between mother and child.

These perceptions of feeling needed by their child were also noted in a recent Australian study of first-time motherhood that explored the experience of breastfeeding in the six months following birth (Schmied & Barclay, 1999). Women in that study expressed satisfaction in acknowledging their own importance to their child and felt personal reward in this dependence. Relinquishing this unique role during the weaning process was not always easy as revealed by participants in this current study. The unique gift of nourishing and comforting that mothers had given could now be fulfilled by other people. Although many participants welcomed this fact, they also acknowledged sadness and loss in sharing this role:

It hurt a bit because I felt that he just didn't want me anymore, I felt needless now that everyone could sort of give him a bottle, but he wasn't like that at all, he still would not, it's only been the past four weeks that he's let my husband give him the bottle ... at first I was glad that he was still dependent on me to put him to sleep and to feed him, but now it's good because I can leave him with certain people and he will take a bottle ... I was just a bit depressed because I felt like he didn't need me anymore and now he's a big boy. (M19)

The emotional task of letting go highlighted how the process of weaning was a transition. As previously noted, this transition could be easy or difficult depending upon participants' perception of their readiness to give up the breastfeeding role and move on to the next stage of mothering. Therefore, the passing of time was acknowledged as being important to resolve this process:

I did feel it's a slight sort of almost period of mourning for it as well. I wanted it to, I did want it to cease and I didn't have any strong motivation to return but I certainly did have a little bit of mourning period for her as well. Before I got on, you know, with the rest of life. (M31)

For some participants, the time required to resolve this transition was days or weeks. However, a smaller number of mothers needed longer time periods to work through this phase of *confirming focus*, particularly those mothers who felt forced to make decisions for which they were not ready:

The stopping the breastfeeding is I suppose your first effort of letting go. First in a long process, so, let him gō ... I'm better as the time goes on, definitely. I couldn't have sat here and talked to you... when you first rang I was still going through the tears stage. (M8)

Even though mothers had resolved these emotions, seeing other mothers breastfeeding could temporarily arouse feelings of sadness and loss. *“I would have liked to have gone on for as long as I could actually. I really wanted to breastfeed and you see other mums doing it and their kids are like eight months, and I think Ohhhh it’s a bit sad” (M4).*

Although this transition was particularly difficult for some participants, they were able to identify factors that assisted them with the phase. A small number of participants noted that, although their child was weaned, their preference to be close to their mother, and occasionally not allow others to feed or comfort them, helped them during this transition period:

Even though I’m not feeding her she still wants mum. So in a way, I’ve never said it to my husband but in a way it gave me a bit of satisfaction that even though I wasn’t still feeding her, you know, she still saw me as her caregiver and the person who she could source for her food and the person who she wanted to hold her still to feed her even though it wasn’t by the breast, she still wanted me so that was good in a way. I think that sort of helped too with the transition that she still wanted me. (M21)

Although this continued dependency on the mother was often transient, these participants enjoyed the feeling of being needed for those extra days and weeks. The transition of feeling needed to not feeling needed required an adaptation for many participants. *“I think I probably felt more at a loss emotionally and I’ve worried about it thinking that I’m going to feel unneeded, it’s lovely to be needed by your child and to give pleasure and to be that close” (M32).*

As well as expressing feelings of sadness and loss, most participants also were able to acknowledge their own efforts in relation to breastfeeding and to feel pride and accomplishment. *“I mean it felt really good to know that I could supply her with food ... I felt that was really good, you know, to know that you can do that for your baby and the feeling and closeness was there” (M9).* No matter what the duration of breastfeeding was, participants recognised the importance of the contribution they gave. *“I was still happy in a way because I knew that she’d got in her at least three weeks on the breast and that, but especially that the first couple of days are the most important with the colostrum” (M13).* Another participant expressed a similar pride in her efforts: *“I thought well at least I’ve given it eight months you know so that was sort of good. It sort of made me feel like I’d accomplished something you know” (M20).*

Reflecting upon positive outcomes of weaning fostered acknowledgement of feelings of pride and accomplishment. As noted, participants worked through these strategies simultaneously as seen in the following mother's statement that incorporated positive outcomes to rationalise her decisions while also expressing her sense of accomplishment:

I sort of felt a sense of accomplishment just getting that far so I sort of thought well you've had seven and a half months and that's good ... Looking back in hindsight it was long enough but like at the time like I said it was because I didn't know I was sort of in a way dreading having to stop because I thought it was going to be difficult and then when she decided to stop early I thought no this isn't right, it's not time yet. But then once we'd stopped and everything was fine well then I was happy with when she stopped and how she stopped because it was her initiative. (M20)

Summary

In summary, participants faced with the dilemma of *incompatible expectations* adopted the process of *constructing compatibility by adapting focus* (Figure 10). Prior to engaging in this process, participants arrived at a turning point where individual tolerance levels of confusion, guilt, and self-doubt were reached. This turning point triggered their entry into the first phase of the process entitled *shifting focus*. During this phase participants took charge of their breastfeeding experience by clarifying and reinforcing the relative importance of their own expectations and goals. A consequence of this clarification was the ongoing development of self-trust and confidence in their judgement and abilities. *Selective focusing*, the second phase of *constructing compatibility by adapting focus* involved participants selectively choosing to focus upon specific compatible sources to accentuate their influence while diminishing the impact of other incompatible sources. Participants employed a strategy of 'embracing' where they actively sought and welcomed expectations that agreed and supported their own. At the same time, the strategy of 'distancing' allowed participants to minimise the impact of incompatible expectations by either avoiding their sources or dismissing the influence of their disagreement and opposition to breastfeeding or weaning choices. Participants moved back and forth from *shifting focus* and *selective focusing* as they made ongoing decisions regarding their breastfeeding in the presence of continually emerging *incompatible expectations*.

Shifting Focus (Phase One)

Definition: Shifting focus refers to participants modifying their mental view of the relative importance of aspects of their breastfeeding and weaning. Participants took charge of their experience by clarifying and reinforcing their expectations and goals within the context of their breastfeeding experience. The consequence of taking charge resulted in an increase in self-trust and confidence for mothers. Confidence developed and expanded as participants began to recognise, acknowledge, and trust their own judgement and abilities. *This phase was triggered when individuals reached their tolerance level of confusion, self-doubt, and guilt due to incompatible expectations.*

Selective Focusing (Phase Two)

Definition: Selective focusing involved choosing to pay attention or selectively focusing on particular sources of expectations. This focus upon specific sources negated or inactivated the impact or influence of other sources.

Strategies

Embracing – seeking and welcoming agreement and support with expectations and decisions



Distancing – avoiding and dismissing disagreement and opposition to expectations and decisions

Confirming Focus (Phase Three)

Definition: Confirming focus involved the act of resolving or becoming settled with breastfeeding and weaning decisions by reflecting upon their experience and verifying that the adapted focus achieved the compatibility desired.

Strategies

Rationalising decisions by focusing upon positive outcomes of weaning for the child, family, and mother.



Acknowledging feelings of loss, sadness, relief, joy, pride, and accomplishment.

Consequences of Confirming Focus

- Letting go of breastfeeding role
- Establishing a positive mothering image
- Encouraging readiness to move onto next stage of mothering

Figure 10: Basic social process: Constructing compatibility by adapting focus

Once participants had completed the process of weaning their child from the breast, they resolved breastfeeding decisions in phase three of the process, entitled *confirming focus*. This reflective phase involved participants 'rationalising their decisions by focusing upon the positive outcomes' for the child, family, and themselves. Finally, the strategy of 'acknowledging feelings' allowed mothers to express their mixed feelings of loss, sadness, relief, pride, and accomplishment. The consequences of working through the phase of *confirming focus* assisted participants to let go of their breastfeeding role, establish a positive mothering image, and encourage readiness to move onto the next stage of mothering.

CHAPTER SIX

Discussion

Introduction

It is hoped that their [mothers'] experiences ... can be used to sensitise health care providers and policy makers to the importance of providing health care services that are accessible, culturally congruent, and empowering (Locklin, 1995, p. 291).

This final chapter includes a summary and diagrammatic schema of *constructing compatibility by adapting focus*, the proposed theory of the management of breastfeeding and weaning from the perspective of mothers. The remainder of the chapter presents a comparison of *constructing compatibility by adapting focus* with existing literature on breastfeeding and mothering, relevant nursing theories, and related social science literature. Finally, implications and recommendations arising from this study are discussed prior to the concluding remarks.

Constructing Compatibility by Adapting Focus: A Theory of the Management of Breastfeeding and Weaning from the Mothers' Perspective

Embarking upon new tasks of motherhood, in this instance, breastfeeding and weaning, resulted in the emergence of expectations for participants. First-time and experienced mothers similarly noted the presence of expectations despite the fact that these expectations often differed considerably between individuals. Although the original focus of this research was on the process of weaning from the perspective of mothers, analysis of data revealed that expectations regarding weaning could not be easily separated from expectations of breastfeeding and mothering. Expectations in the domain of breastfeeding, weaning, and mothering were interrelated as achievements or disappointments attained in one area overflowed to other areas. Frustrations with weaning impacted upon mothers' perceptions of their overall breastfeeding experience and, ultimately, their image of mothering competency. Participants viewed their performance with breastfeeding and weaning as a component of their whole mothering experience. Ultimately, participants wanted to be able to see themselves and be seen as good mothers.

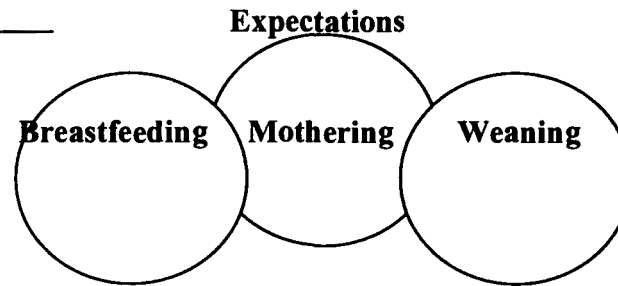
Participants approached their breastfeeding and weaning experiences with specific expectations and goals. Mothers' beliefs and knowledge about these mothering tasks influenced their expectations. Beliefs and knowledge were dynamic in that they changed or were further developed with each breastfeeding and weaning experience. There were several factors identified in the data that influenced mothers' development of their beliefs as well as the progression of their knowledge level. These factors involved the participants' exposure to expert sources such as health professionals, media and written publications; past experiences with previous children; current experiences of breastfeeding and weaning; the experience of significant others such as friends and family members; and finally, input from their partners. Resulting expectations were often derived from a complex personal negotiation and compromise between all of these influencing factors.

Two major categories emerged from the data. *Incompatible expectations* the first category, was the basic social problem faced by all participants during the management of their breastfeeding and weaning experiences. *Incompatible expectations* occurred when mothers noted differing and often conflicting expectations between themselves and others such as their children, partners, family, friends, health professionals, and members of the general public (Figure 11). All participants revealed instances of *incompatible expectations* during their breastfeeding and weaning experiences. These mothers whilst trying to manage their breastfeeding experiences were caught in the middle of the contradictory and confusing debate about the best or ideal way to manage breastfeeding and weaning. There were often as many differing opinions as there were people expressing them. Everyone had opinions and was very willing to offer advice to these women. Consequently, participants were left to sift through all of these differing opinions and suggestions, compare them with their personal goals and the reality of their experience, and discover a balance that was attainable and acceptable.

Management of breastfeeding and weaning

Expectations influenced by Beliefs and knowledge

- Experts
- Past experiences
- Current experience
- Experience of others
- Partner's input



BASIC SOCIAL PROBLEM Incompatible Expectations

Expectations of others
(child, partner, family, friends,
health professionals, society)



INCOMPATIBILITY

Expectations of mother

Consequences of Incompatible Expectations

- Confusion
- Self-doubt
- Guilt

Conditions Influencing Consequences

- Personal meaning of goals and expectations
- Control over decision making
- Relationship with source of expectation
- Proximity & frequency of contact with source
- Perceived credibility of source
- Extent of discrepancy between expectations
- The child's reaction
- Impact upon the family
- Presence of compatible support

Figure 11: Basic social problem: Incompatible expectations

Exposure to *incompatible expectations* resulted in notable consequences for participants. These consequences involved feelings of confusion, self-doubt, and guilt. Data analysis also revealed several conditions that influenced the amount of confusion, self-doubt, and guilt experienced by these mothers. The emotional consequences of *incompatible expectations* were influenced by the following conditions: the personal meaning mothers attributed to their goals and expectations; the perception of control during their decision making; the relationship, perceived credibility, proximity and frequency of contact with the source of opposing expectations; the extent of discrepancy between personal expectations and the opposing source; interpretations of the breastfeeding child's reactions to decisions; the perceived impact of these choices upon the family; and, finally, the presence of some degree of compatible support.

Participants faced with the dilemma of *incompatible expectations* adopted the process of *constructing compatibility by adapting focus* (Figure 12). This process, the second major category, evolved in response to the *incompatible expectations*. *Constructing compatibility by adapting focus* involved three phases: *shifting focus*, *selective focusing*, and *confirming focus*. Prior to engaging in this process, participants arrived at a turning point where individual tolerance levels of confusion, guilt, and self-doubt were reached. This turning point triggered their entry into the first phase of the process entitled *shifting focus*. During this phase participants clarified and/or modified the relative importance assigned to certain aspects of their breastfeeding and weaning. They were then able to take charge of their breastfeeding experience by reinforcing personal expectations and goals. A consequence of this clarification was the ongoing development of self-trust and confidence in their own judgement and abilities.

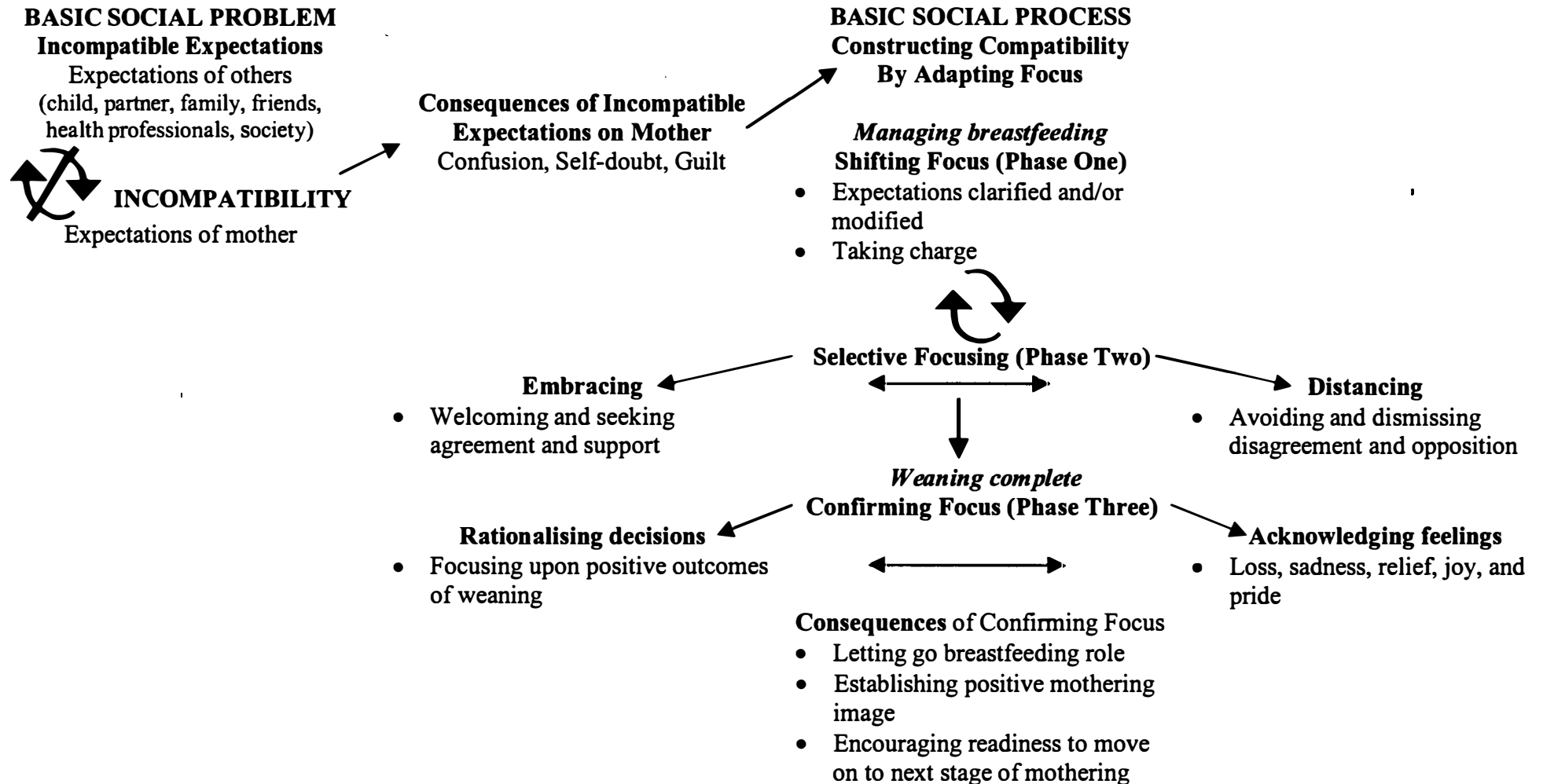


Figure 12: Constructing Compatibility by Adapting Focus: A Theory of the Management of Breastfeeding and Weaning from the Mothers' Perspective

Selective focusing, the second phase of *constructing compatibility by adapting focus*, involved participants selectively choosing to focus upon specific compatible sources to accentuate their influence while diminishing the impact of other incompatible sources. Selectively focusing upon specific sources negated or inactivated the impact or influence of other sources. Two strategies were revealed in this phase. Participants employed a strategy of ‘embracing’ where they actively sought and welcomed expectations that agreed and supported their own. At the same time, the strategy of ‘distancing’ allowed participants to minimise the impact of *incompatible expectations* by either avoiding their sources or dismissing the influence of their disagreement and opposition to breastfeeding or weaning decisions.

Movement through the three phases of *constructing compatibility by adapting focus* was not linear. Participants moved back and forth from *shifting focus* and *selective focusing*. When confronted with ongoing *incompatible expectations* from different sources during their breastfeeding and weaning experiences, these mothers re-examined, clarified, and occasionally modified their expectations. This clarification assisted participants to take charge of their decisions and select an option compatible with their current expectations. Having made a decision, mothers then proceeded to utilise the strategies of ‘embracing’ and ‘distancing’ from the phase of *selective focusing* to cultivate a support network that accepted and reinforced their decisions.

Once these mothers had completed weaning their child from the breast, they resolved breastfeeding decisions in phase three of the process of *constructing compatibility by adapting focus*, entitled *confirming focus*. This phase involved participants resolving or becoming settled with their breastfeeding and weaning experience by verifying that their focus achieved the desired compatibility and acknowledgement of their mothering efforts. Two strategies were used. Participants ‘rationalised their decisions’ by reflecting on the positive outcomes for their children, family, and themselves. Finally, the strategy of ‘acknowledging feelings’ allowed mothers to express their mixed feelings of loss, sadness, relief, joy, pride, and accomplishment. The consequences of using the strategies in the phase of *confirming focus* assisted participants to let go of their breastfeeding role, establish a positive mothering image, and encourage readiness to move onto the next stage of mothering.

Constructing Compatibility: A Comparison with Existing Literature

The proposed theory of *constructing compatibility by adapting focus* offers a significant contribution to the body of knowledge specific to breastfeeding and weaning. A review of the literature did not reveal any theory that resembled these findings. However, there are a number of theories within nursing and the social science literature that suggest propositions that lend support to the findings of this grounded theory study.

Consequently, the theory of *constructing compatibility by adapting focus* will be discussed and compared to recent research studies in the areas of breastfeeding and mothering. Additionally, similarities between the findings of this theory and aspects of five nursing theories, the theory of cognitive dissonance, social cognitive theory, and the health belief model are presented.

The substantive theory of *constructing compatibility by adapting focus* is compared to several nursing theories that contain similarities in their assumptions and propositions to this proposed theory. Callista Roy's Adaptation Model (Phillips et al., 1998; Wesley, 1995), Ramona Mercer's Maternal Role Attainment Theory (Mercer, 1995; Meighan, Bee, Legge & Oetting, 1998; Wesley, 1995), Rosemarie Parse's Human Becoming Theory (Bunting, 1993; Hickman, 1998, Pickrell, Lee, Schumacher & Twigg, 1998; Wesley, 1995), Imogene King's Goal Attainment Theory (George, 1998, Sieloff et al., 1998, Wesley, 1995), and Joan Riehl-Sisca's Interaction Model (Aggleton & Chalmers, 1989; Bell et al., 1998; Riehl-Sisca, 1989) are all discussed briefly to compare relevant aspects of these theories to the theory of *constructing compatibility by adapting focus*.

Early cognitive dissonance theorists such as Festinger (1957) asserted that discrepancies between behaviours and beliefs resulted in psychological discomfort that motivated people to initiate activities to reduce that dissonance. Particular aspects of cognitive dissonance are discussed in relation to the basic social problem of *incompatible expectations*. Bandura's (1986) social-cognitive theory proposed key characteristics of an individual that involved outcome expectations, expectancies, self-efficacy, and skills. "Reciprocal determinism" involved constant interaction between these individual characteristics, the person's behaviour, and the environment (Baranowski, 1997, p. 180).

Selected aspects of social cognitive theory are compared to the process of *constructing compatibility by adapting focus*. The Health Belief Model was developed in the 1950's and 1960's by American Public Health Service investigators influenced by the work of Kurt Lewin while working on applied research problems (Rosenstock, 1974).

Foundations of the Health Belief Model were based upon assumptions that an individual's life was composed of positive, negative, and neutral values. An individual's daily activities were regarded as a process of "being pulled by positive forces and repelled by negative forces" (Rosenstock, 1974, p. 2). The process described within the Health Belief Model is discussed in relation to the dilemma of *incompatible expectations* and how participants in this study adapted to this problem.

Breastfeeding Literature

Whereas no theories were identified within the breastfeeding literature that resembled the theory of *constructing compatibility by adapting focus* proposed in this research, certain aspects were found in the work of others that supported this study's findings. Although not always easy to achieve, Locklin (1995) found that a successful breastfeeding experience had an empowering influence on women when a supportive network acknowledged their efforts. Seventeen educated, low-income, culturally diverse American women supported by peer counsellors were interviewed regarding their breastfeeding experience. Using the constant comparative analysis, five themes were identified: 'making the discovery', 'seeking a connection', 'comforting each other', 'becoming empowered', and 'telling the world'. The theme of 'making the discovery' demonstrates similarities with the first phase of *shifting focus* in the process of *constructing compatibility by adapting focus* where participants developed confidence and trust in their own judgement and abilities. 'Making the discovery' involved a learning process whereby women's knowledge, self-confidence, and personal satisfaction increased as ongoing assessments and problem solving assisted them to understand breastfeeding. Aspects of 'seeking a connection' and 'becoming empowered' support the second phase of *selective focusing* where participants in this study, having clarified their expectations and goals, cultivated a supportive network by 'embracing' compatible support and 'distancing' themselves from opposition. 'Seeking a connection' recognised the importance of informal and formal support and 'becoming

empowered' involved women confidently asserting their own judgements rather than relying upon the suggestions of others. Lastly, having achieved a sense of empowerment through breastfeeding, women in Locklin's study (1995) shared their success by 'telling the world' of their breastfeeding accomplishments. 'Telling the world' supports statements made by participants in the current study, where they actively sought compatibility and created a network of sympathetic people who acknowledged and supported their breastfeeding and mothering efforts and decisions. Thus, although similarities were evident with Locklin's findings, this Western Australian theory further identified and articulated in detail the entire process of breastfeeding and weaning management including the final phase of *confirming focus* and more significantly, how this process evolved in response to the common problem of *incompatible expectations*.

Another Australian study reported findings in relation to breastfeeding that are relevant to this current research. All participants in this current Western Australian study expressed some degree of distress during their breastfeeding. These feelings were reflected as confusion, self-doubt, and guilt when the reality of their experience differed from what was anticipated due to *incompatible expectations* from their child or other significant sources such as partners, family members, health professionals, or society. Participants responded to this distress by initiating the process of *constructing compatibility by adapting focus*. Schmied and Barclay (1999) explored breastfeeding from the perspective of 25 women undergoing their first mothering experience. Mothers in that study revealed that breastfeeding was an embodied or non-discursive experience (Schmied & Barclay, 1999). Thirty-five percent of these mothers felt breastfeeding was a connected, harmonious, and intimate embodiment offering intimacy, sensuality, pleasure, reward, confidence, and harmony. However, 40 percent experienced mixed feelings due to the ambiguities and contradictions between their realities and pro breastfeeding declarations (Schmied & Barclay, 1999, p. 329). The remaining 25 percent of women described their breastfeeding as disappointing and distressing. It is noteworthy that while 65 percent of these 25 women described their breastfeeding experience as disrupted, distorted, and disconnected, 18 or 72 percent of them were still breastfeeding at six months. Persistence demonstrated in the presence of difficulties could indicate the importance and meaning breastfeeding held for these

particular women. Women in Schmied and Barclay's (1999) study regarded breastfeeding to be central to their mothering identity as it represented good mothering. These statements support the current study's findings, as the Western Australian mothers did not regard expectations for mothering, breastfeeding, or weaning as being discrete entities. They regarded breastfeeding as a demonstration of good mothering and evaluated their efforts with that assumption in mind.

This study has highlighted the reality of societal expectations within the Western Australian context as well as the significant impact these expectations have upon breastfeeding mothers. Other studies have begun to unravel the diverse beliefs and expectations different societies place upon breastfeeding women. In a New Zealand study undertaken by Vogel and Mitchell (1998) focus interviews with a variety of mothers and health professionals revealed common themes for both groups. New Zealand mothers overwhelmingly felt they lived in a strong breastfeeding culture and felt disapproval toward bottlefeeding. In contrast, health professionals expressed a range of opinions that acknowledged this pressure to breastfeed but also noted an opposite viewpoint that regarded the dominant culture in New Zealand as promoting bottlefeeding. Findings from British and American researchers have also identified "hostile" social environments to breastfeeding (Malik & Cutting, 1998, p. 1548) and acknowledged the impact of women's social environment upon their breastfeeding decisions (Abramson, 1992; Bick et al., 1998; Morrow & Barraclough, 1994; Wylie & Verber, 1994).

Current attitudes toward breastfeeding that have been recently studied in Australia are presented to demonstrate their agreement with this study's findings. Participant's perceptions of society's expectations regarding breastfeeding in public were generally supported in another Western Australian study (Scott, Binns & Arnold, 1997). At the same time, participants in this study did not always experience the tolerance of breastfeeding in public as noted in Scott et al.'s (1997) study. A series of focus groups were conducted to identify societal attitudes to breastfeeding in Perth. Opinions were sought from a range of different groups, such as parents of small children, male university students, adolescent girls, and members of the Nursing Mothers Association of Australia (NMAA). Although Perth could be regarded as a supportive environment

to breastfeed given initiation rates of 83.8 percent, two of the major themes revealed in Scott's et al.'s (1997) study addressed the issue of breastfeeding in public. Findings revealed that Western Australians generally felt breastfeeding in public was acceptable provided it was carried out discretely, in other words with a minimum of breast exposure. Some participants in this current study did experience this tolerance with public breastfeeding; however, others were confronted by people who were not supportive of this practice. Interestingly, Scott et al.'s sample consisted of younger adults whereas participants in the current study often experienced opposition to public breastfeeding from adults who were from an earlier generation.

Additionally, the second theme identified in Scott et al.'s (1997) study focused upon the provision of appropriate facilities to enable mothers to breastfeed in private which supports the findings of this study as participants highlighted the dilemma of trying to find suitable places to breastfeed while in public. Themes from Scott et al.'s (1997) study supported the prevailing image of the breast being a sexual object rather demonstrating acceptance and recognition of its nurturing function during breastfeeding. Incongruity between the two roles, sexual versus nurturing, was especially noted by the male university students and adolescents girls (Scott et al., 1997, p. 247). Comments regarding the appropriate duration of breastfeeding revealed that many participants in this study felt that once able to walk, a toddler demonstrated an awareness that indicated the child was too old to be breastfed. In support of this finding, developmental age was also noted to construct a "culturally approved age" for appropriate breastfeeding duration by Scott et al. (1997, p. 248).

The reality of social expectations for breastfeeding management was not limited to the Western Australian context explored in this research; other Australian studies support these findings. Attitudes to breastfeeding in public were surveyed from service providers such as restaurant and shopping center managers (Fray, nd; McIntyre et al. 1999b). Although 80 percent didn't mind if women breastfed, these New South Wales participants did place conditions upon acceptance of this practice depending upon expected discreetness and age limits for children beyond one year of age (Fray, nd). Additionally, participants in this study noted that expectations regarding the management of their breastfeeding changed as the growing child reached particular

developmental milestones or acceptable strategies to ensure discreetness were employed. McIntyre et al.'s (1999b) South Australian study also found such variability in support for breastfeeding, which continues to create uncertainty for breastfeeding mothers.

Further studies focusing upon barriers to breastfeeding have supported the finding of *incompatible expectations* in relation to managing breastfeeding in public. McIntyre, Hiller and Turnbull (1999a) utilised focus group interviews with young women, expectant parents, parents, and grandmothers in a low socio-economic area in South Australia (McIntyre, Hiller & Turnbull, 1999a). Members of this South Australian sample were not as tolerant of breastfeeding in public due to embarrassment concerns, which is similar to the reality some participants in this Western Australian study experienced. Moreover, the South Australian fathers were not as supportive of their partner's breastfeeding in public as the sample surveyed in Scott et al.'s (1997) Western Australian study. McIntyre et al. (1999a) concluded that a supportive environment for breastfeeding was not being achieved in lower socio-economic areas. This trend may also be occurring in other Australian states; however the Western Australian study by Scott et al. (1997) did not specify demographic details such as socio-economic status and therefore this conclusion could not be confirmed. In this current study, only 19 of the 33 participants lived in households where the annual income was greater than \$40,000. Although the Western Australian participants perceived a strong pressure to initiate breastfeeding, this study illustrates how ongoing support was a complex issue influenced by beliefs and knowledge that impacted the development of expectations rather than influenced solely by socio-economic factors.

Further support regarding the problem of *incompatible expectations* in relation to breastfeeding in public was found within the international literature. Fifty-one American women shared how they experienced and negotiated the act of breastfeeding in the presence of others (Stearns, 1999). Categories identified in the data included: 'the practice of discretion', 'location', 'the male gaze', 'redefining the breast', 'extended breastfeeding', 'code words', 'medical authority', and 'breastfeeding over time'. These American women were aware that breastfeeding in public could result in negative feedback and, within the American context, the possibility of legal action. Therefore,

practicing discretion was particularly important to these American women. Discovering a suitable location to breastfeed in public involved the necessity of avoiding some places and claiming other spaces. These strategies of avoiding and claiming have similarities to those of 'embracing' and 'distancing' described in the phase of *selective focusing* in this study where participants sought compatible support while distancing themselves from opposition. These Western Australian participants' concern with breastfeeding in the presence of males was also supported in Stearn's (1999) study as American women expressed similar concerns due to societal sexual connotations.

The presence of *incompatible expectations* was suggested although not overtly expressed within the context of Stearn's (1999) American study. The American women in that study also used recent medical research to justify continuing breastfeeding and resist cultural pressures to wean. Ironically, many older friends and relatives of these women had received opposing advice regarding infant feeding in previous years and continued to base their expectations upon their own outdated practices. Stearn (1999) concluded that as confidence and competence with breastfeeding developed over time, these American women reported changes in themselves that assisted them to feel more comfortable with their bodies and breastfeeding. This increased comfort also allowed them to breastfeed longer with subsequent children. The actual process these American mothers implemented to accomplish their expectations and goals was not explored in Stearn's (1999) study and highlights the unique contribution of this current study in exploring this previously unknown social process.

Although similarities were noted between this study and Stearn's (1999) research, there were some differences. The American mothers who chose to breastfeed long-term used code or secret words that allowed them to talk about breastfeeding with their children while avoiding the risk of public reactions (Stearn, 1999). In this current Western Australian study, no participants mentioned the use of special or secret words to describe their breastfeeding. This is noteworthy considering the mean age of weaning was 11 months with nine mothers breastfeeding well into or beyond the second year of their children's lives.

The significant impact of the breastfeeding woman's partner in her breastfeeding and weaning management was revealed and outlined throughout the theory of *constructing compatibility by adapting focus*. Not only did partners influence women's expectations but they were a significant source of *incompatible expectations* in relation to the handling of breastfeeding in public. International research has supported these findings revealing that fathers were not always comfortable with their partners breastfeeding in public. A British study by Voss, Finnis and Manners (1993, p. 176) revealed that fathers did not mind their partners breastfeeding in front of family or friends but did not like them feeding in front of strangers (42%) or in a public place (50%). American fathers in Stearn's (1999) study expressed concern with their partner's public exposure during this act. Freed, Fraley and Schanler's (1992) findings from their study show that the majority of their sample of 268 American men believed it was not acceptable for their partners to breastfeed in public. Moreover, only 58 percent of these men preferred their partner's decision to breastfeed (Freed et al., 1993). In contrast, all partners of participants in this current study were supportive of breastfeeding and assisted their spouses to initiate breastfeeding. The initiation rates of these American studies (Freed et al., 1992; Stearn, 1999) were similar to the national American initiation rate of 59 percent (Ryan, 1997). When compared to Australian initiation rates of between 80 to 89 percent (Bartlett & Pennebaker, 1990; Stamp & Crowther, 1995) they highlight how findings must be considered within cultural contexts that reflect different norms and practices.

Incompatible expectations resulted in participants in this study experiencing feelings of confusion, self-doubt, and guilt. The issue of guilt in relation to breastfeeding has been recognised and widely discussed in the literature (Black, 1993; Dettwyler, 1997; Newman, 1997; Wight, 1995b). However feelings of confusion and self-doubt associated with infant feeding have not been explored and illustrates the unique contribution of this theory of breastfeeding and weaning management. No research was found that specifically examined the phenomenon of guilt in relation to breastfeeding or its impact upon mothers' decision-making. All participants in this current study expressed the term guilt at some point when discussing the common problem of *incompatible expectations*, although the degree of guilt experienced varied. Health professionals have been cautioned by Black (1993) not to induce guilt and potentially

“sour” a mother-child relationship when dealing with women who choose not to breastfeed (p. 193). Other authors have argued that there is nothing wrong with guilt (Dettwyler, 1997; Wight, 1995b). The promotion of what is best for infants was regarded as the important issue. A rational adult would not choose illness over health and therefore, “let the guilt fall where it may” (Wight, 1995b, p. 2). Guilt has also been acknowledged as a “powerful and legitimate motivator” in health advertising when behaviours were accepted and recognised as dangerous, illegal, and uncommon (Dettwyler, 1997, p. 51). This argument assumes that formula feeding must be dangerous, illegal, or uncommon. Within the Western Australian context, formula feeding was not illegal and although 83.8 percent of women initiate breastfeeding (Scott et al., 1997), that rate decreases to 61.8 percent and 49.9 percent at three and six months respectively (Scott et al., 1999). Although all participants in this Western Australian study breastfed, many of these mothers also offered formula to either complement or supplement their breastfeeding at some time. This finding raises the issue of whether formula feeding was recognised by these Western Australian mothers as the dangerous option suggested by the literature (Dettwyler, 1997; Walker, 1993). Participants certainly considered formula to be less than ideal to breast milk but still considered it to be safe.

The maternocentric model proposed by McDade and Worthman (1998) was discussed briefly in Chapter One in the review of literature relevant to weaning. This model suggested that the timing of supplementation was influenced by the determination of maternal burden. The benefits of and supports for breastfeeding were weighed against perceived constraints to produce a margin of depletion (Figure 2, p. 7). These benefits and constraints were affected by ideology, social, and physical ecology and political factors. Participants in this current study identified the presence of *incompatible expectations* as being a constraint on their performance of breastfeeding. The ideology of personal beliefs and expectations and social presence of other sources of expectations impacted upon mothers’ subjective interpretation of benefits, constraints, and support in their decision making. The reality of *incompatible expectations* could be regarded as a maternal burden. The maternocentric model by McDade and Worthman (1998) provides an important recognition and acknowledgement of factors that influence mothers’ management of their breastfeeding and subsequent weaning decisions.

Mothering Literature

Participants in this study viewed breastfeeding as an important component of their mothering role. As early as 1988, findings from Virden's (1988) study regarding infant feeding and maternal role adjustment indicated that American breastfeeding mothers at one month postpartum experienced less anxiety and more mutuality with their children compared to their bottlefeeding compatriots. Virden suggested that the close physical interactions afforded through breastfeeding provided mothers the opportunity to learn their children's behavioural cues and thereby facilitated maternal role adjustment. Essentially, the continual, reciprocal relationship where the mother learnt to interpret infant cues and the child learnt that breasts provided nourishment fostered the transition to parenthood and fulfillment of the maternal role (Biancuzzo, 1999).

Participants in this Western Australian study found it difficult to separate expectations regarding breastfeeding and weaning from mothering. These related expectations were interconnected as success or failure in the management of breastfeeding reflected upon their perceptions of mothering competencies. *Incompatible expectations* arose when participants experienced conflict between their expectations and the expectations of others. First-time mothers, in particular, felt they had not been prepared for the possibility of experiencing *incompatible expectations*. Early motherhood has recently been examined through the experiences of 79 first-time Australian mothers (McVeigh, 1997). This multicultural population of Australian women offered written comments that were analysed to determine recurring themes or categories. The major category identified, entitled 'conspiracy of silence', revealed women's perceptions that the realities of motherhood were often concealed. Participants in Barlow and Cairn's (1997) Canadian study that explored the psychological experience of mothering also stated that women were "reluctant to voice the negative aspects of their experiences because such a discussion undermined one of their few legitimate roles" (p. 245).

This finding of first-time mothers feeling unprepared for motherhood has also been debated in the Australian lay literature, which questioned the openness and honesty in the sharing of information and expectations between women. Maushart (1997) referred to a mask of motherhood where women were comfortable talking about the joys and

positive aspects of motherhood but feelings of sorrow, anger, frustration, pain, and confusion were hidden. She suggested that by clinging to this mask, women were minimising or ignoring the scope of commitment that mothering and important tasks like breastfeeding actually required. “By refusing to tell what we know, to share what we have learned, we increase our arrogance (if we succeed) and our guilt (if we fail) at the same time as we diminish our chances for wisdom” (Maushart, 1997, p. 205).

Participants’ expectation of wanting to be recognised as a good mother was a key finding of this Western Australian study. Participants wanted their performance of breastfeeding and weaning acknowledged as positive efforts towards their mothering accomplishments. Consequently, in the final phase of *confirming focus*, participants focused upon the positive outcomes of their breastfeeding and weaning efforts to reinforce this desired positive mothering image. The need to attain this mothering image may contribute to the conspiracy of silence discussed previously, as admission of negative aspects could contradict the desired recognition of being a good mother. Although authors (Barlow & Cairns, 1997; Bundrock, 1995; Weaver & Ussher, 1997) have argued against the perpetuation of unattainable myths relating to mothering, these myths continue to prevail as revealed by participants’ expectations. Gross (1996) argued against a universal model of what made good parents. She highlighted the complexities of quality parenting that required cultural sensitivity, understanding of child rearing within differing contexts, selection of strategies consistent with parental goals and, finally, an appreciation of the resources available to parents.

The stories shared by the Western Australian participants in this study, particularly by those who were first-time mothers were further supported in other categories revealed in McVeigh’s (1997) Australian study. These categories were similar to the findings of this study and addressed women’s feelings of being unprepared for the unrelenting demands of infant care, their experiences of extraordinary fatigue, their loss of personal time and space, the realities of 24-hour infant care, and the acknowledgement that their partner’s support during the early weeks was indispensable. Although experienced mothers in the current study did not experience the same feelings of being unprepared and were more confident in their abilities, they did acknowledge that each breastfeeding

experience was unique and that unanticipated expectations meant the management of each experience was a new challenge.

Further support for the theory of *constructing compatibility by adapting focus* was noted in research undertaken within Australia by Rogan et al. (1997) that produced a new theory of early motherhood. 'Becoming a mother' evolved from a grounded theory analysis of the experience of 55 first-time mothers derived from the analysis of nine focus group interviews. The core category, 'becoming a mother', epitomized the process of change women experienced in this transition. Six categories encompassed this process: 'realising', 'readiness', 'drained', 'aloneness', 'loss', and 'working it out'. Mothers progressed from a phase where they felt their life was not theirs anymore to being "in a certain tune" with their baby (Rogan et al., 1997, p. 881). The process of 'becoming a mother' was influenced by factors such as the child's behaviour, the available social support, and the mother's previous experience. Participants in this Western Australian study noted how their child's behaviour presented *incompatible expectations* that had to be dealt with. Interpretations of the child's reactions were an important condition that influenced the degree of confusion, self-doubt, and guilt participants faced when dealing with these *incompatible expectations*. The second factor of available social support found by Rogan et al. (1997) strongly supported the importance of the Western Australian mothers in this study placed upon such support. These participants actively sought specific sources to create a compatible network that supported their expectations and decisions during the management of their breastfeeding and weaning experiences. The final factor of mother's previous experience identified by Rogan et al. (1997) was also found to support this study findings, which revealed how mothers' expectations were influenced by their breastfeeding beliefs and knowledge.

Findings from the previously discussed Australian study (McVeigh, 1997) that highlighted the perceptions of being unprepared for the realities of fatigue and personal loss associated with motherhood also supported the categories of 'realising', 'being unready', 'drained', and 'loss' identified in Rogan et al.'s (1997) study. However, Rogan et al.'s (1997) grounded theory of 'becoming a mother' offered greater understanding of the conditions, interactions, and consequences that occurred during this process. The category of 'working it out' and the presentation of a conditional

matrix identifying influencing factors in this process of ‘becoming a mother’ provided the theory with explanatory power beyond simple identification and description of major themes. This current theory of *constructing compatibility by adapting focus* further added to that understanding of mothering within the context of Western Australian and the substantive area of breastfeeding and weaning. The basic process of *constructing compatibility by adapting focus* revealed how participants ‘worked out’ the management of their breastfeeding and weaning experience to enable them to create a supportive network, establish a positive mothering image, and move on to the next stage of mothering.

The basic social problem of *incompatible expectations* identified in this study is further supported in literature that debates academic issues. To illustrate, Bundrock (1995) examined changing ideas of maternity and work in Australian public policy, popular ideology, and health services to reveal the existence of conflicting meanings of the “mother as passive dependent versus mother as active worker” (p. 21). In her scholarly discussion, Bundrock (1995) suggested there are three conflicting ideologies of motherhood. The instrumental ideology asserted that mothers were expected to do what experts told them. These attitudes originated in the 1920’s with the medicalisation of maternity care. Participants in this study demonstrated the impact of this ideology still being present today. The influence of health professionals as the recognised experts was noted in how participants utilised these resources to develop and modify their expectations. Participants anticipated that experts would provide consistent up-to-date information but when their reality conflicted with these expectations, mothers experienced confusion. The credibility of these expert sources of information was questioned and, in some cases, diminished or lost.

The second ideology according to Bundrock (1995) portrayed mothers as martyrs who sacrificed themselves for the sake of others. Participants in this study also reinforced this ideology in their expectations of mothering involving self-sacrifice. The final ideology represented the heroic image of motherhood, where difficulties were viewed as obstacles that women strove to overcome. While sharing their breastfeeding and weaning experiences, participants expressed numerous examples of persistence in the presence of problems. The degree of persistence was often dependent upon the unique

meaning that participants placed upon accomplishing particular goals and expectations. Bundrock (1995) discussed how these understandings of motherhood have been concealed by the economic concept of dependency that consistently treated paid work as more important than the unpaid work of child rearing. She further argued that the effort of breastfeeding illustrated the inappropriateness of distinguishing women as passive or active workers based upon economic dependency. She claimed that women as mothers are workers and acknowledgement of this fact can contribute to a positive sense of self within each woman's identity.

A review of the international research on women's perceptions of motherhood has also revealed evidence to support the findings of this Western Australian study. Two groups of American women completed a survey that examined their current values, health habits, and household and child-rearing activities (DeMeis & Perkins, 1996). Sixty-four full time homemaker mothers and thirty-four full time employed mothers participated in the survey. The findings revealed that being a mother involved the same household duties, regardless of the woman's employment status. However, homemakers were found to have higher expectations for mothering to help legitimise their choice to remain at home. Additionally, lower expectations for employed women justified their choice to pursue paid employment outside the home. Most importantly, all women had a vested interest in maintaining their image of mothering. These findings contain similarities to the findings of this Western Australian study, where mothers utilised the process of *constructing compatibility by adapting focus* to cultivate a supportive network with compatible expectations that would acknowledge their breastfeeding and mothering efforts and reinforce their desired positive mothering image. By defining motherhood in terms of their individual situation, women in DeMeis and Perkin's (1996) study positively reinforced their efforts and accomplishments in support of their expectations.

Two Canadian studies have also revealed interesting similarities and differences from the findings of this study. A phenomenological, feminist approach was used to explore the experience of self-definition for women who were mothers (Hartrick, 1997). Seven Caucasian women participated in in-depth and focus group interviews to share their experience of motherhood. Three elements of self-definition emerged from the data:

‘nonreflective doing’, ‘living in the shadows’, and ‘reclaiming and discovering self’. Themes from Hartrick’s (1997) study endorsed the problem of *incompatible expectations* perceived by participants in this current study and acknowledged their subsequent confusion and guilt. ‘Nonreflective doing’ involved performing a role modeled by other people and temporarily accepting this façade without question. When the resulting confusion or turmoil became overwhelming, participants began ‘living in the shadows’ as their secure foundation deteriorated. These Canadian women described reaching a transition point where their basis for mothering decisions was questioned and change was deemed necessary. Finally, the women began the process of ‘reclaiming and discovery’ to take control of their individual situation and “author their own lives” (Hartrick, 1997, p. 272). This process of self-definition fostered active participation and empowerment for these women’s lives. The theme of ‘reclaiming and discovery’ supports aspects of the phase of *shifting focus* in the proposed theory where participants took charge of their breastfeeding and weaning experience by clarifying their expectations thus fostering a growing confidence in their own judgements and abilities.

The second Canadian study by Barlow and Cairns (1997) utilised the grounded theory method to examine the psychological processes 11 women experienced as they progressed from childlessness through the first twelve years of being a mother. Although that Canadian study acknowledged the impact of societal expectations upon women it did not reveal women’s own expectations or the reality and significance of opposition between differing expectations unveiled in this current Australian study. The core category in Barlow and Cairn’s (1997) study was titled ‘expansion of self’ and included two major categories of ‘engagement’ and ‘immersion’. The first category of ‘engagement’ coincided with the first year of mothering and included four themes: ‘establishing the intention to mother’; ‘encountering ghosts of mothering received’, ‘committing to new life circumstances’; and ‘engaging in the process of self-socialisation’. Acceptance of societal expectations was reported as influencing the commitment to life circumstances and women in Barlow and Cairn’s (1997) study expressed being unprepared for the intensity of this commitment, which endorses the experience of the Western Australian participants.

The final theme, ‘engaging in the process of self-socialisation’, that emerged in Barlow and Cairns’s (1997) study revealed aspects similar to the phase *selective focusing*. The majority of participants in that Canadian study discovered traditional beliefs regarding child rearing that were incompatible with their own value systems. In response to this situation, these women turned to contemporaries for direction and support and were also discerning in what information they chose to accept (Barlow & Cairns, 1997, p. 239). This “sifting, sorting and evaluating” response was similar to the strategies of ‘embracing’ and ‘distancing’ outlined in *selective focusing*. Conclusions presented from the Canadian study promoted recognising mothers as experts of their unique experiences and assisting them to realise the impact of societal pressures upon their decisions. The final recommendation by Barlow and Cairns (1997) challenged enduring mothering myths with the potential to cause undue guilt and confusion, two of the key emotions these Western Australian participants experienced due to their exposure to *incompatible expectations*.

Several Australian and international studies have been compared to the theory of *constructing compatibility by adapting focus* and similarities have been noted regarding selective aspects of these studies. However, the unique contribution of this theory is demonstrated in its detailed presentation of *incompatible expectations*, the consequences of this problem upon breastfeeding mothers, and the conditions influencing these consequences. An understanding of the process mothers adopt in response *incompatible expectations* provides valuable insight to women, health professionals, and societies who want to support breastfeeding.

Nursing Theories

Five contemporary nursing theories are discussed and compared to the theory of *constructing compatibility by adapting focus* presented in this Western Australian study. Sister Callista Roy’s Adaption Model, Ramona Mercer’s Theory of Maternal Role Attainment, Rosemarie Parse’s Theory of Human Becoming, Imogene King’s Goal Attainment Theory, and Joan Riehl-Sisca’s Interaction Model all have aspects in their work that support the proposed theory outlining how Western Australian mothers managed their breastfeeding and weaning experiences.

Roy's Adaptation Model.

Roy's Adaptation Model viewed the person as an adaptive system composed of coping mechanisms (Andrew & Roy, 1986; Galbreath, 1998; Phillips et al., 1998; Wesley, 1995). The adaptation level involved a constantly changing point representing the person's own standard range of stimuli that is responded to with individual adaptive responses. Participants in this Western Australian study were confronted with the problem of *incompatible expectations* during their breastfeeding and weaning experience. Mothers expressed feelings of confusion, self-doubt, and guilt in response to these expectations. These feelings were dynamic and once mothers perceived this changing point as going beyond their accepted standard range of stimuli, they responded with adaptive responses.

Adaptive responses involved coping mechanisms that are acquired ways in which persons respond to their changing environment. These coping mechanisms are influenced by concepts such as role function, self-concept, physiological function, and interdependence. Role function focused upon the role the person occupies in society and in this current study involved the significant role of mothering. A role is a set of expectations (Phillips et al., 1998, p. 246) and the existence and impact of expectations related to breastfeeding, weaning, and mothering were key findings of this study. Self-concept involved the basic need for "psychic integrity", where the person is able to exist with a sense of unity (Wesley, 1995, p. 109). Participants wanted to achieve compatibility with their own expectations and the expectations of others. In order to achieve this goal, firstly they *shifted focus* to clarify and reinforce what was important to them. Secondly, they *selectively focused* upon compatible support by utilising strategies of 'embracing' and 'distancing'. *Confirming focus* provided affirmation that a degree of compatibility and integrity were achieved. This affirmation reinforced a mothering image that enhanced these mothers' perceptions of their self-concept. Within Roy's Model, interdependence focused upon interactions relating to receiving respect and value (Phillips, 1998). Affectional adequacy reinforced the importance of relationships with significant others within a support system. When participants in this study cultivated a compatible support network in the phase of *selective focusing*, they were able to achieve the respect and recognition desired to acknowledge their mothering

efforts. All participants achieved the output of an adaptive response, as outlined within Roy's Adaptation Model, by establishing a positive mothering image, although the actual movement through the process of *constructing compatibility by adapting focus* was a unique journey for each individual woman.

Mercer's Theory of Maternal Role Attainment.

Ramona Mercer proposed a Theory of Maternal Role Attainment that focused upon the mother's attachment to her infant (Mercer, 1995; Meighan et al., 1998; Wesley, 1995). She asserted a number of assumptions that can be related to findings within this Western Australian study. A core self acquired through socialisation determined how a mother defined and perceived her experience. The mother's perceptions of her infant and others' responses to her mothering were the reality which she responded to (Meighan et al., 1998, p. 411). These assumptions correlate strongly with the basic social problem of *incompatible expectations* derived from these findings. Participants perceived the presence of expectations from the child and significant others. They also acknowledged their own expectations. Mothers responded to the reality of *incompatible expectations*. When expectations were compatible with reality, participants proceeded with current strategies. When conflict emerged, mothers were then compelled to react.

A final assumption in the Theory of Maternal Role Attainment proposed that the infant's growth and development reflected the mother's competence in the mothering role (Meighan et al., 1998). The interaction of maternal and infant characteristics was regarded as an important aspect of integrating the self to achieve the maternal identity (Mercer, 1995). An interactive process occurred during this integration whereby each partner in the mother-child relationship affected the other through mood, temperament, or behaviour. This assumption supports the findings of this study as participants evaluated their ongoing breastfeeding and weaning decisions by interpreting their impact upon the child's behaviours. In the process of *constructing compatibility by adapting focus*, participants rationalised their decisions in the third phase of *confirming focus* by concentrating upon the positive outcomes for the child, themselves, and their family.

Maternal Role Attainment involved a process that includes four states of role acquisition (Mercer, 1995; Mēighan et al., 1998). Within the first two stages, the mother learnt the expectations of the role and was guided by the expectations of others within her social network. The third stage, known as Informal, involved the mother developing unique ways of dealing with the role not necessarily supported by her social network. Finally, in the Personal stage, the maternal role was achieved as the mother experienced confidence and competence in the manner in which she performed the role. The first two stages of Mercer's theory correlate positively with current findings where participants became intensely aware of the existence of expectations and their subsequent impact upon their management of their breastfeeding and weaning experiences. A question emerges as to why mothers in Mercer's theory went on to develop unique aspects to their mothering in the third stage? Were mothers responding to a problem of *incompatible expectations*? The phase of *shifting focus* where participants acknowledged and trusted their own judgements and subsequent phase of *confirming focus* in this study correlated with descriptions of this third Informal stage. The final phase of *confirming focus* adopted in the process of *constructing compatibility by adapting focus* has parallel aspects to Mercer's fourth Personal stage where the mother experiences harmony, confidence, and competence in her performance.

Parse's Theory of Human Becoming.

Rosemarie Parse developed a Theory entitled Human Becoming using the work of Carl Rogers (Bunting, 1993; Hickman, 1987; Pickrell et al., 1998; Parse, 1981; Wesley, 1995). In that theory, the key themes of 'meaning', 'rhythmicity', and 'cotranscendence' lead to the development of Human Becoming. Reality acquired meaning in response to lived experiences (Wesley, 1995). Individuals cocreated through imaging, valuing, and language to construct meaning of their situations by making choices (Bunting, 1993; Wesley, 1995). The emergence and significance of the expectations for the participants in this study was cocreated through the meaning that these mothers placed upon their expectations. The finding that breastfeeding, weaning, and mothering expectations were interrelated further clarified the constructed meanings of these tasks. Participants transformed their values and beliefs onto their chosen expectations. Humans convey meanings that were personal and reflected their dreams

and hopes (Hickman, 1998) or, as applied to this study, the expectations of breastfeeding, weaning and mothering. Parse offered the assumption that Human Becoming was “freely choosing personal meaning in situations in the intersubjective process of relating value priorities” (Pickrell et al., 1998, p. 467).

The second theme of ‘rhythmicity’ involved the “human and universe cocreating a universe in rhythmical patterns while simultaneously living with paradoxes of connecting-separating, enabling-limiting, and revealing-concealing” (Wesley, 1995, p. 130). The problem of *incompatible expectations* revealed that participants in this Western Australian study lived within the reality of a major paradox. Mothers adopted a process of *constructing compatibility by adapting focus* and during the second phase of *selective focusing* they utilised strategies comparable to ‘connecting-separating’. This rhythmical pattern of relating and distancing, enabled the person to focus on one aspect and simultaneously distance themselves from another (Wesley, 1995). The strategy of ‘embracing’ closely resembled the pattern of ‘connecting’ whereas the strategy of ‘distancing’ correlated closely with ‘separating’. The rhythmical pattern of ‘enabling-limiting’ further supported the strategies of ‘embracing’ and ‘distancing’. By making choices within the phase of *selective focusing*, participants were both enabled in that they found compatible support but were also limited and recognised that support from incompatible sources would not be forthcoming.

Parse’s third theme of ‘cotranscendence’ involved “powering unique ways of originating in the process of transforming” (Bunting, 1993, p. 19). The person constantly changed and transformed as their viewpoint shifted to illuminate new possibilities (Wesley, 1995). Participants in this Western Australian study also underwent a transformation by adapting their focus to respond to the presence of *incompatible expectations* in the management of their breastfeeding and weaning. In the phase of *shifting focus* participants clarified their goals and expectations and illuminated the possibility of altering their current focus. During the second phase of *selective focusing* they “energised forces” and selectively created the support they wanted (Wesley, 1995, p. 131). In the final phase of *confirming focus*, participants confirmed that their transformation constructed the compatibility needed to confirm their desired mothering image. Acknowledgement of the feelings experienced by

participants during this transformation was important for the resolution of their completed breastfeeding role. As Williams (1997) asserted, health professionals who work closely with breastfeeding women have an important role to fulfill in trying to “understand and support mothers’ emotional transitions into their own maternal identity” (p. 59). The comparison of Parse’s Theory of Human Becoming to *constructing compatibility by adapting focus* has demonstrated considerable support for this study’s findings and reinforces the applicability of her themes to the experience of managing breastfeeding and weaning within the Western Australian context.

King’s Goal Attainment Theory.

The theory of goal attainment described the nature of nurse-client interactions leading to the achievement of goals (George, 1998; King, 1981; Sieloff et al., 1998; Wesley, 1995). To illustrate, two people meet within a health care organisation to help and be helped achieve a state of health that fosters functioning within their specific social roles (George, 1998). King’s theory proposed that congruent role expectations and role performance between the nurse and client enhanced these transactions between people. Transactions that were purposeful interactions lead to goal attainment (Sieloff et al., 1998, p. 306).

Stress occurred within these transactions if the client, nurse, or both parties perceived any role conflict. This proposition supports the findings of this current study. When participants perceived *incompatible expectations* between themselves and health professionals, such as child health nurses or doctors, they experienced stress in the form of confusion, self-doubt, and guilt. Once these mothers began the process of *constructing compatibility by adapting focus* and clarified their own goals and expectations, they progressed to phase two of *selective focusing* where they actively chose to embrace or distance themselves from the influence of particular sources of support. As King’s theory indicated, within the process of interactions each member makes judgments that result in action and reaction (Sieloff et al., 1998). For example, participants who experienced incongruence in their expectations with health professionals often chose to distance themselves from these people. Some mothers continued to visit a health professional but dismissed advice that opposed their expectations whereas others chose not to return to their service and, thus, avoided

further confrontation. King's hypothesis that role conflict decreased transactions within nurse-patient interactions is supported in this study's findings (Sieloff et al., 1998).

King's theory further suggested that while incongruence decreased interactions, congruence within role expectations and role performance increased transactions within the nurse-client relationship (King, 1981; Sieloff et al., 1998). Within the phase of *selective focusing* this proposition was also demonstrated. Participants who perceived compatible expectations from another source, such as family members, friends, or health professionals, sought and welcomed those people into their support network.

Within King's open systems framework (Wesley, 1995), people were open systems that constantly interacted with their environment. Three systems, namely personal, interpersonal, and social, influenced the interactions. Perceptions drawn within the personal system influenced interpersonal communication and the resulting social system that evolved to include selective family members, friends, and health professionals. Cultivation of this social system correlated with an outcome of the process of *constructing compatibility by adapting focus* whereby these Western Australian mothers created a supportive network congruent with their own goals and expectations.

Riehl-Sisca's Interaction Model.

Joan Riehl-Sisca also developed an interactionist model of nursing (Aggleton & Chalmers, 1989; Bell et al., 1998; Riehl-Sisca, 1989). This Interaction Model was based upon the theory of symbolic interaction and suggested that people behave in a manner that is meaningful for them (Riehl-Sisca, 1989; Aggleton & Chalmers, 1989). People interpreted symbols and responded accordingly. As early as 1909, Cooley (cited in Aggleton & Chalmers, 1989) stated that "people actively build up understandings of themselves by imagining how others might see and judge them" (p. 404). Consequently, a key concept of this model suggested that people interpreted behaviour and understandings and adopted roles that were congruent with these interpretations. Interestingly, the findings of this study suggested that participants recognised that their decisions relating to breastfeeding and weaning would be judged by others, but rather than compromising personal expectations that held a significant meaning, they cultivated a congruent social network of people who acknowledged and supported their

decisions. Self-evaluation also has an important role within Riehl-Sisca's Interaction Model because it emphasised the importance of the patient's perception and understanding of their personal situation. In the case of this study, the situation reflected mothers' perceptions of their breastfeeding, weaning, and mothering competence based upon their personal interpretations.

According to Riehl-Sisca (1989), the self-concept was a "mirrored image of the self conveyed by others" (p. 387). People not only reacted to others' actions, but they interpreted those actions. In order to establish a positive self-concept specific to mothering, participants in this current study adapted their focus to cultivate compatibility between their expectations and the supportive network they created. In the final phase of *confirming focus*, these mothers interpreted their decisions utilising a strategy of 'rationalising'. By focusing upon the positive outcomes of their decisions, participants promoted a positive self-concept in relation to their mothering efforts. Riehl-Sisca (1989) also proposed management strategies for the use of the Interaction Model, which correlated positively with the process of *constructing compatibility by adapting focus*. These statements encouraged nurses to trust the patient's perspective and thereby supported the development of positive self-concept and confidence. These were also important concepts within *shifting focus*, phase one of *constructing compatibility by adapting focus*. Despite being confronted with *incompatible expectations*, these Western Australian mothers' actions fostered development of a positive mothering image which supports the premise within the Interaction Model that social action evolved through the individual's process of noting and interpreting (Bell et al., 1998).

Cognitive Dissonance

Leon Festinger presented his Theory of Cognitive Dissonance in 1957. He asserted that individuals strive toward consistency and in the presence of dissonance, which is psychologically uncomfortable, people become motivated to reduce the dissonance and achieve consonance (Festinger, 1957). A second hypothesis by Festinger suggested that in the presence of dissonance, people actively avoid situations and information likely to increase that dissonance. These hypotheses have been examined and supported in a number of research studies. Shaw, McCombs, Weaver and Hamm (1999) presented a

model of agenda melding to account for the role of the media in helping individuals move toward or away from groups. Groups were organised around agendas that represented ways of relating to the world. To reduce the dissonance of living in “intellectual isolation”, Shaw et al., (1999) proposed that individuals sought out the agendas of other supportive groups using mass media.

In another study that focused on social comparison in the context of apparel and beauty product advertisement, focus group interviews with American college women revealed dissonance with idealised images and unwanted social comparison (Lennon, Lillethun & Buckland, 1999). The findings of the focus group interviews revealed themes representing strategies women employed to reduce this perception of dissonance. In order to distance themselves from the images in the advertisements, these women selectively attended to specific advertisements by filtering others out. These findings suggested that women did not passively absorb harmful media images but were able to actively filter images and selectively attend to those that interested them (Lennon et al., 1999).

The presence of *incompatible expectations* revealed in this current Western Australian study is strongly supported by the propositions related to cognitive dissonance theory. The consequences of *incompatible expectations* upon the participants described as confusion, self-doubt, and guilt were undoubtedly psychologically uncomfortable. In response to the dissonance of these conflicting expectations, mothers adopted a process that attempted to achieve a degree of consonance in the management of their breastfeeding and weaning. In accordance with Festinger’s (1957) hypothesis, these Western Australian mothers actively avoided situations and information that would increase the dissonance by ‘distancing’ themselves from disagreement and opposition in *selective focusing*, the second phase of the basic social process identified in this study.

Cognitive dissonance has been further examined in relation to the mechanisms that influenced how people chose between strategies to reduce dissonance (Stone, Wiegand, Cooper & Aronson, 1997). Stone et al. (1997) suggested that psychological discomfort was reduced through direct or indirect strategies. Examples of direct strategies were: altering elements of discrepant cognitions such as changing one’s beliefs; making

compensations for unwanted behaviours; reducing the importance of an opposing expectation; or altering perceptions of circumstances that led to the discrepancy (Stone et al., 1997). In the context of this current study, participants utilised a number of direct strategies to reduce the impact of *incompatible expectations*. During the phase of *shifting focus*, participants clarified their expectations by modifying the relative importance assigned to aspects of their breastfeeding and weaning. Moreover, some participants modified expectations indicating a significant change in their beliefs.

Examples of indirect strategies involved redirecting the psychological discomfort to something other than the discrepancy or focusing upon other valued aspects of the self (Stone et al., 1997). Again, instances of these strategies were noted in the phase of *confirming focus*. Participants focused upon positive outcomes of their weaning decisions such as having more time for other family members, being able to work and contribute financially to the family, focusing upon other mothering achievements besides breastfeeding, and fostering a closer relationship between the child and other significant people.

Festinger (1957) also discussed the role of social support in relation to the Theory of Cognitive Dissonance. He suggested that one of the “most effective ways of eliminating dissonance is to discard one set of cognitive elements in favour of another, something which can sometimes only be accomplished if one can find others who agree with the cognitions one wishes to retain and maintain” (Festinger, 1957, p. 177). This assertion was supported in a recent study by Abraham (1999) who found that social support lessened the negative impact of emotional dissonance on organisational commitment within the workplace. The importance of social support was strongly evident in this current study where participants adopted the process of *constructing compatibility by adapting focus* to cultivate the supportive network these mothers desired for their breastfeeding and weaning. In phase two of *selective focusing*, participants actively sought and welcomed agreement and support from sources whose expectations were compatible with their own.

The reality of experiencing cognitive dissonance can not be ignored and strategies to reduce this dissonance have value beyond current conflicts. Cooper (1998) suggested

that learning to resolve dissonance was a way for people to deal with anxiety and emotional pain. The process of dealing with cognitions that resulted in unpleasant emotions was an essential part of an individual's development. The concept of congruence was examined in relation to self-concept, personal image, and purchase behaviour (Onkvisit & Shaw, 1987). In the conclusions drawn from that study, Onkvisit and Shaw (1987) argued that the basis of human activity was the protection, maintenance, and enhancement of the self-concept. Additionally, they reinforced the necessity of determining the importance of goals in providing the expected satisfaction. Although the focus of this research was on consumer marketing, these conclusions can be applied to this current study on breastfeeding and weaning management. Participants wanted to see themselves and be seen as good mothers in the performance of their breastfeeding and weaning behaviours. The presence of *incompatible expectations* necessitated implementation of a process to not only reduce this dissonance but to ensure participants were able to achieve their desired mothering image through the process of *constructing compatibility by adapting focus*.

Social Cognitive Theory

The Social Cognitive Theory proposed by Bandura (1986; 1997) involved a process of "reciprocal determinism" that described the interdependent interaction and influence between characteristics of the person, the person's behaviour, and the environment (Baranowski, 1997, p. 180). The characteristics of the person included outcome expectations, expectancies, self-efficacy, and skills. Outcome expectations and expectancies were regarded as motivation variables where the individual assessed results and consequences of particular behaviours. Baranowski (1997) offered a relevant example of outcome expectations relating to breastfeeding. He suggested that outcome expectations were helpful predictors of breastfeeding behaviours. For example, outcome expectations such as personal inconveniences and perceived benefits for the mother were important predictors for breastfeeding duration.

In Social Cognitive Theory, the concept of intention played an important role in how an individual regulated their behaviour (Bandura, 1986). Bandura (1986) defined intention as determination to achieve goals. In the current study, the participants presented their intentions as expectations or goals. Bandura (1986) asserted that when

individuals perceive discrepancies between what they planned to do in their goals and what they actually achieved, self-dissatisfaction resulted. This proposition was supported in this current study when, for example, participants perceived incompatibilities between their own expectations and the expectations of their child. The reality of not being able to achieve personal expectations and being confronted with opposition to those expectations from others resulted in mothers experiencing feelings of dissatisfaction represented as confusion, self-doubt, and guilt.

Self-efficacy was said to involve the person's confidence in having the skills not only to perform behaviours but have the competence to overcome any potential barriers (Bandura, 1986). Goals were deemed to be essential in the development of self-efficacy because reaching a goal builds self-efficacy. Not reaching a goal can be either motivating or disheartening depending upon the individual's perceptions of their abilities to achieve desired behaviours. The closer the individual came to reaching their goals, the greater the degree of positive reinforcement. Unrealistic goals often resulted in disappointment. According to Bandura (1986) repeated failure weakened self-efficacy and the motivation to perform the behaviour. In this current study, participants experienced *incompatible expectations* and in order to deal with their confusion, self-doubt, and guilt they re-examined their own expectations. This clarification process occurred during the phase of *shifting focus* and offered participants the opportunity to modify expectations that were perceived to be unattainable to goals that were within the mother's perceived self-efficacy and therefore attainable.

Bandura (1986) suggested that a greater degree of participation in goal setting intensified the commitment to goal attainment. Within the phase of *shifting focus*, participants were able to take charge of their experience by clarifying and reinforcing expectations and goals that were important to them. Participants set and reinforced their own expectations and acquired a conviction to trust their own judgments and abilities. This trust further accentuated their growing confidence in their abilities to achieve what they wanted for their breastfeeding and weaning experience. Participants then went on to cultivate the support and acknowledgement they wanted in the second phase of *selective focusing*. Bandura (1986) further argued that when goals were imposed by others, individuals do not necessarily accept them. Again, this proposition was

supported within the phase of *selective focusing*, when participants chose to distance themselves from sources opposed to their personal expectations.

Within Bandura's (1997) discussion of self-efficacy, he noted that uncertainty in important matters was unsettling to individuals who consequently selected and created environmental supports that contributed guidance to their lives (p. 2). Mothers in this Western Australian study created the environmental support they wanted through the process of *constructing compatibility by adapting focus*. Additionally, perceptions of self-efficacy were also said to be influenced by the personal value of the desired activity (Bandura, 1997). For instance, if individuals invested their self-worth in the activity, they would be particularly vulnerable to loss of self-esteem if they judged themselves as inefficacious in that activity. Participants in this current study viewed perceptions of success with breastfeeding and weaning as a positive reflection of their mothering abilities. Consequently, they perceived expectations regarding breastfeeding, weaning, and mothering to be interrelated because achievement or failure in one area impacted upon other areas. Finally, Bandura (1997) proposed the concept of freedom as the process of reflection where individuals exercised self-influence to bring about desired outcomes. In the phase of *confirming focus*, participants utilised a reflexive process to verify that their adapted focus achieved the compatibility they desired.

In a recent publication, Dennis (1999) demonstrated the applicability of the self-efficacy framework to understanding maternal confidence with breastfeeding. She asserted that women's breastfeeding decisions were influenced by performance accomplishments, vicarious experience, verbal persuasion, and inferences from physiological and affective states. Additionally, self-efficacy influenced breastfeeding behaviour in four areas: choice of behaviour, effort and persistence, thought patterns, and emotional reactions.

In the management of their breastfeeding and weaning experiences, participants in this study revealed findings that corroborate with aspects of this framework. Mother's expectations were influenced by their own beliefs and knowledge, molded by the impact of experts, past and current breastfeeding experiences, the experience of others, and their partners' input. These influences can be compared with the antecedent sources of information noted in the framework (Figure 13).

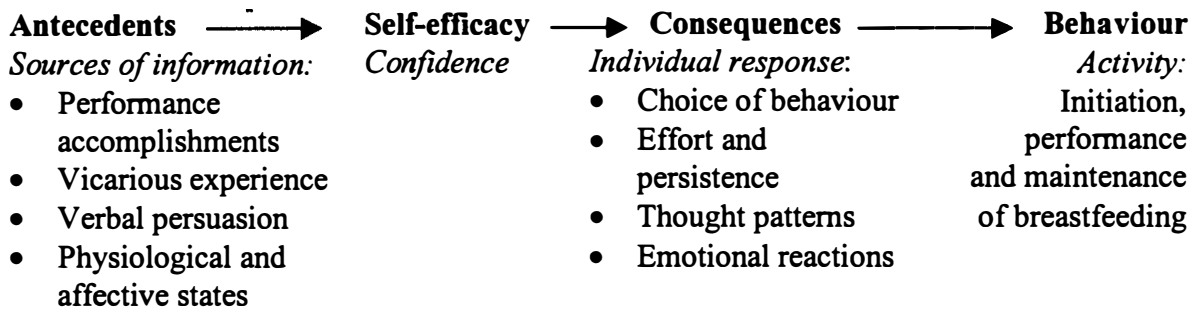


Figure 13: Self-efficacy framework applied to breastfeeding (Dennis, 1999, p. 197).

The self-efficacy framework can be applied to the findings of this study. For example, performance accomplishments involved participants' interpretation of their actual experiences. Vicarious experience referred to the impact of observing other individuals' performances or breastfeeding experiences upon the development of consequent expectations for women's own experiences. Verbal persuasion involved the acceptance of others' appraisals of mothers' abilities such as evaluations from health professionals, family members, and friends. Finally, participants made positive and negative inferences about their abilities from their physiological and affective states. For instance, satisfaction and acknowledgement enhanced confidence in their mothering abilities whereas unanticipated *incompatible expectations* from different sources led them to question their abilities and, consequently, interfered with the development of self-confidence.

Health Belief Model

The Health Belief Model developed in America during the 1950's and 1960's in response to a group of investigators' examination of a number of independent applied research problems (Rosenstock, 1974). The basis of the model was also influenced by the work of Kurt Lewin who proposed that an individual's life was composed of components, of which some were positive, negative, or neutral. Consequently, an individual's activities were viewed as a process of being "pulled by positive forces and repelled by negative forces" (Rosenstock, 1974, p. 2). The Health Belief Model has been used to explain health related behaviour, guide health behaviour interventions, and

direct the evaluation of chosen interventions (Strecher, Champion & Rosenstock, 1997). Key variables in the Health Belief Model are presented in Figure 14.

Within the Health Belief Model, behaviour changed if the individual felt threatened by their current behaviour and believed that a specific course of action would result in a perceived benefit (Rosenstock, 1974; Strecher et al., 1997). However, the individual's beliefs about various courses of actions and not the objective facts determined what decisions were made. Rosenstock (1974) also suggested that these beliefs were influenced by "the norms and pressures of his social groups" (p. 4).

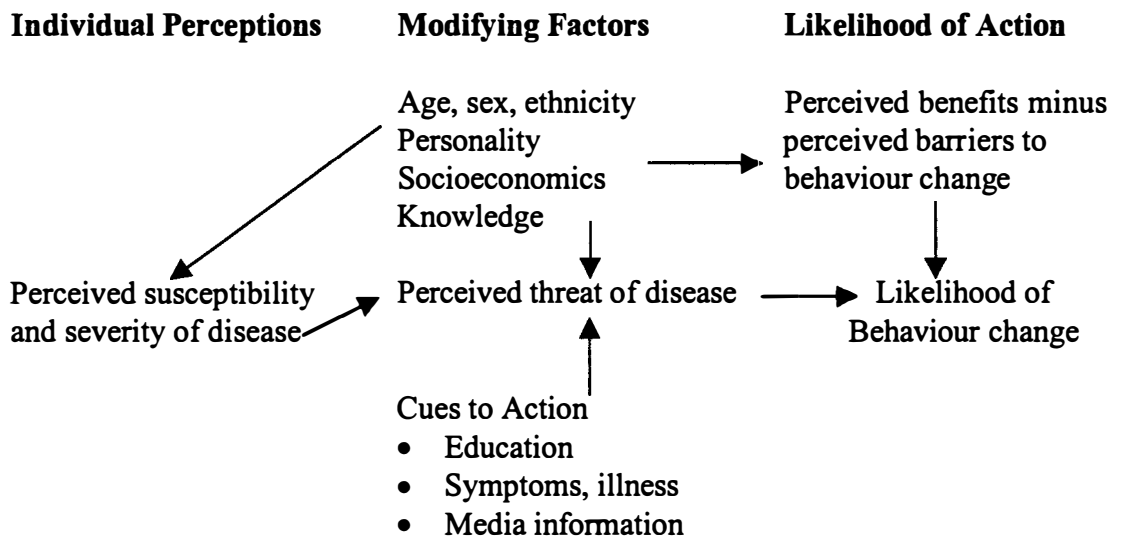


Figure 14: Key variables in Health Belief Model (Strecher et al., 1997, p. 71)

When comparing the Health Belief Model to this current study, it is apparent that participants were influenced by positive and negative forces (Rosenstock, 1974) during their management of their breastfeeding and weaning experience. The existence of *incompatible expectations* represented an example of the negative force, as mothers were faced with direct opposition to their own expectations and goals. At the same time, while engaged in the process of *constructing compatibility by adapting focus*, participants actively sought and welcomed perceived positive forces by utilising the strategy of 'embracing' in the phase entitled *selective focusing*.

The Health Belief Model can be applied to the decision making process participants undertook during *constructing compatibility by adapting focus*. When mothers perceived expectations to be compatible with their own views, they felt acknowledged and supported. However, when confronted with conflicting expectations, participants expressed this dilemma through feelings of confusion, self-doubt, and guilt. Participants evaluated the source and then decided whether or not to accept these opposing expectations. Participants assessed the perceived threat or potential outcome if they chose to accept or not accept specific expectations from different sources. The perceived credibility of the source was one factor that influenced how mothers interpreted these expectations. For example, participants who were advised not to offer a bottle of formula by a health professional, assessed the perceived threat of doing so based upon their knowledge level, past experience, and advice from family members or friends. Participants made their decision based upon their judgment of the perceived benefits of offering the formula compared to potential barriers or negative outcomes. Although the risks of formula were published within professional literature (Walker, 1993) no participant in this study felt that offering formula would result in harm to their child and information from the lay literature, family, and friends also supported this assumption.

The Health Belief Model proposed that the subjective interpretation that individuals made of their susceptibility and potential risk influenced their likelihood of following recommended health actions (Rosenstock, 1974; Strecher et al., 1997). The findings from this study revealed that the information regarded by some health professionals as being accurate and up-to-date were not always perceived as such by mothers. Participants exposed to *incompatible expectations* from a variety of sources did not always choose to embrace the advice from health professionals regarding infant feeding. Mothers also used tactics such as avoiding and dismissing, outlined under the strategy of 'distancing', with perceived expert sources such as health professionals, media, newspapers, and books.

The predictive value of the Health Belief Model was regarded as stronger when there was greater disagreement in a particular health belief (Prohaska & Clark, 1997). This hypothesis was relevant for the proposed theory of *constructing compatibility by*

adapting focus due to the reality of *incompatible expectations*, which indicated notable disagreement between sources of expectations. However, Prohaska and Clark (1997) further clarified that the Health Belief Model was regarded as more effective in predicting the initiation of a behaviour rather than its continuation or termination. Although the predictive value of this model may be limited in a study that examined the decisions made during the ongoing management of breastfeeding and weaning, recognition and application of variables such as perceptions of susceptibility, threat, and behaviour outcomes provided opportunity to consider how these potential variables could influence mothers' likelihood of choosing specific feeding options.

Conclusions

The findings of this Western Australian study have implications for all health professionals who have contact with breastfeeding women in their clinical practice. Furthermore, these findings also have implications for women as consumers involved in managing their own breastfeeding experience or attempting to support other women undergoing these important mothering tasks. Additionally, societal support for breastfeeding could be enhanced in light of the findings of this study. Recommendations for health professionals, women, and society are discussed in light of these implications. Finally, as most research often produces as many questions as answers, recommendations for future research are presented before the closing remarks.

Implications and Recommendations for Health Professionals

The findings of this study have particular significance for health professionals and are discussed under the following topics: awareness of women's expectations regarding breastfeeding and weaning and their meaning to the role of mothering; acknowledgement of mothering efforts in relation to breastfeeding and weaning performance; the use of anticipatory guidance; and the issue of informed choice.

Awareness of expectations.

Although participants expressed a wide range of expectations regarding their breastfeeding and weaning, they revealed that these expectations could not be considered separate from expectations regarding mothering. Interpretations by self and

others of their performance were seen to be a reflection of mothering competency. Based upon these findings, health professionals need to be aware of the significance of the tasks of breastfeeding and weaning to individual mothers. Women could be encouraged to explore the meaning these tasks hold for them and to share this information with their health professionals, thus enabling care to be tailored to their individual needs.

In his scholarly discussion of the social construction of self, Russell (1999) offered a framework whereby people identified what was important to them and how they defined themselves. This reflexive practice is compatible with the role of health professionals who could encourage mothers to clarify and articulate their expectations and goals regarding their own breastfeeding, weaning, and mothering experiences. Reflexivity and self-awareness were central to the process of clarification needed to enable participants in this study to trust their own judgments and abilities. The establishment of this trust was necessary for the development of ongoing confidence in the management of their breastfeeding and weaning. Finally, if health professionals are aware of individual mother's expectations, they will be better able to support these goals and acknowledge the efforts undertaken to reach the goals.

Acknowledgement of mothering efforts.

Participants in this study revealed the importance of self-evaluation and the interpretations of others in the acknowledgement and reflection of their mothering efforts in relation to breastfeeding and weaning. In their discussion of breastfeeding in Australia, Lund-Adams and Heywood (1995) stated that "today breastfeeding is encouraged and it is expected that new mothers will breastfeed rather than bottlefeed" (p. 78). All participants in this study did breastfeed and felt their decision to breastfeed reflected good mothering. However, these mothers became very aware that although their expectations in managing their breastfeeding were supported by some sources, there were other sources that did not support ongoing decisions. Mothers wanted acknowledgement and support for their decisions and in order to ensure that support would be forthcoming, they sought and created compatible support.

An example of how mothers were judged and labeled regarding the appropriateness of their decisions was demonstrated in a public discussion entitled “bottlefeeding sinners verses breastfeeding saints” in an Australian Women’s Health Newsletter (Cannold, 1995a, p. 1). A debate ensued between health professionals (Cannold, 1995b; Holmes, 1995; Minchin, 1995) in response to the controversy over women’s infant feeding decisions and the reality of choice. In her discussion of “the worst of breast is best” Maushart (1997) referred to bottlefeeders as the social outcasts, who were regarded as “the socio-economically disadvantaged, the teenaged mums, the unwed, the smokers, and others too ignorant or selfish to do the right thing” (p. 201). These comments were based upon research suggesting that women who chose to formula feed held mother-centered views compared to the infant centered mother who decided to breastfeed (Losch et al., 1995). Health professionals had a significant impact upon participants in this study who expected unconditional support for their decisions. However, they often received support that was conditional upon meeting the expectations of the health professional. Therefore, more effort must be made to acknowledge the effort demonstrated by women in the performance of important mothering tasks of breastfeeding and weaning.

Choice: Is it informed and respected?

The findings from this study raise important concerns regarding informed choice. Are women truly informed when making decisions regarding infant feeding or has choice been slowly eroded? Firstly, the provision of consistent information and support from all sources must be considered and, secondly, once women have been given the relevant information, are their decisions respected, especially if they differ from the source of support, namely health professionals?

The issue of whether mothers are truly informed of all relevant aspects of infant feeding when making decisions must be questioned in view of the findings of this study that suggested participants received conflicting and at times out-dated and biased information from some health professionals. The provision of evidence-based breastfeeding information without bias or prejudice is an important obligation of all health professionals (Harding, 2000; Jamieson, 1995; Newman, 1997). “Women are entitled to research-based, up-to-date information about breastfeeding ... only then can

they be said to have real choice” (Dykes, 1995, p. 545). Walker (1993) argued that the paternalistic attitude of protecting parents from “knowing the possible consequences of making poor choices ... robs them of their right to informed decision making” (p. 103). She then suggested that parents receive information in antenatal breastfeeding classes such as “feeding decisions are neither right or wrong, nor are they good or bad” and “there is a difference between being OK and developing optimal health and cognitive potential” (p. 104). Walker’s (1993) second statement possessed a value judgement implying that formula feeding was a poor decision thereby threatening children’s potential and again illustrated the challenge of presenting truly unbiased information.

A more balanced view in the presentation of infant feeding information is recommended. The reality of mixed messages about breastfeeding, specifically from the media, has been recently supported in an Australian study that investigated representations of breastfeeding in the Australian press and popular magazines (Henderson, 1999). Findings revealed mixed messages with breastfeeding portrayed as natural and ideal but difficult in practice. Therefore, provision of a realistic picture must be advocated rather than “an unrealistic rosy glow” (Jordan & Wall, 1993, p. 32) or the predominant and/or subtle negative views about breastfeeding revealed in the media (Henderson, 1999; Vnuk, 1997).

In order to make an informed decision, women should have access to infant feeding information relevant to both infant and maternal health that includes physiologic, psychosocial, and environmental factors. Breastfeeding is often promoted as an infant health issue with minimal emphasis given to maternal health issues (Dermer, 1998). After all, maternal decisions are influenced by the physical, social, ideological, and political factors defined by the culture they live in (McDade & Worthman, 1998). Women have the right to be informed of the realities of breastfeeding revealed in current qualitative studies that have explored the subjective experience of breastfeeding and motherhood (Barlow & Cairns, 1997; Bottorff, 1990; Britton, 1998; Bryant, 1993; Dignam, 1995; Hartrick, 1997; McVeigh, 1997; Morse & Bottorff, 1992; Rogan et al., 1997; Schmied, 1998; Schmied & Barclay, 1999; Sterns, 1999; Weaver & Ussher, 1997). These studies provide an understanding of collective experiences and variations within individual breastfeeding experiences. Personal realities endured by many

breastfeeding women are rarely presented in the literature and their findings reflect some “resistance to the demands of the pro-breastfeeding rhetoric and child centred discourses of mothering” (Schmied & Barclay, 1999, p. 332). The provision of this subjective information of breastfeeding and mothering could assist women to develop realistic expectations and reduce the possibility of perceiving their experience as a failure due to unrealistic expectations.

As well as being truly informed about the facts of breastfeeding, parents also need to be exposed to current knowledge regarding formula. Wiessinger (1996) noted that the current language used to promote breastfeeding actually reinforced bottlefeeding as the accepted norm. She identified how terms describing breastfeeding as “advantageous, enhancing bonding, and strengthening immunity” implied optimal conditions rather than minimal standards, thus endorsing the normalcy, safety, and adequacy of formula feeding. She concluded that failing to describe the “hazards of artificial feeding” deprived women of “crucial decision-making information” (Wiessinger, 1996, p. 1). An unsentimental presentation of the positive and negative aspects of infant feeding would allow parents to feel confidence in their choices and assess their own experiences with more realistic standards.

Health professionals, in particular, must ensure they provide evidence-based practice as their credibility and influence can be questioned and once lost, it may or may not be regained. Many participants in this study were aware of recommended practices relating to infant feeding and cited instances where health professionals provided advice that was out-dated, strongly biased towards breastfeeding, or intolerant of bottlefeeding. The credibility of these health professionals was destroyed forcing participants to rely on other sources for information. In addition to information from family members and friends, mothers today are exposed to a wealth of information via books, newspapers, television, magazines, and parenting and breastfeeding websites such as Nursing Mother’s Association of Australia (NMAA). This exposure accentuates the likelihood of encountering *incompatible expectations*, but also increases the mother’s knowledge base. Health professionals must also recognise that research findings alone may not be sufficiently convincing to prompt individuals to question the wisdom and experience of close family members or friends. Once parents are given the opportunity to review all

the evidence and make a truly informed choice, health professionals must then respect that choice. Demonstrating that respect is particularly challenging when decisions directly oppose the health professional's preferences.

Anticipatory guidance.

Expectations regarding breastfeeding and weaning directly influenced participants' plans and goals during their experience. Therefore, once health professionals have a clear picture of women's expectations they could utilise anticipatory guidance to assist mothers assess the realistic nature of these goals. According to Pridham (1993) the purpose of anticipatory guidance is to prevent undesired consequences or conditions based upon expert knowledge. Participants based their expectations upon their beliefs and knowledge regarding breastfeeding and weaning. Although experts were cited as one source of knowledge, these women also utilised their past and current experience, the experience of others, and their partners' input to influence their expectations and subsequent goals. Numerous examples of *incompatible expectations* emerged in this study due to unrealistic expectations such as the effort required for breastfeeding, the relationship between sleeping and breastfeeding, or how healthy, contented children were expected to behave. Pridham (1993) presented a construct of a working model to assist breastfeeding mothers and encouraged a process of "characterising the individual's goals" to allow health professionals to respond sensitively and with understanding to parents' descriptions of their internal working model of infant feeding (p. 54). Health professionals, perceived as a credible source of information, can use this anticipatory guidance to correct and dispel myths and incorrect advice offered from sources such as the media, family members, friends, and acquaintances.

Although the degree of *incompatible expectations* varied, all participants in this study revealed instances of this problem during their breastfeeding and weaning experiences. Given the findings of this study, health professionals have the opportunity to utilise this process of anticipatory guidance to prepare women for the reality of being exposed to sources of opposition. If women could anticipate the reality of *incompatible expectations*, they may not feel the degree of confusion, self-doubt, and guilt that participants in this study experienced. Because experienced mothers were aware of the possibility of being confronted with *incompatible expectations* from previous

circumstances, they responded more quickly to this dilemma, generally experienced a lower level of confusion, self-doubt, and guilt, and reinforced the confidence and trust developed with previous breastfeeding experiences.

The presence of *incompatible expectations* revealed in this study reinforce the reality that women receive inconsistent information from many sources. The importance of mothers' receiving consistent support for their breastfeeding efforts has been reinforced in the literature (Ellis et al., 1993); however, the recognition of this inconsistency has focused upon the advice and expectations of health professionals. The presence of such inconsistent advice and information from health professionals has been found within the Western Australian context (Fetherston, 1995). However, Ellis et al. (1993) was one of the few authors who acknowledged the reality of mothers receiving inconsistent support from many potential sources. In their problem-solving approach to assist breastfeeding women they advocated assessing the degree of consistent support mothers received with their breastfeeding efforts from a variety of sources such as family members and significant others in addition to health care providers.

Implications and Recommendations for Consumers

The findings from this study and the literature confirm the concerns of many women, particularly first-time mothers, feeling unprepared for the realities of breastfeeding and mothering. As well as health professionals addressing the issue of mothers feeling unprepared through effective prenatal education, the 'conspiracy of silence' noted between women could be replaced with an openness and honesty in sharing experiences. This informal women-to-women support could enable new mothers to feel comfortable sharing their feelings and not be embarrassed to seek the support needed for breastfeeding and weaning. Continuing myths associated with mothering and breastfeeding must not be perpetuated. Sharing the realities of these experiences provides women with an understanding of the realistic variations within breastfeeding and weaning experiences.

Women could also be made aware of strategies that other mothers use to manage their breastfeeding and weaning experiences such as 'embracing' to seek out sources of compatible expectations and establish a supportive network and 'distancing' to manage

the impact of the incompatible sources. Additionally, the effectiveness of utilising such strategies such as ‘rationalising decisions by focusing upon positive outcomes’ and ‘acknowledging feelings’ associated with decisions could also be made known to breastfeeding mothers. Finally, knowing that other women use these strategies could help them manage their experiences, feel comfortable with their decisions, and not feel so alone in their mothering.

Women as consumers need to be encouraged to be discerning and critical of all information presented to them regarding infant feeding. The ability to search for and utilise credible information resources is a skill that women need to develop. As well as having access to the current research findings on breast milk and formula, a component of belief is required before parents will be motivated to act upon this knowledge (Dettwyler, 1997). Therefore, consumers must assert their right to resources that are credible and up-to-date. These resources are also assets that consumers must recognise and value. Health professionals inform women of current research findings; however, women also receive information from their informal support network that contradicts these facts. The significant impact of informal support upon women has been acknowledged in the literature (Bryant, 1993; Isabella & Isabella, 1994; Raj & Plichta, 1998). Women as consumers must take responsibility for the pursuit of their knowledge to assist them to assess the information provided and make informed confident choices.

Implications and Recommendations for Society

Based upon the findings of this study, if our society values breastfeeding it must provide an environment truly supportive of its practice. The creation of a supportive breastfeeding environment must be focused beyond the information needs of breastfeeding women, but also include measures to increase the knowledge of their partners, extended family members, and the community in general. Fathers’ approval of breastfeeding has been found to be an important factor influencing mothers’ decisions with breastfeeding (Freed et al., 1993; Littman et al., 1994; Raj & Plichta, 1998; Sharma & Petosa, 1997; Wylie & Verber, 1994). Specific educational interventions to promote breastfeeding must target both parents and society in general with the ultimate aim of helping parents to anticipate and manage the challenges of breastfeeding (Jordan & Wall, 1993).

Support for breastfeeding has been found to be most abundant during the early stages of hospitalisation and early postpartum follow-up. However, there is a growing recognition that support from formal and informal sources must continue and permeate into the community over the longer term of the breastfeeding experience (Arlotti et al., 1998; Fulton, Kentley & Swift, 1998; Kistin et al., 1994; Raj & Plichta, 1998; Wylie & Verber, 1994). Although support is recognised as important for the breastfeeding women, findings from this study suggest that not all support is positive. Negative social support can actually interfere with women achieving breastfeeding success (Raj & Plachta, 1998).

Society has a vested interest in promoting breastfeeding as it has been suggested that \$11.5 million could be saved if 80 percent of Australian women were exclusively breastfeeding at three months (Drane, 1997). In addition, further cost savings have also been suggested in that by increasing breastfeeding prevalence the severity and duration of infant illness and maternal employment absenteeism could be reduced (Drane, 1997). Breastfeeding promotion in Australia has been conceptualised as a nutritional issue (Morrow & Barraclough, 1993) and Shelton (1994), Barclay (1997, p. 11) and Scott and Binns (1999) argued that until the social, economic, cultural, and environmental factors were considered, strategies for “creating a culture of breastfeeding” could not become a reality. For instance, priorities must be set to provide adequate facilities for women to be able to manage their breastfeeding in public places such as shopping centres. For those women who do choose to breastfeed in public, they must feel confident that consequences such as negative comments or the risk of being asked to leave a public facility will not occur. Finally, the dilemma of continuing breastfeeding while entering employment must be addressed so that it will not pose the predicament facing current mothers in the workforce. Adequate provision of onsite childcare facilities to allow the proximity needed during the breastfeeding experience could assist women manage this problem. Additionally, maternal leave allowances and adequate financial compensation for those women who temporarily leave the workforce would also deliver the message that society truly values ongoing breastfeeding and the benefits that breast milk offers to the mother and child.

Implications and Recommendations for Future Research

The findings from this current study also introduce implications and recommendations for further research. As more qualitative research has been undertaken in recent years, discussion has ensued regarding the potential of synthesising findings about related phenomena from diverse samples as a powerful approach to theory development (Estabrooks, Field & Morse, 1994; Jensen & Allen, 1996; Kearney, 1998; Wuest, 2000). This process of “meta-analysis” offers greater explanatory power by developing a more general theory “applicable to individuals experiencing a common phenomenon across contexts and populations” (Kearney, 1998, p. 180). Grounded theory studies, in particular, that have produced substantive theories focusing upon a narrow scope, present the opportunity for this further analysis. For example, ten American and Canadian grounded theory studies involving 200 participants with a focus on drug and alcohol abuse were utilised in an analysis of women’s process of addiction and recovery (Kearney, 1998). A further example was demonstrated in the presentation of the theory of ‘uncertain motherhood’ that explained a model of coping when the outcome of motherhood was uncertain (Marck et al., 1994). The findings from five grounded theory studies and one phenomenological study were utilised in this analysis addressing contexts of uncertainty involving situations of infertility, unexpected pregnancy, stillbirth, high risk pregnancy, preterm birth and when the child has a birth defect (Brady-Fryer, 1994; Diachuk, 1994; Harris, 1994; Hense, 1994; Marck, 1994; McGeary, 1994).

The development of a substantive theory on the management of breastfeeding and weaning provides opportunity for further analysis and synthesis with other grounded theory findings related to the focus of breastfeeding and mothering. This current Western Australian study provided explanation for a problem and process that was specific to this context. However, a broader more generalised process may be occurring in a variety of contexts within and between countries. For example, grounded theory studies have explored the breastfeeding experiences of culturally diverse American women (Locklin, 1995) and the experience of mothering in Canada (Barlow & Carins, 1997) and Australia (Rogan et al., 1997). Further qualitative methods utilising the method of discourse analysis have also been undertaken to examine Australian mothers’

experience of breastfeeding (Schmied & Barclay, 1999) and British (Weaver & Ussher, 1997) and Canadian (Hartrick, 1996) women's experiences of mothering. Therefore, the potential exists for further analysis and synthesis of qualitative research studies within a broader scope and beyond the limited focus of the substantive area.

Proposing the possibility of further analysis to extend the scope and focus of a study area does raise issues that are still being debated in the literature (Hinds, Vogel & Clarke-Steffen, 1997; Jensen & Allen, 1996; Thorne, 1998; Wuest, 2000). A solid methodological foundation to guide designs and procedures for secondary analysis does not exist as this time (Thorne, 1998). Although using secondary analysis has been suggested to extend the potential of original research questions and maximise qualitative data bases, utilising this strategy also poses some ethical and representational risks. Theoretical challenges must be overcome in examining whether the primary research design and existing data fit with a secondary question (Hinds et al., 1997; Thorne, 1998). Further ethical concerns of ensuring confidentiality, fidelity, and nonmaleficence while securing informed consent beyond the primary research must also be clearly considered together with issues of sampling biases and whose voice is represented before pursuing any form of secondary analysis or meta-synthesising (Thorne, 1998).

Within the Western Australian context, the majority or 83.8 percent (Scott et al., 1997) of women initiate breastfeeding. Given the significance the participants in this study placed upon their breastfeeding experience reflecting their mothering competency, it raises the issue of the mothering experience for the remaining 16.2 percent of Western Australian women who chose not to breastfeed. To not attempt to breastfeed within this pro-breastfeeding context must produce a unique experience not encountered by the majority of Western Australian mothers. However, this phenomenon still represents a significant number of Western Australian mothers and although not included in this study is worthy of further exploration.

Although the majority of Western Australian women initiate breastfeeding, Scott et al.'s (1999) study also found that by three months only 61.8 percent of women continued to breastfeed. Therefore, 22 percent of those women who initiated breastfeeding ceased

prior to the recommended four to six months for exclusive breastfeeding (WHO, 1989a). Again, given the pro-breastfeeding context within this state, do these women perceive their breastfeeding, weaning, and mothering efforts were supported and acknowledged? Additionally, a comparison between the decision-making processes of these non-breastfeeding women and those women who cease breastfeeding prior to three months could also reveal similarities and differences between these important early experiences of mothering.

Closing Remarks

To conclude, participants in this Western Australian study revealed the presence of a common problem during the management of their breastfeeding and weaning experiences. In response to this problem identified as *incompatible expectations*, these participants adopted a social process of *constructing compatibility by adapting focus*. The delineation of this process in responding to the problem of *incompatible expectations* resulted in a substantive theory explaining how these mothers managed their breastfeeding and weaning experiences. This theory provides a unique perspective of the management of breastfeeding and weaning decisions within the Western Australian context and contributes to the existing body of knowledge on infant feeding. Expectations and performances relating to breastfeeding and weaning were found to have a significant impact upon participants' interpretations of their mothering accomplishments. Ultimately, the meaning of these expectations must be acknowledged and considered from the perspective of each mother. It is only fitting to reinforce these final statements with the words of a participant who captured the essence of her breastfeeding experience as follows:

I think you set yourself up to be saint mummy. You do everything all nurturing, all giving ... I felt that I was being a good mother in breastfeeding, it was rewarding, feeling satisfied within, being happy with your nurturing abilities at that stage ... So I think if anything breastfeeding gave me one little link to a positive mothering side (M32).

REFERENCES

- Abraham, R. (1999). The impact of emotional dissonance on organisational commitment and intention to turnover. *The Journal of Psychology*, 133(4), 441-455.
- Abramson, R. (1992). Cultural sensitivity in the promotion of breastfeeding. *NAACOGS Clinical Issues in Perinatal and Womens Health Nursing*, 3(4), 717-722.
- Aggleton, P. & Chalmer, H. (1989). Working with the Riehl model of nursing. In J. Riehl-Sisca (Ed.) *Conceptual models for nursing practice*. (3rd ed.). (pp. 401-411). Norwalk, Connecticut: Appleton & Lange.
- Ahern, K. (1999). Pearls, pith, and provocation: Ten tips for reflexive bracketing. *Qualitative Health Research*, 9(3), 407-411.
- Alexy, B. & Martin, A. (1994). Breastfeeding: Perceived barriers and benefits/enhancers in a rural and urban setting. *Public Health Nursing*, 11(4), 214-218.
- Al-Mazrou, Y., Aziz, K. & Khalil, M. (1994). Breastfeeding and weaning practices in Saudi Arabia. *Journal of Tropical Pediatrics*, 40(5), 267-271.
- American Academy of Pediatrics. (1997). Breastfeeding and the use of human milk. *American Academy of Pediatrics Policy Statement*, 100(6), 1035-1039.
- Ammon-Gaberson, K. & Piantanida, M. (1988). Generating results from qualitative data. *Image: Journal of nursing Scholarship*, 20(3), 159-161.
- Andrews, H. & Roy, C. (1986). *Essentials of the Roy Adaptation Model*. Norwalk, Connecticut: Appleton Century-Crofts.
- Anells, M. (1996). Grounded theory method: Philosophical perspectives, paradigm of inquiry, and postmodernism. *Qualitative Health Research*, 6(3), 379-393.
- Appleton, J. (1995). Analysing qualitative interview data: Addressing issues of validity and reliability. *Journal of Advanced Nursing*, 22, 993-997.
- Arlotti, J., Cottrell, B., Lee, S. & Curtin, J. (1998). Breastfeeding among low-income women with and without peer support. *Journal of Community Health Nursing*, 15(3), 163-178.
- Australian College of Midwives Inc. (1992). *A breastfeeding protocol: For the healthy full term baby with the well mother*. (3rd ed.). Canberra: A. C. T. Branch, ACMI.

- Bagwell, J., Kendrick, O., Stitt, K., & Leeper, J. (1993). Knowledge and attitudes toward breastfeeding: Differences among dietitians, nurses, and physicians working with WIC clients. *Journal of the American Dietetic Association*, 93(7), 801-804.
- Bailey, V. & Sherriff, J. (1992). Reasons for the early cessation of breastfeeding in women from lower socio-economic groups in Perth, Western Australia. *Australian Journal of Nutrition and Dietetics*, 49(2), 40-43.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. New Jersey: Prentice Hall Inc.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York: WH Freeman & Co.
- Baranowski, T. (1997). Families and health actions. In D. Gochman (Ed.). *Handbook of health behaviour research I*. (pp. 179-206). New York: Plenum Press.
- Barclay, L. (1997, October). Creating a culture of breastfeeding. *Proceedings from Breastfeeding The Natural Advantage: An International Breastfeeding Conference. Sponsored by Nursing Mothers' Association of Australia* (pp. 11-16). Sydney: Royal Randwick Racecourse.
- Barclay, L. & Lupton, D. (1999). The experiences of new fatherhood: A socio-cultural analysis. *Journal of Advanced Nursing*, 29(4), 1013-1020.
- Barlow, C. & Cairns, K. (1997). Mothering as a psychological experience: A grounded theory exploration. *Canadian Journal of Counselling*, 31(3), 232-247.
- Barnett, E., Sienkiewicz, M., & Roholt, S. (1995). Beliefs about breastfeeding: A statewide survey of health professionals. *Birth: Issues in Perinatal Care and Education*, 22(1), 15-20.
- Bartlett, H. & Pennebaker, D. (1990). *Report of the ministerial task force to review obstetric, neonatal and gynaecological services in Western Australia*. Vol 3. Perth: Health Department of Western Australia.
- Beck, C. (1993). Qualitative research: The evaluation of its credibility, fittingness, and auditability. *Western Journal of Nursing Research*, 15(2), 263-266.
- Becker, A. (1998). Is primary prevention of asthma possible? *Canadian Respiratory Journal*, 5 Suppl A, 45A-49A.
- Bell, Q., Crawford, D., Gochnauer, A., Hissa, D., Hofmann, B., & Miller, K. M. (1998). Joan Riehl-Sisca: Symbolic interactionism. In A. Marriner-Tomey & M. Alligood (Eds.), *Nursing theorists and their work*. (4th ed.). (pp. 375-386). Sydney: Mosby-Year Book Inc.

- Benner, P. (1994). The tradition and skill of interpretive phenomenology in studying, health, illness, and caring. In P. Benner (Ed.). *Interpretive phenomenology: Embodiment, caring, and ethics in health care*. (pp. 99-128). London: Sage.
- Bennison, J. (1997). Breastfeeding does not always work. *British Medical Journal*, 315(7110), 754.
- Benoiel, J. (1996). Grounded theory and nursing knowledge. *Qualitative Health Research*, 6(3), 406-428.
- Bergh, A. (1993). Obstacles to and motivation for successful breastfeeding. *Curationis*, 16(2), 24-29.
- Bergum, V. (1989). *Woman to mother: A transformation*. South Hadley, MA: Bergin & Garvey.
- Bergum, V. (1997). *A child on her mind: The experience of becoming a mother*. Westport, Connecticut: Bergin & Garvey.
- Biancuzzo, M. (1999). *Breastfeeding the newborn: Clinical strategies for nurses*. Sydney: Mosby.
- Bick, D., MacArthur, C., & Lancashire, R. (1998). What influences the uptake and early cessation of breastfeeding? *Midwifery*, 14, 242-247.
- Black, P. (1993). A confident start to a new relationship: Biological and psychological aspects of breastfeeding. *Professional Nurse*, Dec, 193-197.
- Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. New Jersey: Prentice-Hall, Inc.
- Bocar, D. (1997). Combining breastfeeding and employment: Increasing success. *Journal of Perinatal Neonatal Nursing*, 11(2), 23-43.
- Booksh, A. C. (1994). Getting off the back room team. In *New Beginnings* [Online]. La Leche League. Available: <http://www.lalecheleague.org/NB/NBMarApr94.html> [1997, November 12].
- Bottorff, J. (1990). Persistence in breastfeeding: A phenomenological investigation. *Journal of Advanced Nursing*, 15, 201-209.
- Bower, A. (1997, August 5). Breast best, say experts. *West Australian newspaper*, p 35.
- Brady-Fryer, B. (1994). Becoming the mother of a preterm baby. In P. A. Field & P. B. Marck. *Uncertain motherhood: Negotiating the risk of the childbearing years*. (pp. 195-222). London: Sage Publications.

- Breastfeeding: A topic close to every mothers' heart. (1999, July 28). *The West Australian Today Supplemental*, p. 15.
- Brink, P. & Wood, M. (1994). *Basic steps in planning nursing research: From question to proposal*. London: Jones & Bartlett Publishers International.
- Britton, C. (1998). Feeling letdown: An exploration of an embodied sensation associated with breastfeeding. In Sarah Nettleton & Jonathan Watson (Eds.) *The body in everyday life*. (pp. 64-81) London: Routledge.
- Brockopp, D. & Hastings-Tolsma, M. (1995). *Fundamentals of nursing research*. (2nd ed.). London: Jones and Bartlett Publishers.
- Brown, S., Lumley, J., Small, R. & Astbury, J. (1994). *Missing voices: The experience of motherhood*. Melbourne: Oxford University Press.
- Bryant, C. (1993). Empowering women to breast feed. *International Journal of Childbirth Education*, 8(2) 13-5.
- Bunce, T. (1997). Trusting my heart. In *New Beginnings* [Online]. La Leche League. Available: URL <http://www.lalecheleague.org/NB/NBMayJun97tod.html> [1997 November 12].
- Bundrock, V. (1995). Women as mothers: Mothers through their own words and the words of others. *Breastfeeding Review*, 3(1), 21-26.
- Bunting, S. (1993). *Rosemarie Parse: Theory of human becoming*. London: Sage Publications.
- Burgum, M. (1994). What encourages continued full breastfeeding? Some opinions of Western Australian child health nurses and Nursing Mothers' Association of Australia group leaders. *Australian Journal of Nutrition and Dietetics*, 51(4), 175-179.
- Cannold, L. (1995a). Bottle feeding sinners and breastfeeding saints: The erosion of choice in the infant feeding decision. *Healthsharing Women*, 6(1), 3-7.
- Cannold, L. (1995b). Individual autonomy and the public good: A reply to Wendy Homes and Maureen Minchin. *Healthsharing Women*, 6(2), 15.
- Chandrasekhar, U., Vasanthaviani, G. & Thomas, A. (1990). Infant feeding and weaning practices among Irulas of Attapadi Hills and Lambas of Katchuvadi Hills. *Indian Journal of Nutrition and Dietetics*, 27(6), 175-180.
- Chenitz, W. & Swanson, J. (1986). *From practice to grounded theory*. Menlo Park, CA: Addison-Wesley.

- Chezem, J., Montgomery, P., & Fortman, T. (1997). Maternal feelings after cessation of breastfeeding: Influence of factors related to employment and duration. *Journal of Perinatal Neonatal Nursing, 11*(2), 61-70.
- Cook, W. & Douglas, M. (1998). The looking-glass self in family context: A social relations analysis. *Journal of Family Psychology, 12*(3), 299-309.
- Cooke, M. (1996). Mothers' experience of infant feeding: A new theory. In L. Barclay & L. Jones (Eds.), *Midwifery: Trends and practice in Australia* (pp. 69-84). Melbourne: Churchill Livingstone.
- Cooper, J. (1999). Unlearning cognitive dissonance: Toward an understanding of the development of dissonance. *Journal of Experimental Social Psychology, 34*, 562-575.
- Corbin, J. (1986). Qualitative data analysis for grounded theory. In W. Chenitz & J. Swanson. *From practice to grounded theory: Qualitative research in nursing*. (pp. 91-119). Menlo Park, California: Addison-Wesley Publishing Co.
- Coreil, J. & Murphy, J. (1988). Maternal commitment, lactation practices, and breastfeeding duration. *Journal of Obstetric, Gynecological, and Neonatal Nursing, 17*, 273-278.
- Cox, S. & Turnbull, C. (1994). Choosing to breast feed or bottle feed: An analysis of factors which influence choice. *Breastfeeding Review, 11*(10), 459-464.
- Creswell, J. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. London: Sage Publications.
- D'Angelo, L. (1998). New breastfeeding guidelines. *Parenting, 12*(1), 32.
- DeMeis, D. & Perkins, H. (1996). Supermoms of the nineties. *Journal of Family Issues, 17*(6), 776-792.
- Dennis, C. (1999). Theoretical underpinnings of breastfeeding confidence: A self-efficacy framework. *Journal of Human Lactation, 15*(3), 195-201.
- Denzin, N. & Lincoln, Y. (1994). Introduction: Entering the field of qualitative research. In N. Denzin & Y. Lincoln (Ed.). (pp. 1-18). *Handbook of qualitative research*. London: Sage Publications.
- Dermer, A. (1998). Breastfeeding and women's health. *Journal of Women's Health, 7*(4), 427-433.
- Dettwyler, K. (1987). Breastfeeding and weaning in Mali: Cultural context and hard data. *Social, Science and Medicine, 24*(8), 633-644.

- Dettwyler, K. (1995a). A time to wean. In P. Stuart-Macadam & K. Dettwyler (Eds.). *Breastfeeding: Biocultural perspectives*. (pp. 39-73). New York: Aldine De Gruyter.
- Dettwyler, K. (1995b). When nature intended humans to wean. In *La Leche League International Website*. [Online] Available: <http://prairienet.org/community/health/laleche/detwean.html> [1996 April 11].
- Dettwyler, K. (1997, October). Promoting breastfeeding: Promoting guilt? *Proceedings from Breastfeeding The Natural Advantage: An International Breastfeeding Conference*. Sponsored by Nursing Mothers' Association of Australia (pp. 47-55). Sydney: Royal Randwick Racecourse.
- DeVito, J. (1998). *The interpersonal communication book*. (8th ed.). Melbourne: Addison-Wesley Educational Publishers Inc.
- Diachuk, M. G. (1994). When a child has a birth defect. In P. A. Field & P. B. Marck (Eds.), *Uncertain motherhood: Negotiating the risks of the childbearing years*. (pp. 223-267). London: Sage Publications.
- Dignam, D. (1995). Understanding intimacy as experienced by breastfeeding women. *Health Care for Women International*, 16(5), 477-486.
- Dix, D. (1991). Why women decide not to breast feed. *Birth*, 18(4) 222-5.
- Donovan, D. (1998). Weaning one year old without guilt. In *Parentsplace Website*. [online]. Available: <http://www.parentsplace.com/expert/lactation/weaning/qa/0,3459,6184,00.html> [1998 November 26].
- Drane, D. (1997). Breastfeeding and formula feeding: A preliminary economic analysis. *Breastfeeding Review*, 5(1), 7-15.
- Drew, N. (1989). The interviewer's experience as data in phenomenological research. *Western Journal of Nursing Research*, 11(4), 431-439.
- Duckett, L., Henly, S., Avery, M., Potter, S., Hills-Bonczyk, S., Hulden, R., & Savik, K. (1998). A theory of planned behavior-based structural model for breastfeeding. *Nursing Research*, 47(6), 325-336.
- Dykes, F. (1995). Valuing breastfeeding in midwifery education. *British Journal of Midwifery*, 3(10), 544-547.
- Dykes, F. & Griffiths, H. (1998). Societal influences upon initiation and continuation of breastfeeding *British Journal of Midwifery*, 6(2) 76-80.
- Earland, J., Ibrahim, S. & Harpin, V. (1997). Maternal employment: Does it influence feeding practices during infancy? *Journal of Human Nutrition and Dietetics*, 10(5), 305-311.

- Ellis, D., Livingstone, V. & Hewat, R. (1993). Assisting the breastfeeding mother: A problem-solving process. *Journal of Human Lactation*, 9(2), 89-93.
- Elman, M. & Gilbert, L. (1984). Coping strategies for role conflict in married professional women with children. *Family Relations*, 33, 317-327.
- Elson, V. (1998). Weaning your baby. In *Family.com Parenting Website*. [Online]. Available: http://family.disney.com/Features/family_1999_04/alpn47wean/alpn47wean.html [1998 November 26].
- Emmons, C., Biernat, M., Tiedje, L., Lang, E. & Wortman, C. (1990). Stress, support, and coping among women professionals with preschool children. In J. Eckenrode & S. Gore (Eds.). *Stress between work and family* (pp. 61-93). New York: Plenum.
- Estabrooks, C., Field, P. A. & Morse, J. (1994). Aggregating qualitative findings: An approach to theory development. *Qualitative Health Research*, 4(4), 503-511.
- Eunson, B. (1997). *Dealing with conflict*. Brisbane: John Wiley & Sons.
- Fein, S. B. & Roe, B. (1998). The effect of work status on initiation and duration of breastfeeding. *American Journal of Public Health*, 88(7), 1042-1046.
- Festinger, L. (1957). *A theory of cognitive dissonance*. Stanford, California: Stanford University Press.
- Fetherston, C. (1995). Factors influencing breastfeeding initiation and duration in a private Western Australian maternity hospital. *Breastfeeding Review*, 3(1), 9-14.
- Forgas, J. (1985). *Interpersonal behaviour: The psychology of social interaction*. Sydney: Pergamon Press Pty Ltd.
- Forster, C., Abraham, S., Taylor, A., & Llewellyn-Jones, D. (1994). Psychological and sexual changes after the cessation of breastfeeding. *Obstetrics and Gynecology*, 84(5), 872-876.
- Fowler, C. & Gornall, P. (1991). *How to stay sane in your baby's first year: The Tresillian guide*. Australia: Simon & Schuster.
- Fray, S. (No date). Attitudes to breastfeeding in public. In *The Blue Mountains Village Views Australian Website*. [Online]. Available: <http://www.hermes.net.au/bmvv/breast.html> [1999, July 30].
- Freed, G., Fraley, J., & Schanler, R. (1992). Attitudes of expectant fathers regarding breastfeeding. *Pediatrics*, 90(2), 224-227.

- Freed, G., Fraley, J., & Schanler, R. (1993). Accuracy of expectant mothers' predictions of fathers' attitudes regarding breastfeeding. *Journal of Family Practice*, 37(2), 148-152.
- Friedman, M. (1996). Mother's milk: A psychoanalyst looks at breastfeeding. In A. Solnit, P. Neubauer, S. Abrams, & A. Dowling (Eds.). *Psychoanalytic Study of the Child*. (pp. 475-490). New York: Yale University Press.
- Friedman, A., Weinberg, H., & Pines, A. (1998). Sexuality and motherhood: Mutually exclusive in perception of women. *Sex Roles*, 38(9/10), 781-800.
- Fulton, C., Kentley, L., & Swift, S. (1998). Breastfeeding support in a deprived area. *Community Practitioner*, 71(5), 172-174.
- Furman, L. (1995). A developmental approach to weaning. *Maternal Child Nursing*, 20(1), 322-325.
- Galbreath, J. G. (1998). Callista Roy. In J. George (Ed.). *Nursing theories: The base for professional nursing practice*. (4th ed.). (pp. 251-279). Norwalk, Connecticut: Appleton & Lange.
- George, J. (1998). Imogene M. King. In J. George (Ed.). *Nursing theories: The base for professional nursing practice*. (4th ed.). (pp. 209-228). Norwalk, Connecticut: Appleton & Lange.
- Gigacz, J. (Ed.) (1999a). Just for fathers. In *Nursing Mothers' Association of Australia (NNMA) Website* [Online]. Available: <http://www.vicnet.net.au/~nmaa/bfinfo/father.html> [1999 March 3].
- Gigacz, J. (Ed.) (1999b). Why breast is best. In *Nursing Mothers' Association of Australia (NNMA) Website* [Online]. Available: <http://www.vicnet.net.au/~nmaa/bfinfo/general.html> [1999 March 3].
- Gigacz, J. (Ed.) (1999c). Nursing Mothers' Association of Australia: Who are we? In *Nursing Mothers' Association of Australia (NNMA) Website* [Online]. Available: <http://www.nmaa.asn.nmaa/index.html> [1999 November 9].
- Gigliotti, E. (1995). When women decide not to breast feed. *Maternal Child Nursing*, 20(1), 315-321.
- Glaser, B. & Strauss, A. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine.
- Glaser, B. (1978). *Theoretical sensitivity: Advances in methodology of grounded theory*. San Francisco: Sociology Press.
- Glaser, B. (1992). *Basics of grounded theory analysis: Emergence vs forcing*. Mill Valley, CA: Sociology Press.

- Glaser, B. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, CA: Sociology Press.
- Gorgas, R. (Ed.). (1997). Toddler tips: Criticism from relatives. In *La Leche League Website* [Online]. Available: <http://www.lalecheleague.org/NB/NBJanFeb90.tod.html> [1997 November 12].
- Greiner, T. (1995). Sustained breastfeeding, complementation and care. *Food Nutrition Bulletin*, 16, 313-319.
- Greiner, T. (1996). The concept of weaning: Definitions and their implications. *Journal of Human Lactation*, 12(2), 123-128.
- Gross, D. (1996). What is a good parent. *Maternal Child Nursing*, 21(4), 178-182.
- Grossman, L., Harter, C., Sachs, L. & Kay, A. (1990). The effect of postpartum lactation counselling on the duration of breastfeeding in low-income women. *American journal of Diseases of Children*, 144, 471-474.
- Guba, E. & Lincoln, Y. (1994). Competing paradigms in qualitative research. In N. Denzin & Y. Lincoln (Ed.). (pp. 105-117). *Handbook of qualitative research*. London: Sage Publications.
- Halken, S., Hacobsen, H., Host, A. & Holmenlund, D. (1995). The effect of hypo-allergenic formulas in infants at risk of allergic disease. *European Journal of Clinical Nutrition*, 49 Suppl (1), S77-S83.
- Hall, W. (1994). New fatherhood: Myths and realities. *Public Health Nursing*, 11(4), 219-228.
- Hall, J. (1997). Breastfeeding and sexuality: Societal conflicts and expectations. *British Journal of Midwifery*, 5(6), 350-354.
- Harding, D. (2000). Making choices in childbirth. In L. Page (Ed.). *The new midwifery science and sensitivity in practice*. (pp. 71-85). London: Churchill Livingstone.
- Harris, R. (1994). The process of infertility. In P. A. Field & P. B. Marck. *Uncertain motherhood: Negotiating the risk of the childbearing years*. (pp. 15-81). London: Sage Publications.
- Harrison, M., Morse, J. & Prowse, M. (1985). Successful breastfeeding: The mother's dilemma. *Journal of Advanced Nursing*, 10, 261-269.
- Hartrick, G. (1997). Women who are mothers: The experience of defining self. *Health Care for Women International*, 18(3), 263-277.
- Hauck, Y. (1992). *Evaluation of an information booklet on breastfeeding duration: A clinical trial*. Masters thesis, Curtin University of Technology, Perth, Western Australia, Australia.

- Hauck, Y. & Dimmock, J. (1994). Evaluation of an information booklet on breastfeeding duration: A clinical trial. *Journal of Advanced Nursing*, 20, 836-843.
- Hauck, Y. & Reinbold, J. (1996). Criteria for successful breastfeeding: Mothers' perceptions. *Australian College of Midwives Incorporated Journal*, 9(1), 21-27.
- Health Department of Western Australia. (1993). *Preparation for parenthood: A guide book*. (3rd ed.). Perth: Health Promotion Services Branch Health Department of Western Australia.
- Health Department of Western Australia. (1994). *A solid start: A guide to baby's first foods*. [Brochure]. Perth, Western Australia: Author.
- Henderson, A. (1999). Mixed messages about the meanings of breastfeeding representations in the Australian press and popular magazines. *Midwifery: An International Journal*, 15(1), 24-31.
- Hense, A. L. (1994). Livebirth following stillbirth. In P. A. Field & P. B. Marck. *Uncertain motherhood: Negotiating the risk of the childbearing years*. (pp. 163-194). London: Sage Publications.
- Hervada, A. & Newman, D. (1992). Weaning: Historical perspectives, practical recommendations, and current controversies. *Current Problems in Pediatrics*, 22, 223-240.
- Hewat, R. (1992). Living with an incessantly crying infant. *Phenomenology and Pedagogy*, 10, 160-171.
- Hickman, J. (1998). Rosemarie Rizzo Parse. In J. George (Ed.). *Nursing theories: The base for professional nursing practice*. (4th ed.). (pp. 335-354). Norwalk, Connecticut: Appleton & Lange.
- Hinds, P., Vogel, R. & Clarke-Steffen, L. (1997). The possibilities and pitfalls of doing a secondary analysis of a qualitative data set. *Qualitative Health Research*, 7(3), 408-424.
- Hitchcock, N. & Coy, J. (1988). Infant feeding practices in Western Australia and Tasmania: A joint survey 1984-1985. *Medical Journal of Australia*, 148, 114-117.
- Hill, P., Humenick, S., Argubright, T., & Aldag, J. (1997). Effects of parity and weaning practices on breastfeeding duration. *Public Health Nursing*, 14(4), 227-234.
- Hills-Bonczyk, S., Avery, M., Savik, K., Potter, S. & Duckett, L. (1993). Women's experiences with combining breastfeeding and employment. *Journal of Nurse-Midwifery*, 38, 257-266.

- Hills-Bonczyk, S., Tromiczak, K., Avery, M., Potter, S., Savik, K., & Duckett, L. (1994). Women's experiences with breastfeeding longer than 12 months. *Birth*, 21(4), 206-211.
- Holmes, W. (1995). Breastfeeding promotion and the prevention paradox. *Healthsharing Women*, 6(2), 12-13.
- Huberman, A. M. & Miles, M. B. (1994). Data management and analysis methods. In N. Denzin & Y. Lincoln (Ed.). *Handbook of qualitative research*. (pp. 428-444). London: Sage Publications.
- Huggins, K. & Ziedrich, L. (1994). *The nursing mother's guide to weaning*. Boston, Massachusetts: The Harvard Common Press.
- Humenick, S., Hill, P., & Spiegelberg, P. (1998). Breastfeeding and health professional encouragement. *Journal of Human Lactation*, 14(4), 305-310.
- Hutchinson, S. (1993). Grounded theory: The method. In P. Munhall & C. Boyd (Eds.), *Nursing research: A qualitative perspective*. (2nd ed.). (pp. 180-212). New York: National League for Nursing Press.
- Hyde, J., DeLamater, J., Plant, E., Ashby, B. & Janis, M. (1996). Sexuality during pregnancy and the year postpartum. *Journal of Sex Research*, 33(2) 143-151.
- Isabella, P. & Isabella, R. (1994). Correlates of successful breastfeeding: A study of social and personal factors. *Journal of Human Lactation*, 10(4), 257-264.
- Jackson, D., Imong, S., Wongsawasdii, L., Silprasert, A., Preunglampoo, S., Leelapat, P., Drewett, R., Amatayakul, K. & Baum, J. (1992). Weaning practices and breastfeeding duration in Northern Thailand. *British Journal of Nutrition*, 67(2), 149-165.
- Jamieson, L. (1995). Educating for successful breastfeeding. *British Journal of Midwifery*, 3(10), 535-539.
- Janke, J. (1993). The incidence, benefits, and variables associated with breastfeeding: Implications for practice. *Nurse Practitioner*, 18(6), 22,23,28,31,32.
- Janke, J. (1994). Development of the breastfeeding attrition prediction tool. *Nursing Research*, 43(2), 100-104.
- Jasper, M. (1994). Issues in phenomenology for researchers of nursing. *Journal of Advanced Nursing*, 19, 309-314.
- Jensen, L. & Allen, M. (1996). Meta-synthesis of qualitative findings. *Qualitative Health Research*, 6(4), 553-560.

- Johnson, D. (1997). *Reaching out: Interpersonal effectiveness and self-actualization* (6th ed.). Sydney: Allyn and Bacon.
- Jordan, P. & Wall, V. (1993). Supporting the father when an infant is breast fed. *Journal of Human Lactation*, 9(1) 31-4
- Keane, E. (1989). Listening and the counselling process. *Nursing Standard*, 13(4), 34-36.
- Kearney, M., Cronenwett, L. & Reinhardt, R. (1990). Caesaren delivery and breastfeeding outcomes. *Birth*, 17, 97-103.
- Kearney, M. (1998). Ready-to-wear: Discovering grounded formal theory. *Research in Nursing and Health*, 21, 179-186.
- Kendall-Tackett, K. & Sugarman, M. (1995). The social consequences of long term breastfeeding. *Journal of Human Lactation*, 11(3), 179-183.
- Khan, M. (1990). Breastfeeding and weaning practices in India. *Asia-Pacific Population Journal*, 5(1), 71-88.
- King, I. (1981). *A theory for nursing: Systems, concepts, process*. New York: Wiley.
- Kistin, N., Abramson, R. & Dublin, P. (1994). Effect of peer counselors on breastfeeding initiation, exclusivity, and duration among low-income urban women. *Journal of Human Lactation*, 10(1), 11-15.
- Kneidel, S. (1990). Nursing beyond one year. In *New Beginnings*. La Leche League. [Online]. Available: <http://www.lalecheleague.org/NB/NB6.4.90.1.html> [1997 November 12].
- Kools, S., McCarthy, M., Durham, R. & Robrecht, L. (1996). Dimensional analysis: Broadening the conception of grounded theory. *Qualitative Health Research*, 6(3), 312-330.
- Kunz, C., Rodriguez-Palmero, M., Koletzko, B. & Jensen, R. (1999). Nutritional and biochemical properties of human milk, Part I: General aspects, proteins, and carbohydrates. *Clinics in Perinatology*, 26(2), 307-333.
- LaCour, A. (1994). Weaning naturally. In *New Beginnings*. La Leche League. [Online]. Available: <http://www.lalecheleague.org/NB/NBJanFeb94.html> [1997 November 12].
- Lawson, K. & Tulloch, M. (1995). Breastfeeding duration: Prenatal intentions and postnatal practices. *Journal of Advanced Nursing*, 22, 841-849.
- Lazzaro, E., Anderson, J., & Auld, G. (1995). Medical professionals' attitudes toward breastfeeding. *Journal of Human Lactation*, 11(2), 97-101.

- Leach, P. (1996). Winning at weaning. In *Family Starwave Website*. [Online]. Available: <http://family.starwave.com/experts/leach/archive/le102495.html> [1996 November 4].
- Lead breastfed. (1997, October 21). *West Australian newspaper*, p 27.
- Leff, E., Gagne, M., & Jefferis, S. (1994). Maternal perceptions of successful breastfeeding. *Journal of Human Lactation*, 10(2), 99-104.
- Lennon, S., Lillethun, A., & Buckland, S. (1999). Attitudes toward social comparison as a function self-esteem: Idealised appearance and body image. *Family and Consumer Sciences Research Journal*, 27(4), 379-405.
- Libbus, K., Bush, T. A. & Hockman, N. (1997). Breastfeeding beliefs of low-income primigravidae. *International Journal of Nursing Studies*, 34(2), 144-150.
- Lindberg, L. (1996). Women's decisions about breastfeeding and maternal employment. *Journal of Marriage and the Family*, 58(1), 239-251.
- Lindberg, L., Bohlin, G., Hagekull, B., & Thunstrom, M. (1994). Early food refusal: Infant and family characteristics. *Infant Mental Health Journal*, 15(3), 262-277.
- Lindenberg, C., Artola, R., & Estrada, V. (1990). Determinants of early infant weaning: A multivariate approach. *International Journal of Nursing Studies*, 27(1), 35-41.
- Lipsky, S., Stephenson, P., Koepsell, T., Gloyd, S, Lopex, J. & Bain, C. (1994). Breastfeeding and weaning practices in rural Mexico. *Nutrition and Health*, 9(4), 255-263.
- Littman, H, Medendorp, S. & Goldfarb, J (1994) The decision to breast feed: The importance of fathers' approval. *Clinical Pediatrics*, 33(4), 214-9.
- Locklin, M. (1995). Telling the world: Low income women and their breastfeeding experiences. *Journal of Human Lactation*, 11(4), 285-291.
- Losch, M., Dungy, C., Russell, D. & Dusdieker, L. (1995). Impact of attitudes on maternal decisions regarding infant feeding. *The Journal of Pediatrics*, 126(4), 507-514.
- Lothian, J. (1995). It takes two to breast feed: The baby's role in successful breastfeeding. *Journal of Nurse-Midwifery*, 40(4), 328-334.
- Lowe, T. (1990). Breastfeeding: Attitudes and knowledge of health professionals. *Breastfeeding Review*, 2(2):85-87.
- Lowe, T. (1994). Breastfeeding: What happens during the first 12 months? *Breastfeeding Review*, 11(10), 487-490.

- Lowe, T. (1997, October). An optimistic study of breastfeeding rates in Victoria. *Proceedings from Breastfeeding The Natural Advantage: An International Breastfeeding Conference*. Sponsored by Nursing Mothers' Association of Australia (pp. 135-136). Sydney: Royal Randwick Racecourse.
- Lubbe, T. (1996). Who lets go first: Some observations on the struggles around weaning. *Journal of Child Psychotherapy*, 22(2), 195-213.
- Lund-Adams, M. & Heywood, P. (1995). Breastfeeding in Australia. In A. Simopoulos, J. Dutra de Oliveira & I. Desai (Eds.) *Behavioral and metabolic aspects of breastfeeding* (vol 78, pp. 74-113) Basel, Karger: World Review of Nutrition and Dietetics.
- Lund-Adams, M. & Heywood, P. (1996). Australian breastfeeding rates: The challenge of monitoring. *Breastfeeding Review*, 4(2), 69-71.
- Maher, V. (1995). Breastfeeding in cross-cultural perspective. In V. Maher (Ed.). *The anthropology of breastfeeding: Natural law or social construct*. (pp. 1-36). Oxford: Berg Publishers Ltd.
- Malik, A. N. & Cutting, W. A. (1998). Breastfeeding : The baby friendly initiative. *British Medical Journal*, 316(7144), 1548-1549.
- Malloy, M. & Berendes, H. (1998). Does breastfeeding influence intelligence quotients at 9 and 10 years of age? *Early Human Development*, 50(2), 209-217.
- Marck, P. B. (1994). Unexpected pregnancy: The uncharted land of women's experience. In P. A. Field & P. B. Marck. *Uncertain motherhood: Negotiating the risk of the childbearing years*. (pp. 82-138). London: Sage Publications.
- Marck, P. B., Field, P. A., & Bergum, V. (1994). A search for understanding. In P. A. Field & P. B. Marck (Eds.), *Uncertain motherhood: Negotiating the risks of the childbearing years*. (pp. 268-298). London: Sage Publications.
- Margiotta, P. (1989). When to wean. *Community Outlook*, October, 9-12.
- Martin, J. (1995). The politics of breastfeeding. In *Parentsplace Website*. [Online]. Available: <http://www.parentsplace.com/readroom/articles/politics.html> [1998 June 22].
- Matterson, N. (1990). *Is he biting again?* (2nd ed.). Victoria, Australia: Marion Books.
- Maushart, S. (1997). *The mask of motherhood: How mothering changes everything and why we pretend it doesn't*. Sydney: Vintage Australia.
- McDade, R. & Worthman, C. (1998). The weanling's dilemma reconsidered: A bio-cultural analysis of breastfeeding ecology. *Journal of Developmental and Behavioral Pediatrics*, 19(4) 286-299

- McGeary, K. (1994). The influence of guarding on the developing mother-unborn child relationship. In P. A. Field & P. B. Marck. *Uncertain motherhood: Negotiating the risk of the childbearing years*. (pp. 139-162). London: Sage Publications.
- McIntyre, E. (1995). Management practice in lactation. *Breastfeeding Review*, 3(2), 77-86.
- McIntyre, E., Hiller, J. C., & Turnbull, D. (1999a). Determinants of infant feeding practices in a low socio-economic area: Identifying environmental barriers to breastfeeding. *Australian and New Zealand Journal of Public Health*, [Online], 23(2), 4 pages. Available: <http://proquest.uli.com/pqdweb?TS=937195714&RQT=309&cc=1&Dtp=1&Did=0000000/9/13/9901&Mt> [1999 September 13].
- McIntyre, E., Turnbull, D. & Hiller, J. (1999b). Breastfeeding in public places. *Journal of Human Lactation*, 15(2), 131-134.
- McKenna, J. & Bernshaw, N. (1995). Breastfeeding and infant-parent co-sleeping as adaptive strategies: Are they protective against SIDS? In P. Stuart-Macadam & K. Dettwyler (Eds.). *Breastfeeding: Biocultural perspectives*. (pp. 265-303). New York: Aldine De Gruyter.
- McVeagh, P. (1999). Paediatric news breastfeeding in Australia. In *Royal Australasian College of Physicians: Fellowship Affairs Website*. [Online]. Available: <http://www.medeserv.com.au/racp/faffairs/0299pn2.htm> [1999 July 30].
- McVeigh, C. (1997). Motherhood experiences from the perspective of first time mothers. *Clinical Nursing Research*, 6(4), 335-348.
- Mercer, R. (1995). *Becoming a mother: Research on maternal identity from Rubin to the present*. New York: Springer Publishing Company.
- Mercer, R. & Rerketich, S. (1995). Experienced and inexperienced mothers' maternal competence during infancy. *Research in Nursing and Health*, 18, 333-343.
- Meighan, M., Bee, A., Legge, D., & Oetting, S. (1998). Ramona Mercer: Maternal role attainment. In A. Marriner-Tomey & M. Alligood (Eds.), *Nursing theorists and their work*. (4th ed.). (pp. 407-422). Sydney: Mosby-Year Book Inc.
- Melia, K. (1996). Rediscovering Glaser. *Qualitative Health Research*, 6(3), 368-378.
- Meremikwa, M., Asindi, A. & Antia-Obong, O. (1997). The influence of breastfeeding on the occurrence of dysentery, persistent diarrhoea and malnutrition among Nigerian children with diarrhoea. *West African Journal of Medicine*, 16(1), 20-23.
- Miller, S. & Fredericks, M. (1999). How does grounded theory explain? *Qualitative Health Research*, 9(4), 538-551.
- Minchin, M. (1995). Saints and sinners revisited. *Healthsharing Women*, 6(2), 13-14.

- Minichiello, V., Aroni, R., Timewell, E., & Alexander, L. (1995). *In-depth interviewing*. (2nd ed.). Melbourne, Australia: Addison Wesley Longman Australia Pty Limited.
- Mitchell, G. & Cody, W. (1993). The role of theory in qualitative research. *Nursing Science Quarterly*, 6(4), 170-177.
- Mohrbacher, N. & Stock, J. (1997). *The breastfeeding answer book*. (Rev. Ed.). Schaumburg, Illinois: La Leche League International.
- Morgan, J. & Stordy, J. (1995). Infant feeding practices in the 1990s. *Health Visitor*, 68(2), 56-58.
- Morrow, M. & Barraclough, S. (1994). Breastfeeding and public policy in Australia: Limitations of a nutritional focus. *Breastfeeding Review*, 11(9), 408-416.
- Morse, J. (1994a). Qualitative research: Fact or fantasy? In J. Morse (Ed.). *Critical issues in qualitative research methods*. (pp. 1-9). London: Sage.
- Morse, J. (1994b). Emerging from the data: The cognitive processes of analysis in qualitative inquiry. In J. Morse (Ed.). *Critical issues in qualitative research methods*. (pp. 23-43). London: Sage.
- Morse, J. (1995). The significance of saturation. *Qualitative Health Research*, 5, 147-148.
- Morse, J. (1998). Validity by committee. *Qualitative Health Research*, 8(4), 443-445.
- Morse, J. & Harrison, M. (1987). Social coercion for weaning. *Journal of Nurse-Midwifery*, 32(4), 205-209.
- Morse, J., Harrison, M., & Prowse, M. (1986). Minimal breastfeeding. *Journal of Obstetric, Gynecological, and Neonatal Nursing*, July/August, 333-338.
- Morse, J. & Bottorff, J. (1992). The emotional experience of breast expression. In J. Morse (Ed.). *Qualitative Health Research*. (pp. 319-332). London: Sage Publications.
- Morse, J. & Field, P. A. (1995). *Qualitative research methods for health professionals*. (2nd ed.). London: Sage Publications.
- Morse, J. & Field, P. A. (1996). *Nursing research: The application of qualitative approaches*. (2nd ed.). United Kingdom: Stanley Thornes Publishers Ltd.
- Mosby's Dictionary*. (4th ed.) (1994). Sydney: Mosby.

- Munhall, P. L. (1993). Epistemology in nursing. In P. Munhall & C. Oiler-Boyd (Ed.). *Nursing research: A qualitative perspective*. (2nd ed.). (pp. 39-65). New York: National League for Nursing Press.
- Murad, P. (Ed.). (1994). Toddler tips: Anxiety about weaning. In *New Beginnings*. La Leche League. [Online]. Available: <http://www.lalecheleague.org/NB/NBSepOct94.tod.html> [1997 November 12].
- National Health & Medical Research Council (1985). *Report of the working party on implementation of the WHO international code of marketing of breast milk substitutes*. Canberra: Australian Government Publishing Service.
- Newbold, D. (1999). Breastfeeding out and about. In *Nursing Mothers' Association of Australia (NMAA) Website*. [Online]. Available: <http://www.vicnet.net.au/~nmaa/bfinfo/out.html> [1999 March 3].
- Newman, J. (1997). Breastfeeding and guilt. In *Parentsplace Website*. [Online]. Available: <http://www.parentsplace.com/cgi-bin/objects/features/wbfweek3.data> [1998 June 22].
- Nursing Mothers' Association of Australia. (1982). *Working and breastfeeding*. Nunawading, Victoria: Author.
- Nursing Mothers' Association of Australia. (1985). *Weaning*. (2nd ed.). . Nunawading, Victoria: Author.
- Nursing Mothers' Association of Australia. (1986). *Expressing and storing breast milk*. (1986). (2nd ed.). Nunawading, Victoria: Author.
- Nutbeam, D., Wise, M., Bauman, A., Harris, E. & Leeder, S. (1993). *Goals and targets for Australia's health in the year 2000 and beyond*. Canberra: Australian Government Publishing Service.
- Oiler-Boyd, C. (1993). Philosophical foundations of qualitative research. In P. Munhall & C. Oiler-Boyd (Ed.). *Nursing research: A qualitative perspective*. (2nd ed.). (pp. 66-93). New York: National League for Nursing Press.
- Onkvisit, S. & Shaw, J. (1987). Self concept and image congruence: Some research and managerial implications. *The Journal of Consumer Marketing*, 4(1), 13-23.
- Owen, S. K. (1989). *Weaning ways: A collection of mothers' nursing and weaning experiences*. Garberville, California: Shared Experiences Publishing.
- Parse, R. (1981). *Man-living-health: A theory of nursing*. New York: Wiley.

- Paton, M. (1997, October). 33 years of breastfeeding support in Australia. *Proceedings from Breastfeeding The Natural Advantage: An International Breastfeeding Conference*. Sponsored by Nursing Mothers' Association of Australia (pp. 162-164). Sydney: Royal Randwick Racecourse.
- Peck, D. & Secker, J. (1999). Quality criteria for qualitative research: Does context make a difference? *Qualitative Health Research*, 9(4), 553-558.
- Phillips, K., Blue, C., Brubaker, M., Fine, J., Kirsch, M., Papazian, K., Riester, C., & Sobiech, M. (1998). Sister Callista Roy: Adaptation model. In A. Marriner-Tomey & M. Alligood (Eds.), *Nursing theorists and their work*. (4th ed.). (pp. 243-266). Sydney: Mosby-Year Book Inc.
- Pickrell, K., Lee, R. E., Schumacher, L. P., & Twigg, P. (1998). Rosemarie Parse: Human becoming. In A. Marriner-Tomey & M. Alligood (Eds.), *Nursing theorists and their work*. (4th ed.). (pp. 463-481). Sydney: Mosby-Year Book Inc.
- Pillitteri, A. (1995). *Maternal and child health nursing: Care of the childbearing and childrearing family*. (2nd ed.). Philadelphia: J. B. Lippincott Co.
- Piper, S. & Parks, P. (1996). Predicting the duration of lactation: Evidence from a national survey. *Birth*, 23, 7-12.
- Plea for mothers on drugs. (1997, October 25). *West Australian newspaper*, p 61.
- Poland, B. (1995). Transcription quality as an aspect of rigor in qualitative research. *Qualitative Inquiry*, 1(3), 290-310.
- Price, J. (1988). *Motherhood: What it does to your mind*. London: Pandora Press Unwin Hyman Ltd.
- Pridham, K. (1993). Anticipatory guidance of parents of new infants: Potential contribution of the internal working model construct. *Image: Journal of Nursing Scholarship*, 25(1), 49-55.
- Prohaska, T. & Clark, M. (1997). Health behaviour and the human life cycle. In D. Gochman (Ed.). *Handbook of health behaviour research III*. (pp. 29-48). New York: Plenum Press.
- Pugh, L. & Milligan, R. (1998). Nursing intervention to increase the duration of breastfeeding. *Applied Nursing Research*, 11(4), 190-194.
- Quarles, A., Williams, P., Hoyle, D., Brimeyer, M., & Williams, A. (1995). Mothers' intention, age, education and the duration and management of breastfeeding. *Maternal Child Nursing Journal*, 22, 102-108.
- Raj, V. & Plichta, S. (1998). The role of social support in breastfeeding promotion: A literature review. *Journal of Human Lactation*, 14(1), 41-44.

- Rao, S. & Rajpathak, V. (1992). Breastfeeding and weaning practices in relation to nutritional status of infants. *Indian Pediatrics: Journal of the Indian Academy*, 29(12), 1533-1539.
- Redman, S., Watkins, J., Evans, L. & Lloyd, D. (1995). Evaluation of an Australian intervention to encourage breastfeeding in primiparous women. *Health Promotion International*, 10(2), 101-113.
- Retalleck, S., Simmer, K., Makrides, M. & Gibson, R. (1994). Infant weaning practices in Adelaide: The results of a shopping complex survey. *Journal of Paediatric Child Health*, 30, 28-32.
- Rew, L., Bechtel, D. & Sapp, A. (1993). Self-as-instrument in qualitative research. *Nursing Research*, 42(5), 300-301.
- Rich, T. (Ed.). (1996). Making it work: Finding support. In *La Leche League Website*. [Online]. Available: <http://www.lalecheleague.org/NB/NBJanFeb96.work.html> [1997 November 12].
- Rich, T. (Ed.). (1995). Making it work: Long term support. In *La Leche League Website*. [Online]. Available: <http://www.lalecheleague.org/NB/NBJanFeb95.work.html> [1997 November 12].
- Richards, L. (1998). Closeness to data: The changing goals of qualitative data handling. *Qualitative Health Research*, 8(3), 319-328.
- Richardson, D. (1993). *Women, motherhood and childrearing*. London: Macmillan Press.
- Riehl-Sisca, J. (1989). The Riehl interaction model: An update. In J. Riehl-Sisca (Ed.) *Conceptual models for nursing practice*. (3rd ed.). (pp. 383-401). Norwalk, Connecticut: Appleton & Lange.
- Robley, L. (1995). The ethics of qualitative nursing research. *Journal of Professional Nursing*, 11(1), 45-48.
- Robrecht, L. (1995). Grounded theory: Evolving methods. *Qualitative Health Research*, 5(2), 169-177.
- Rodgers, B. & Cowles, K. (1993). The qualitative research audit trial: A complex collection of documentation. *Research in Nursing and Health*, 16, 219-226.
- Rodriguez-Garcia, R. & Frazier, L. (1995). Cultural paradoxes relating to sexuality and breastfeeding. *Journal of Human Lactation*, 11(2), 111-115.
- Roe, B., Whittington, L., Fein, S. B., & Teisl, M. F. (1999). Is there competition between breastfeeding and maternal employment? *Demography*, 36(2), 157-171.

- Rogan, W. & Gladen, B. (1993). Breastfeeding and cognitive development. *Early Human Development*, 31(3), 181-193.
- Rogan, F., Schmied, V., Barclay, L., Everitt, L. & Wyllie, A. (1997). Becoming a mother: Developing a new theory of early motherhood. *Journal of Advanced Nursing*, 15, 877-885.
- Rosenstock, I. (1974). Historical origins of the health belief model. In M. Becker (Ed.). *The health belief model and personal health behaviour*. (pp. 1-8). New Jersey: Charles Slack, Inc.
- Rubin, R. (1984). *Maternal identity and the maternal experience*. New York: Springer.
- Russell, J. (1999). Counselling and the social construction of self. *British Journal of Guidance & Counselling*, 27(3), 339-351.
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8(3), 27-37.
- Sandelowski, M. (1993a). Theory unmarked: The uses and guises of theory in qualitative research. *Research in Nursing and Health*, 16, 213-218.
- Sandelowski, M. (1993b). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science*, 16(2), 1-8.
- Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing and Health*, 18, 179-183.
- Scariati, P., Grummer-Strawn, L. & Fein, S. (1997). A longitudinal analysis of infant morbidity and the extent of breastfeeding in the United States. *Pediatrics*, 99(6), E5.
- Schatzman, L. (1991). Dimensional analysis: Notes on an alternative approach to the grounding of theory in qualitative research. In D. R. Maines (Ed.). *Social organisation and social processes*. (pp. 303-314). New York: Aldine De Gruyter.
- Schmied, V. (1998). *Blurring the boundaries: Breast feeding as discursive construction and embodied experience*. Ph.D. thesis, University of Technology, Sydney, New South Wales. (Edith Cowan University Microfilms No. MF 649.33 SCH).
- Schmied, V. & Barclay, L. (1999). Connection and pleasure, disruption and distress: Women's experience of breastfeeding. *Journal of Human Lactation*, 15(4), 325-333.
- Schmitt, B. (1998). Breastfeeding basics. In *Family.com Parenting Website*. [Online]. Available: http://family.disney.com/Categories/Parenting/Features/family_0307_02/dony/dony77babre11/26/98ny77ba [1998 November 26].

- Schwandt, T. (1994). Constructivist, interpretivist approaches to human inquiry. In N. Denzin & Y. Lincoln (Ed.). *Handbook of qualitative research*. (pp. 118-137). London: Sage Publications.
- Scott, J., Binns, C. & Aroni, R. (1996). Breastfeeding in Perth: Recent trends. *Australian and New Zealand Journal of Public Health*, 20(2), 210-211.
- Scott, J., Binns, C. & Arnold, R. (1997). Attitudes toward breastfeeding in Perth, Australia: Qualitative analysis. *Journal of Nutrition Education*, 29(5), 244-249
- Scott, J. & Binns, C. (1999). Factors associated with the initiation and duration of breastfeeding: A review of the literature. *Breastfeeding Review*, 7(1), 5-16.
- Scott, J., Aitkin, I., Binns, C. & Aroni, R. (1999). Factors associated with the duration of breastfeeding amongst women in Perth, Australia. *Acta Paediatrica*, 88(4), 416-421.
- Seafood improves child intelligence. (1997, November 1). *West Australian newspaper*, p 61.
- Seidel, J. (1994). *The ethnograph v4.0: A programme for the management and analysis of text-based data*. [Software]. Amherst, MA: Qualis Research Associates.
- Sharma, M. & Petosa, R. (1997). Impact of expectant fathers in breastfeeding decisions. *Journal of the American Dietetic Association*, 97(11), 1311-1313.
- Shaw, D., McCombs, M., Weaver, D. H., & Hamm, B. J. (1999). Individuals, groups, and agenda melding: A theory of social dissonance. *International Journal of Public Opinion Research*, 11(1), 2-12.
- Shelton, K. (1994). Empowering women to breast feed successfully. *Breastfeeding Review*, 11(10), 455-458.
- Shrago, L. & Bocar, D. (1990). The infant's contribution to breastfeeding. *Journal of Obstetric, Gynecological, and Neonatal Nursing*, 19(3), 209-215.
- Sieloff, C., Ackermann, M., Brink, S., Clanton, J., Jones, C., Marriner-Tomey, A., Moody, S., Perlich, G., Price, D. & Prusinski, B. (1998). Imogene King: Theory of goal attainment. In A. Marriner-Tomey (Ed.). *Nursing theorists and their work*. (4th ed.). (pp. 300-319). Sydney: Mosby.
- Singh, R., Kumar, O. & Rana, R. (1992). Breastfeeding and weaning practices among urban Muslims of District Lucknow. *Indian Pediatrics: Journal of the Indian Academy*, 29(2), 217-219.
- Stamp, G. & Crowther, C. (1995). Breastfeeding: Why start? Why stop? A prospective survey of South Australian women. *Breastfeeding Review*, 3(1), 15-19.

- Stark, Y. (1995). Breastfeeding and the generation gap. In *Parentsplace Website*. [Online]. Available: <http://www.parentsplace.com/readroom/articles/gap.html> [1998 June 22].
- Stearns, C. (1999). Breastfeeding and the good maternal body. *Gender and Society*, 13(3), 308-325.
- Stern, P. (1994). Eroding grounded theory. In J. Morse (Ed). *Critical issues in qualitative research methods*. (pp. 212-223). London: Sage.
- Stone, J., Wiegand, A., Cooper, J., & Aronson, E. (1997). When exemplification fails: Hypocrisy and the motive for self-integrity. *Journal of Personality and Social Psychology*, 72(1), 54-65.
- Storey, J. (1995). Weaning from breast or bottle. *Parents*, July, 87.
- Strauss, A. (1987). *Qualitative analysis for social scientists*. Melbourne: Cambridge University Press.
- Strauss, A. (1995). Notes on the nature and development of general theories. *Qualitative Inquiry*, 1(1), 7-18.
- Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Menlo Park, CA: Sage.
- Strauss, A. & Corbin, J. (1994). Grounded theory methodology: An overview. In N. Denzin & Y. Lincoln (Ed.). *Handbook of qualitative research*. (pp. 273-285). London: Sage Publications.
- Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. (2nd.ed.). Menlo Park, CA: Sage.
- Strecher, V., Champion, V. & Rosenstock, I. (1997). The health belief model and health behaviour. In D. Gochman (Ed.). *Handbook of health behaviour research I*. (pp. 71-89). New York: Plenum Press.
- Streubert, H. & Carpenter, D. (1995). *Qualitative research in nursing: Advancing the humanistic imperative*. Philadelphia: J. B. Lippincott Company.
- Swigart, J. (1998). *The myth of the perfect mother: Parenting without guilt*. Chicago, Illinois: Contemporary Books.
- Tardy, R. & Hall, C. (1998). Bonding and cracking: The role of informal, interpersonal networks in health care decision making. *Health Communication*, 10(2), 151-173.
- Tarkka, M., Paunonen, M., & Laippala, P. (1999). Factors related to successful breastfeeding by first-time mothers when the child is 3 months old. *Journal of Advanced Nursing*, 29(1), 113-118.

- Tesch, R. (1991). Computer programs that assist in the analysis of qualitative data: An overview. *Qualitative Health Research, 1*(3), 309-325.
- Thompson, E. (1995). *Introduction to maternity and pediatric nursing*. (2nd ed.). Sydney: W. B. Saunders Company.
- Thorne, S. (1998). Ethical and representational issues in qualitative secondary analysis. *Qualitative Health Research, 8*(4), 547-555.
- Tice, D. (1992). Self-concept change and self-presentation: The looking glass self is also a magnifying glass. *Journal of Personality and Social Psychology, 63*(3), 435-451.
- Tickner, L. (1998, March 21). Health alert for bottlefed babies. *West Australian newspaper*, p. 42.
- Tienboon, P., Rutishauser, I., & Wahlqvist, M. (1994). Maternal recall of infant feeding practices after an interval of 14 to 15 years. *Australian Journal of Nutrition and Dietetics, 51*(1), 25-27.
- Uwaegbute, A. (1991). Weaning practices and weaning foods of the Hausas, Yorubas and Ibos of Nigeria. *Ecology of Food and Nutrition, 26*(2), 139-153.
- Vandiver, T. (1997). Relationship of mothers' perceptions and behaviours to the duration of breastfeeding. *Psychological Reports, 80*, 1375-1384.
- Vijayasree, Y. & Satya Vani, K. (1992). Weaning and infant care practices in an urban area. *The Journal of Family Welfare, 38*(2), 40-47.
- Virden, S. F. (1988). The relationship between infant feeding method and maternal role adjustment. *Journal of Nurse-Midwifery, 33*(1), 31-35.
- Visness, C. & Kennedy, L. (1997). The frequency of coitus during breastfeeding. *Birth: Issues in Perinatal Care, 24*(4), 253-257.
- Vnuk, A. K. (1997). An analysis of breastfeeding print educational material. *Breastfeeding Review, 5*(2), 29-35.
- Vogel, A. & Mitchell, E. (1998). The establishment and duration of breastfeeding Part 2: Community influences. *Breastfeeding Review, 6*(1), 11-16.
- Voss, S., Finnis, L., & Manners, J. (1993). Fathers and breastfeeding: A pilot observational study. *Journal of the Royal Society of Health, 113*(4), 176-180.
- Walker, M. (1993). A fresh look at the risks of artificial infant feeding. *Journal of Human Lactation, 9*(2), 97-107.
- Walker, C. (1995). When to wean: Whose advice do mothers find helpful? *Health Visitor, 68*(3) 109-111.

- Wambach, K. (1997). Breastfeeding intention and outcome: A test of the theory of planned behavior. *Research in Nursing and Health*, 20, 51-59.
- Weaver, J. & Ussher, J. (1997). How motherhood changes life: A discourse analytic study with mothers of young children. *Journal of Reproductive and Infant Psychology*, 15(1) 51-68.
- Wesley, R. (1995). *Nursing theories and models*. (2nd ed.). Springhouse, Pennsylvania: Springhouse Corporation.
- Western Australian child health survey: Developing health and well-being in the nineties*. (1995). Perth, Western Australia: Australian Bureau of Statistics. Institute for Child Health Research. ABS Catalogue No. 4303.5.
- Wiessinger, D. (1996). Watch your language. *Journal of Human Lactation*, 12(1), 1-4.
- Wigg, N., Tong, S., McMichael, A., Baghurst, P., Vimpani, G. & Roberts, R. (1998). Does breastfeeding at six months predict cognitive development? *Australian and New Zealand Journal of Public Health*, 22(2), 232-236.
- Wight, N. (Ed.). (1995a). A look at breastfeeding: Past, present and future. In *San Diego County Breastfeeding Coalition Website*. [Online]. Available: <http://www.breastfeeding.org/alookat.htm> [1999 July 30].
- Wight, N. (Ed.). (1995). The guilt issue. In *San Diego County Breastfeeding Coalition Website*. [Online]. URL <http://www.breastfeeding.org/guilt.htm> [1999 July 30].
- Wight, N. & Johnson, T. (Eds.). (1995). How to feel comfortable with breastfeeding almost anywhere. In *San Diego County Breastfeeding Coalition Website*. [Online]. URL <http://www.breastfeeding.org/anywhere.htm> [1999 July 30].
- Williams, N. (1997). Maternal psychological issues in the experience of breastfeeding *Journal of Human Lactation*, 13(1) 57-60.
- Williams, K. & Morse, J. (1989). Weaning patterns of first time mothers. *Maternal Child Nursing*, 14(3), 188-192.
- Williams, E. & Hammer, L. (1995). Breastfeeding attitudes and knowledge of pediatricians-in-training. *American Journal of Preventive Medicine*, 11(1), 26-33.
- Wilson, H. & Hutchinson, S. (1991). Triangulation of qualitative methods: Heideggerian hermeneutics and grounded theory. *Qualitative Health Research*, 1(2), 263-276.
- Wilson, H. & Hutchinson, S. (1996). Methodologic mistakes in grounded theory. *Nursing Research*, 45(2), 122-124.

- World Health Organisation (1981). *Code of marketing of breast milk substitutes*. Geneva: World Health Organisation.
- World Health Organisation (1989a). *Protecting, promoting and supporting breastfeeding. A Joint World Health Organisation/United Nations International Children's Emergency Fund Statement*. Geneva: Author.
- World Health Organisation. (1989b). The prevalence and duration of breastfeeding: Updated information 1980-1989. *Weekly Epidemiological Record*, 42(part 1), 321-324; 43(part 2), 331-335.
- Wright, J. (1999, March 14). Babies at risk. *Sunday Times*, Suppl. p. 14.
- Wrigley, E. & Hutchinson, S. (1990). Long term breastfeeding: The secret bond. *Journal of Nurse Midwifery*, 35(1), 35-41.
- Wuest, J. (1995). Feminist grounded theory: An exploration of the congruency and tensions between two traditions in knowledge discovery. *Qualitative Health Research*, 5(1), 125-137.
- Wuest, J. (2000). Negotiating with helping systems: An example of grounded theory evolving through emergent fit. *Qualitative Health Research*, 10(1), 51-70.
- Wylie, J. & Verber, I. (1994). Why women choose not to breastfeed. *Maternal and Child Health*, March, 76,78,80.
- Yimyam, S., Morrow, M., & Srisuphan, W. (1999). Role conflict and rapid socio-economic change: Breastfeeding among employed women in Thailand. *Social Science and Medicine*, 49(7), 957-965.

APPENDIX A

Consent Form

Research Title: Weaning A Child From The Breast

Researcher: Yvonne Hauck
Ph.D. student at the School of Nursing
Edith Cowan University

I understand that Yvonne Hauck is researching the mother's experience of weaning an infant from the breast as part of her Ph.D. study.

My involvement in the study is to share my experience of weaning my infant from the breast in a taped interview with Yvonne. Sharing my experience may require one or more interviews. The number of interviews is an individual matter to be decided by Yvonne and myself. Names will not be used when the tape is copied onto paper. Each interview will be coded by a number to ensure confidentiality. Yvonne may contact me at a later date to ask me to confirm if her findings reflect my experience.

I know that my participation in this study is strictly voluntary and that I have the right not to answer any questions that I may be uncomfortable with. I also know that I may withdraw from the study at any time.

I agree to participate in this study and have received a copy of this consent form. I have been assured that my identity will not be revealed while the study is being conducted or when the study is published in a journal. If I have any queries or concerns I know that I can contact Yvonne Hauck on 9273-8570 at the School of Nursing at Edith Cowan University.

Participant's Signature

Researcher's Signature

APPENDIX B

Interview Guide

Begin talking about your most recent breast feeding experience but also compare and contrast this with your previous experiences at any time.

- Tell me how your breast feeding stopped.

(prompt: when was the decision made, mother or infant led)

- What were your thoughts during the time your breast feeding stopped?
- What were your feelings during the time your breast feeding stopped?
- Did you feel ready to stop?
- What else was going on in your life at this time?

(prompts: support or pressure to wean; other significant events such as teething; family situation such as other children; work related concerns)

- How do you think your baby felt about it? How did that affect you?
- Do you think your baby was ready to stop?
- How did your partner feel about it? How did that affect you?
- How did your weaning affect your family?

(prompt: other children, extended family)

- Did any other people influence your breast feeding or weaning?

Who?

How did they influence you?

- How did breast feeding in public affect you?
- Tell me your reasons for choosing to breast feed.
- Did you have any specific goals or plans?

(prompts: comparison to previous experience; developmental milestones such as teeth, going onto a cup; time frame; work plans)

- Is there anything else you would like to add?

APPENDIX C**Newspaper Advertisement to Recruit Participants
Who Had Breast Fed For Over 18 Months****MOTHERS WHO HAVE BREASTFED**

Have you recently breastfed a baby longer than 18 months but are not currently breastfeeding?

A study is being undertaken by a nursing Ph.D. student to determine mothers' strategies, thoughts, and feelings on stopping breastfeeding.

If you would be willing to share your breastfeeding experience(s), please contact Yvonne Hauck on 9273 8570 at the School of Nursing.

All information will be held in the strictest confidence.

Edith Cowan University LOGO

APPENDIX D

Methodological Memo / Coding Notes

March 4, 1997

The criteria used to consider selection for the initial interviews. Purposive sampling was used to select the initial 7 participants. Participants 2 to 8 were chosen from the larger study. The participants had completed a questionnaire at around 6 months that provided the following information regarding their breast feeding: if they changed from breast to bottle feeding when that was, the reasons for the change, the decision to stop, how satisfied they were with how long they breast fed, how their baby weaned, how long it took and how satisfied they were with how the baby was weaned.

To obtain open sampling the following criteria were used:

- Satisfied with weaning verses not satisfied with weaning
- Duration of breast feeding (6 weeks to 6 months was available at this time)
- Weaning pattern (sudden verses gradual)
- Infant initiated weaning verses mother initiated weaning

A wide variety of women were chosen to cover a diversification of the above criteria. (From an initial list of 16 mothers). For example:

Satisfaction 2 mothers who were very satisfied were chosen

4 mothers who were satisfied were chosen

1 mother who was not satisfied was chosen (there were only 3 mothers who had indicated dissatisfaction and 2 of those mothers had not managed to reach the minimal breast feeding duration of 6 weeks; they had only breast fed for a few days and were not eligible for my criteria of reaching a minimal of 6 weeks)

Duration of breast feeding 12 weeks - 1 mother; 16-18 weeks - 2 mothers, 20-22 weeks - 4 mothers

Weaning Pattern - 1 week - 2 mothers; 2 weeks - 2 mothers; 3-4 weeks - 2 mothers; 6 weeks - 1 mother.

Initiated by - mother (6 mothers); infant (1 mother)

SUMMARY: Of these 7 participants chosen for open sampling, the majority were satisfied with their weaning, breast fed for 16-22 weeks (4 to 5 months), weaned in 2 to 4 weeks and initiated the weaning themselves.

7 mothers who discussed the weaning experience of 12 children.

Underrepresented are: sudden weaning (2 siblings experiences were discussed that involved sudden weaning); **Mothers dissatisfied with the weaning, duration between 6 and 11 weeks, duration longer than 22 weeks, and infant led weaning.**

APPENDIX E

Theoretical Memo / Coding Notes

Follow up Telephone Interview Sept 16, 1997 33 minutes

Mother 21 - 3 weaning experiences:

1st disappointing at 4 ½ months,

2nd very satisfying at 13 months, gradual and both ready,

3rd very disappointing at 9 months cold turkey because of work commitments and had tried to gradually wean for 1 week but it wasn't working so decided that cold turkey would be the only way for this particular child

3rd experience - very disappointed, sudden weaning, no time to grieve over it; 4 months have passed since that time.

How had her feelings/thoughts changed since that time?

Still disappointed; getting on with it (life); able to see the advantages, the positive things (results) that have happened since the weaning i.e. she is not as clingy now. Disappointed because it was "ripped out of my hands" and was "not able to let go in a way you could feel comfortable with".

2nd child - weaning was comfortable and gradual for both (mother and child were ready)

3rd child - didn't have chance to build up to letting go, it was so sudden. Able to rationalise now that it probably would have been only a difference of 4 months if she could have continued breast feeding. Positive Outcomes - able to see her taking a bottle from her husband that he could not do before, the daughter would refuse, mother's attitude has changed because the child has gradually been able to let go. Weaning created changes in the child. It made her into a "nicer" kid. Unexpected positive results the clinginess stopped from "having to have me only and all the time" (tiring and demanding). She began enjoying other people. Being able to walk out of the room without her crying. Father able to care for her. Prior to that he has tried to bathe her but she cried the whole time so he stopped.

Sadness in that the child doesn't need me anymore. Felt some comfort when child was so difficult in taking the bottle (she still wants me). When she finally did readily accept the bottle (I'd lost her). Not her source of nourishment anymore / "was cut like a knife" / "connection was cut".

APPENDIX F

Letter to Coordinators in Child Health (Metropolitan Areas)

Date

Address

Dear XXX,

I am a full time Ph.D. student in nursing at Edith Cowan University, researching mothers' experiences of weaning their child or children off the breast. My study involves a qualitative research method and I have interviewed a number of women regarding their perceptions of their weaning experience(s). They have shared their strategies, thoughts, and feelings experienced during stopping breast feeding. During the interviews, mothers have mentioned the significant impact of child health nurses upon their weaning. Therefore, although my focus is upon the mothers' perceptions of weaning, I would also like to interview a small number (5 - 8) of child health nurses for feedback on their experiences with mothers trying to stop breast feeding. The key questions I am interested in are:

- What reactions have you observed from mothers trying to wean their child from the breast?
- What do you think may influence mothers during this process?
- What reactions have you observed from the child being weaned?
- What reactions have you observed from other family members (ie. father and other children) during this weaning period?
- What impact do you think health professionals have on the process of weaning the child off the breast?

I am seeking your permission to approach the child health nurses in your area with an introductory letter seeking interest in being interviewed. I would mail the proposed introductory letter included with this letter, to individual child health nurses or their respective child health centres, whatever you advise, and invite the nurses to contact me if they are interested in the study. Again, I am only looking at a small number of child health nurses (5 - 8) as they may be able to corroborate or expand on mothers' stories. In qualitative research, providing this form of validity check can provide a more comprehensive explanation of the phenomenon under study.

I would be happy to supply you with further information regarding my research topic as necessary. Approval for this study has been obtained in 1996 from the Edith Cowan University Ethics Committee. A one page abstract of the research or the full proposal are available upon request. If you have any further queries, please contact me. Thank you for your attention.

Sincerely yours,

Yvonne Hauck

Phone 9273 8570
 FAX 9273 8699
 e-mail y.hauck@cowan.edu.au

APPENDIX G

Letter to Individual Child Health Nurses

Date

Child Health Centre

Dear

I am a Ph.D. student in nursing, researching mothers' experiences of weaning their child/ren from the breast. I have interviewed a number of women to date regarding perceptions of their weaning experience(s). They shared their stories with me, which included their thoughts, feelings and weaning strategies plus their child or children's reactions to this process.

Being a child health nurse affords you the opportunity of being a key resource person for breastfeeding mothers. I would like to find out what you think this process involves for women. I am still interested in the mother's perspective of weaning but your observations, as a close observer and resource person can offer a different vantage point or window to this experience. From your experience of working with women, the key questions I am interested in are:

- What reactions have you observed from mothers trying to wean their child from the breast?
- What do you think may influence mothers during this process?
- What reactions have you observed from the child being weaned?
- What reactions have you observed from other family members (i.e. father and other children) during this weaning period?
- What impact do you think health professionals have on the process of weaning the child off the breast?

If you are interested in sharing your observations and perceptions, I would like to arrange an interview at a time and place convenient to you. Participation in this study is strictly voluntary and you have the right not to answer any question that you are uncomfortable with. Your identity will not be revealed while the study is being conducted or when the study is published. Please contact me on 9273 8570 if you would like further information about my research and if you wish, we can then set up an interview time. XXX (Co-ordinator of Community Nursing) is aware of my research and gave me a list of child health nurses in the XXX Health Service.

Thank you for your attention.

Sincerely yours,

Yvonne Hauck

Phone 9273 8570
FAX 9273 8699
e-mail y.hauck@cowan.edu.au

APPENDIX H

Consent Form for Individual and Discussion Group Interviews

Research Title: **Weaning A Child From The Breast**

Researcher: **Yvonne Hauck, Midwife**
 Ph.D. student at the School of Nursing
 Edith Cowan University

I understand that Yvonne Hauck is researching the mother's experience of weaning an child from the breast as part of her Ph.D. study. As child health nurses are a key resource for breastfeeding mothers, Yvonne will be interviewing a small number of child health nurses to see how their observations coincide with the mothers' perceptions and to add a more complete picture to the weaning experience.

My involvement in the study is to share my perceptions and observations of mothers who have weaned their child from the breast based upon my experience as a child health nurse. The interview with Yvonne will be taped. Names will not be used when the tape is copied onto paper. Each interview will be coded by a number to ensure confidentiality. Yvonne may contact me at a later date to ask me to confirm if her findings reflect my perceptions and observations.

I know that my participation in this study is strictly voluntary and that I have the right not to answer any questions that I may be uncomfortable with. I also know that I may withdraw from the study at any time.

I agree to participate in this study and have received a copy of this consent form. I have been assured that my identity will not be revealed while the study is being conducted or when the study is published in a journal. If I have any queries or concerns I know that I can contact Yvonne Hauck on 9273-8570 at the School of Nursing at Edith Cowan University.

 Participant's Signature

 Researcher's Signature

Date _____

APPENDIX I

Interview Guide for Child Health Interviews

NOTE: Questions to be used for either individual or discussion group interviews with child health nurses

- What reactions have you observed from mothers trying to wean their child from the breast?
- What do you think may influence mothers during this process?
- What reactions have you observed from the child being weaned?
- What reactions have you observed from other family members (i.e. father and other children) during this weaning period?
- What impact do you think health professionals have on the process of weaning the child off the breast?

APPENDIX J

Letter To Participants and Partners Who Had One Child

Date

Address

Dear participant & partner,

Thank you for sharing your breastfeeding experience with me during our interview last year. Just as a reminder, my research was looking at mothers' perception of the process of weaning their child off the breast. I have talked to 25 mothers so far and am continuing to interview. Although I am focusing upon the mothers' perspective of how she stopped breastfeeding, I would also like to find out their partner's reaction. I am interested in your partner's answers to the following questions:

- How do you think XXX reacted while she was stopping breastfeeding?
- What may have affected her during the time she was stopping her breastfeeding?
- What do you think were the main issues during this time?
- How do you think your child reacted while the breastfeeding was stopping?
- How did stopping breastfeeding affect you and your family?
- What do you think were good and bad outcomes of stopping breastfeeding?

If you feel your partner may be willing to give his opinion on these questions, I would appreciate his feedback. I am flexible in the way he may want to offer his ideas. We can arrange a telephone interview, a personal interview or he can answer the questions on the sheet provided. Please let your partner fill in his answers without too much influence from you! I want his thoughts and opinions. After he has filled in the form or been interviewed, then please go ahead and talk about your ideas.

Participation in this study is strictly voluntary and he can choose not to answer any question that he is uncomfortable with. Both your identify and your partner's identity will not be revealed while the study is being conducted or when the study is published.

Please contact me on 9273 8570 if you would like further information about my research and if you wish, we can then set up an interview time or you can return your answers in the envelope supplied. Also, if you are interested in any information about my research so far, please contact me and I can bring you up to date on my work.

Thank you for your attention.

Sincerely,

Yvonne Hauck

Phone 9273 8570
 FAX 9273 8699
 e-mail y.hauck@cowan.edu.au

APPENDIX L

Substantive Code List Following Open Coding

Break	1. mother needing a break
Choice	2. loss of choice
Freedom	3. loss of freedom
Determined	4. determination to breast feed
Embarras	5. embarrassment
Sad	6. sadness
Pride	7. pride
Guilt	8. guilt
Relief	9. relief
Enjoy	10. enjoyment / satisfaction/disappointed
Madistress	11. mothers' distress
Comfort	12. comfort feeding
Persist	13. persistence
Mabenefit	14. benefits of breast feeding for mother
Chbenefit	15. benefits of breast feeding for child
Enough	16. mother had enough
Trustself	17. listening to self / trusting self
Nolisten	18. not listening to others
Intimacy	19. loss of closeness / intimacy
Timing	20. timing
Alone	21. alone / isolated
Notexpect	22. experience not as expected
Vulnerable	23. mother vulnerable
Questions	24. mother questioning
Discrete	25. being discrete when feeding in public
Public	26. comfort when feeding in public
Pubcomment	27. comments from others feeding in public
Otherchild	28. other children
Dadsupport	29. father's support
O-mothers	30. other mothers
Family	31. comments / reactions from family
Friends	32. comments / reactions from friends
CHN	33. child health nurses' input
DR	34. doctors' input
Resources	35. other resources (lactation consultant, NMAA)
Contradic	36. contradictory messages
Teeth	37. teething
Person	38. child's personality
Content	39. content child
Unsettle	40. unhappy / unsettled child
Sleep	41. child sleeping patterns
Refuse-br	42. child refusing breast
Refuse-bot	43. child refusing bottle
Accept-bot	44. child accepting bottle
Pain	45. mother's pain / discomfort
Leak	46. leaking milk

Supply	47. milk supply
Exhaust	48. exhaustion
Pastexp	49. past experiences with weaning
Stratwean	50. strategies to wean
Society	51. media influences
Stratbf	52. strategies to keep breast feeding
Sucking	53. child sucking problems
Depress	54. depression
Expect	55. mother's expectations & goals
Express	56. expressing breast milk
Acknow	57. acknowledging mothers' efforts
Duration-w	58. duration of weaning
Durationbf	59. duration of breast feeding
Work	60. work commitments
Begin	61. beginnings with breast feeding
Problems	62. physical problems
Overcame	63. overcame problems
Life	64. other life events
Reject	65. mother's feelings of rejection
Struggle	66. struggles
Sexual	67. breasts as sexual
Stop	68. pressure to stop
Continue	69. pressure to continue
Hindsight	70. looking back/resolving
React	71. child's reaction
Literature	72. literature from books, web sites, newspapers

APPENDIX M

Theoretical Memo on Contradictory Messages

August 18, 1998

Expectations of others

Mothers having to deal with the expectations of others. For example, feeling uncomfortable with a child health nurse because you are still breast feeding at 18 months. The CHN's expectations were that she should have stopped by then. The child health nurse also reflected the expectations of society regarding long term breast feeding. Is it truly acceptable after 12 months? Do mothers feel pressure not to be breast feeding after 12 months? And if they are breast feeding, do they feel they need to hide the fact because what they are doing is not socially acceptable. Old fashioned ways (cultural expectations) *If it was up to my dad (child) would have been on a bottle since the day he was born. That's because he's an old Italian from the old fashion ways (M19).* Assumptions such as: *My husband just said to look eventually he's going to be on a bottle anyway so why don't you just try a bottle once, just to make sure he'll take it (M3).*

Mother caught in the middle trying to deal with her own expectations, her partner's expectations, her family's expectations, her friend's expectations, and society's expectations. She has to weigh the importance of all of these expectations and come to an acceptable balance for her and her child's needs. Everyone is more than happy to offer their opinions to the breast feeding woman, even those people who have never breast fed before. Those women who have breast fed are offering opinions based upon their limited breast feeding experiences. How did you cope being in the middle? (partner & mother saying stop and CHN saying persist) *I just cried a lot and then I thought I've done what I can and I gave him six weeks of breast milk (M17).* This mother was also feeling pressure from her friends to continue breast feeding. *Sometimes you tend to listen like when your friends make comments and you think well, maybe I'm a bad mother because I'm giving up and they're saying you should keep going but then on the other hand I think you know, no it's better off for us so we'll do it our way (M22).*

Contradictory advice given in hospital undermines a mother's confidence and trust in the health professionals and leaves the mother confused and floundering. What do I do and who can I turn to? Who is right and who is wrong? The issues of communicating to people from the critical parent ego state disempowers the mother. It treats them like a child and reinforces the position of being powerless and vulnerable. *What am I supposed to do ... and so I had nobody to sort of tell me, nobody to sort of say "well that's a load of rubbish" don't listen to that (M21).*

The greater the contact with a variety of health professionals, the greater the likelihood of receiving contradictory advice. The multiple of opinions and options that are presented serve to further confuse and frustrate the mother. One health professional will often undermine the advice of another health professional, by saying "don't do what she said, do what I say". The mother is left feeling, who do I trust? Superficial contact with many different resources (DR, CHN, NMAA, lactation consultants) do not allow the resource persons to get to know the mother and child as individuals. The responses from the resources tend to be "textbook" which do not consider the family unit in a holistic manner.

APPENDIX N

Reflexive Journal

September 1997

Personal Assumptions (bias) regarding weaning based upon own experiences

- First weaning experience will greatly affect subsequent experiences
 i.e. My first experience was infant led at 12 months (child fussed and refused to feed), breast offered a few times but child not interested. Initially surprised & sad but able to rationalise that child initiated weaning so obviously his needs were met. Expected second child to do the same (infant led) but by 20 months child showed no interest in weaning and I was beginning to not enjoy breast feeding anymore (felt too tied down, she could not go to sleep without feeding, not able to go out alone in the evenings). Breast feeding had decreased to the point of one breast per evening and one evening she fell asleep without feeding. “That was it”. The breast was not offered again but for months someone had to lie with her at night to get her to sleep (she would put her hand down your shirt for comfort [mother or father]) for the closeness. The goal of achieving infant led weaning was not met and it took time to be able to view that experience as successful because an important goal was not met.
- Weaning will be greatly influenced by the partner’s wishes. If the partner wants the mother to stop she will feel pressure to do so and if he wants her to continue she will also feel pressure.
- Mothers feel “pressure” from social as to the “right” time to breast feed (between 4 to 12 months) i.e. as recommended by health professionals and WHO to breast feed for 4 to 6 months. After 12 months and the child is not an infant anymore, social pressures to not breast feed in public will be greater.
- Mothers may feel sad when they finish breast feeding because it is a “letting go” of their child. Weaning is symbolic that their dependency on the mother has decreased. Mothers want to be needed.
- Mothers who have an unsatisfactory weaning experience (that does not come up to their expectations) will need to resolve those feelings. She may feel it reflects upon her mothering abilities. What factors are needed to help her resolve the experience, I don’t know? Acknowledgement from the partner, family, friends, or health professionals? Which is most important?

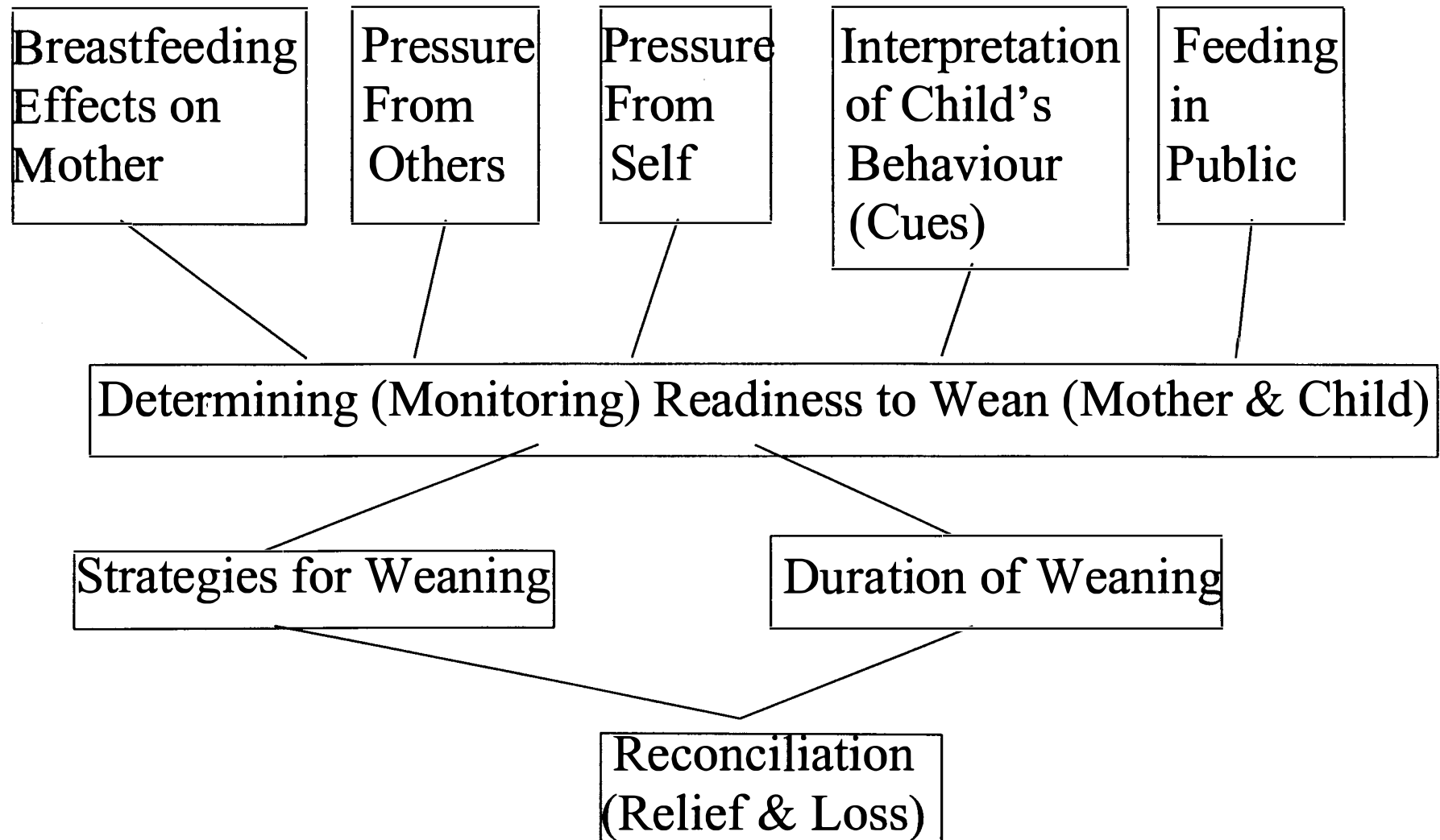


Figure 4. Example of diagramming from early data analysis (August 20, 1997)