

Young mothers' negotiations of infant feeding. A qualitative study with ethnographic methods.

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Abstract

Background: In the UK, mothers under 20 are the group least likely to breastfeed. Recent public health interventions to promote breastfeeding in the under 20s have met with limited success. Suggested factors include cultural constructions of normative behaviour, environmental and practical barriers, and a lack of professional and community support. However, less is known about the journey through infant feeding and the interrelation of the various influences on the experiences of young mothers.

Methods: Ethnographic interviews and participant observation were used to explore the lived experience of ten young mothers aged 16-18 and their babies, from pregnancy to weaning. The data were analysed using Thematic Network Analysis and the emerging themes developed into a coherent description of the influences on infant feeding practices and why these influences seem to lead to formula feeding.

Results: The influences were found to relate to three broad thematic areas: the immediate context and the importance of family relationships; the external context of public spaces (which could include the public areas of the home) and the themes of the babies and the milk.

Discussion: Theories of the interplay of practical experiences of the young mothers with moral discourses of good motherhood were developed. Using the Ricœurian theory of the narrative of the self (ipse identity) the work of becoming a mother and making feeding decisions in a morally charged environment are explicated. This approach has begun to reframe the discourse on health research on the public health approach to breastfeeding to encompass and integrate personal identities and social relationships with cultural norms of infant feeding.

Conclusions: The findings gave new insights into both why breastfeeding rates are low in this group and why existing interventions have not significantly changed behaviour. The need for a consideration of the social, cultural and moral meanings of infant feeding to young mothers has been highlighted. Practical suggestions for supporting young mothers who wish to breastfeed have also been developed from these research findings.

Introduction

This small, in depth study sets out to further the understanding of why mothers under 20 have the lowest rates of breastfeeding initiation and the sharpest decrease in continuation in the United Kingdom (McAndrew et al. 2012). Against the background of improving rates overall and much public investment and growing professional expertise in supporting breastfeeding mothers, why are young mothers still predominately formula feeding their babies?

From the existing research on the subject of young mothers and breastfeeding, cultural constructions of normative behaviour (Condon et al. 2013), cultural barriers (Dykes et al. 2003), practical barriers (Radius and Joffe 1998) and interactions with health care professionals (Dykes et al. 2003) all appear to play a part in explaining the low prevalence of breastfeeding in young mothers.

“Bottle-feeding remains the predominant method of feeding babies in the United Kingdom with strong cultural prevalence in young mothers and disadvantaged groups.” (Dykes et al. 2003, pg. 391).

This primary research sets out to look at the young mothers' entire journey through infant feeding, from being pregnant and thinking about infant feeding, right through to weaning.

Over nearly a year I followed ten young mothers, from the third trimester (28 to 40 weeks) of pregnancy until their babies were weaned onto solid food. I attempted at least four interviews and participant observation episodes with them, though there were some participants who contributed much more than others. They were all 16-18 years old of varying ethnicity and religion, with varying levels of social support and resources.

The first chapter (Background, chapter 1) begins with a brief reassessment of the evidence for the benefits of breastfeeding. Whilst the evidence is known to be in

favour of its health benefits over formula milk; I wanted to present a fresh overview of some of the benefits, since within the very emotive arena of infant feeding there can sometimes be either hyperbole or vigorous understatement of the evidence available. The Background chapter then covers the public health context of breastfeeding and young mothers and briefly discusses the current interventions to increase breastfeeding rates in the UK. The comprehensive literature review and a more detailed meta-synthesis of 15 key papers are found in section 1.4 of this chapter. My primary and secondary research questions are set out in the final section (1.5) of chapter 1.

Chapter 2 section 1 sets out the methods and underpinning philosophy of the research. It opens with a discussion of the ethnographic methodology and health research and describes my use of Ricœur's theories of narrative and relational identity to make sense of my narrative data. There is also a brief discussion of the feminist lens in the research approach. Following this section 2 presents the research methods, presenting the ethical and governance procedures, identification and recruitment of participants, data generation and qualitative analysis methods.

Chapters 3-6 present the results, starting with a 'get to know' the participants section; vignettes of their journeys, primarily in their own words. Three further chapters in thematic sections follow. Chapter 4 presents findings in relation to the immediate context; that of the family and the self. Chapter 5 covers the external context; how the mothers negotiate the professional and lay discourses of infant feeding and interact with the environment around them. The final chapter in the results section focuses on the babies and the milk, in which the mothers describe their relationships with their babies and their lived experiences of their baby's behaviours when feeding.

Chapter 7, Discussions and conclusions, begins with a discussion of the overarching theories developed from the data. There then follows a discussion of the possible implications of this study and prior theoretical work for understandings of young mothers and breastfeeding in the context of the previous literature and the implications for practice and further research. The strengths and weaknesses of the

primary research and a discussion of trustworthiness and transferability are presented next. The chapter ends with a conclusion, which summarises the implications for theory, policy and practice.

Reflective introduction

My interest in breastfeeding is part of my abiding interest in social inequality and feminism, which is the reason I studied anthropology and midwifery and why I am now doing my doctorate in public health. Breastfeeding is at once both an empowering and deeply personal act of nurture and a bodily practice that is annexed and made exclusive by the machinations of an unfair social system. In short, those who would most benefit from breastfeeding are the least likely to do so; those who would benefit most from being breastfed are the most likely to be bottle-fed.

Both my theoretical position as a feminist and my experience as a clinician shapes both the questions and the results of this study. My aim is to reframe young mothers infant feeding to be understood in the same terms that we need to look at any mothers' feeding – as both culturally bounded and requiring intense physical, emotional and moral work. This positionality is recognised when discussing the results and I have used reflection throughout the study to better describe the lens through which these data are presented and analysed.

I trained as an anthropologist in the late 1990s. Then, after a brief career in charity management, I retrained as a midwife. During my training and initial practice as a case loading midwife in London I worked at one of the teenage pregnancy clinics that ran out of a *Connexions* centre in Lewisham. The young mothers' discussions about how to feed their babies were always interesting and sometimes surprising. I felt that I wanted to know more.

Another curious observation that influenced my choice of PhD topic was the fact that the young mothers I cared for, or knew, would breastfeed only in private, and bottle feed in public. However, all the 'middle class mums' I came across would only bottle feed at home (usually a bottle before bed for a 'longer sleep') but breastfeed in

public, often not admitting to 'mixed feeding'. What kind of a culture is this, where both modalities of infant feeding are proscribed as in some way shameful or embarrassing? Are there two different 'cultures' at work here, or is this a continuation of the same dilemma, solved in different ways? This developed into the core of my research.

My own personal experience as a mother who breastfed her daughter for several years and during the research itself, is also entwined with my analysis of the topic. For me breastfeeding was the only part of the maternity journey in which I felt I had done well; a difficult pregnancy with multiple pathologies was followed by a failed induction leading to an emergency caesarean section and a major obstetric haemorrhage. My breastfeeding was comparatively easy and enjoyable for us both and this played a huge part in my recovery from a difficult and traumatic birth. However, the personal predisposition to see the psycho-social gains possible in breastfeeding does not outweigh years of experience in watching women, of all backgrounds, struggle both physically and emotionally with breastfeeding. Nor does my own experience cloud my feminist ideological standpoint, that breastfeeding is a practice requiring physical and emotional work that needs to be understood in a context of gendered values and societal pressures for all women.

It is possible that some of the challenges in infant feeding are the same and some may be different for young mothers, but for them, the solution to these challenges appears to be bottle feeding. My research has given me insight into some of the reasons why this is so, and I hope it will be of some use to others.

Chapter One: Background

Introduction

This chapter sets out the background for my doctoral research on young mothers' negotiations of infant feeding. The chapter begins with the definition and usage of terms used throughout the thesis.

An overview of the evidence for the benefits of breastfeeding is followed by the epidemiology of infant feeding in the UK. The reasons why the issue of young mothers' low rates of breastfeeding is important in a public health context are discussed and some of the current interventions to increase breastfeeding among deprived groups are described.

The literature review provides a comprehensive review of the relevant literature and a meta-synthesis of 15 key papers, which are directly concerned with young mothers and breastfeeding in any country. Finally, the rationale for the research and the contribution it intends to make is explained. The research questions and objectives are set out at the end of the chapter.

1.1 Definition and usage of terms

Modalities of infant feeding

There is discussion below on the methodological problems with the categories of breastfeeding used in research but for the purpose of clarity the following terms will be used throughout this thesis. The term breastfeeding refers to the practice of feeding a child human milk directly from the breast. This can be exclusive (no other food, drink or supplements other than medications) or partial breastfeeding, where formula milk is also given in a bottle or cup. Formula feeding refers to the feeding of an infant with commercially available formula milk from a bottle. Where expressed breast milk (EBM) is given with a bottle this will be made explicit in the discussion.

However, this mode of feeding EBM is usually categorised as breastfeeding within the literature as a whole (Abrahams and Labbok 2009). It is worth remembering that whilst these definitions are important for an understanding of the research, since only 1-2% of all mothers are exclusively breastfeeding at six months in the UK (McAndrew et al. 2012), the majority of mothers will use some or all of these modalities of feeding.

Young mothers

The most difficult term to decide upon was what to call young mothers. The implications of stigma and judgment implied in terms such as 'teenage mothers' and 'pregnant teenagers' made this an important choice of words. The term 'young mothers' is used throughout this thesis as I felt it was the most descriptive with the minimum of pejorative overtones. It is taken from the Infant Feeding Survey (McAndrew et al. 2012) to describe any mother who gives birth before the age of 20 years. In the majority of the literature on young mothers the upper age limit is between 20-24, so whilst this primary research only included those between 16 and 20 years old, some of the discussion in the literature review may also pertain to slightly older mothers.

Lived experience

The concept of 'lived experience' is used in this work to describe the composite experience of the young mother's interactions, practices, values, feelings and wider social life. It is also intended to refer only to the person, and is used instead of the similar concept 'habitus' (Bourdieu 1990) as this sometimes indicates a wider cultural or societal experience and in medical literature habitus means the physique or body shape. The concept of lived experience is key to the development of the theoretical discussion of the study because it is essentially the focus of the research – the lived experience of the young mothers as they negotiate infant feeding.

1.2 The public health perspective

In this section, the global public health benefits of breastfeeding are critically assessed, on the basis of epidemiological evidence for a causal relationship with a reduction in morbidity and mortality for both mother and child. There follows a description of the epidemiological data that is relevant to young mothers in particular, mostly using studies sited in the UK. There follows a short review of the current interventions to increase breastfeeding rates. Lastly, the methodological difficulties with researching infant feeding in all research paradigms are discussed.

The benefits of breastfeeding

In order to both situate the qualitative review in an epidemiological context and to provide justification for the research proposal as of benefit to public health, there follows a brief overview of the most up-to-date, available meta-analyses for some of the key outcomes associated with breastfeeding. The benefits to the child are from a lower risk of atopy; hospitalisation with otitis media and gastrointestinal infections, childhood obesity and diabetes (Horta et al. 2007). The benefits to the mother include a reduction in the life-course risk of some cancers (Eidelman et al. 2012) and in aiding and sustaining weight loss (Liu et al. 2010). On a societal level, breastfeeding reduces costs in treating the above diseases and reduces infant acute admissions from infectious diseases (Renfrew et al. 2012, Victora et al. 2016). A comprehensive literature review for relevant meta-analyses was performed using Medline and then the World Health Organisation (WHO) systematic review of *"Evidence on the long-term effects of breastfeeding"* (Horta et al. 2007) was used as a framework for the review, using more recent meta-analyses to supplement the previous review's findings. In addition, the recent paper by Victora et al. (2016) was reviewed as it is the most recent evidence and a powerful meta-analysis of the benefits of increasing breastfeeding rates from both an epidemiological and an individual perspective. Victora et al. (2016) provide overwhelming confirmation of the importance of breastfeeding to public health and to the individual's risk of many diseases over the life-course. They conclude that *"Possibly, no other health*

behaviour can affect such varied outcomes in the two individuals who are involved" (Victora et al. 2016 page 485, paragraph 7). They also demonstrate that the UK has one of the lowest rates of children receiving any breast milk by 12 months in the world. This suggests that understanding why this rate is so low in the UK, so that solutions may be found, is now more urgent than ever.

Diarrhoeal illness

Reduction of morbidity and mortality from diarrhoea by exclusive breastfeeding is the single biggest public health issue on a global scale in infant feeding. There is good evidence that breastfeeding greatly reduces mortality (Lamberti et al. 2011). Physiologically, breast milk and breastfeeding protect infants via three mechanisms - it supports the commensal bacteria; prevents ingestion of contaminated substances in the vulnerable period of early infancy; and it provides specific and non-specific immunity via various pathways as discussed below.

Lamberti et al.'s (2011) meta-analysis of epidemiological studies since 1980 found that the major gain was in the reduction of the severity and duration of diarrhoeal episodes, rather than a dramatic reduction in the incidence thereof. They also found that there was a reduction in 'all cause' mortality among breastfed babies, probably because they were not already weakened by diarrhoeal illness and malnutrition and because of the immunologic support, mentioned above, provided by the breast milk.

The largest effect was seen in diarrhoea mortality between exclusively breastfed and not breastfed children aged 0-5 months. The RR of death for not breastfed children was 10.52 (95% CI 2.79-39.6). In children aged 6-23 months of age, any breastfeeding protected the child compared to non-breastfed children aged 6-23 with RR of mortality of 2.28 (95% CI 0.85-6.13). The two main mechanisms of immunologic action in breastfeeding are the antimicrobial and immunological. The anti-inflammatory and immunomodulatory agents in breast milk are leukocytes, glycoproteins and oligosaccharides (promote the growth of commensal bacteria) and lactoferrin. The immunomodulatory function is the unique bacterial and hormonal interactions between mother and baby. The specific antibodies present in breast milk

are dependent on what the baby and mother are exposed to and to the mother's own immune system (Lamberti et al. 2011).

There have been several recent changes to breastfeeding advice in the UK, including the update of the NICE guidelines to reflect current consensus on age of weaning (6 months) and to promote breastfeeding of unlimited frequency and duration (NICE 2011). The Cochrane meta-analysis (Kramer and Kakuma 2012) found that infants exclusively breastfed to six months are less likely to have gastrointestinal infections than mixed-fed or early weaned babies and show no significant markers of malnutrition. In addition, weight loss and delayed menses were found for the breastfeeding mother in all trials. Micro-nutritional status, where measured, was not of clinically significant difference between any of the groups (Kramer and Kakuma 2012). Early weaning onto solid food and the use of supplementation with teas, water or milk is a common problem in many countries, including the UK, particularly in young mothers and in deprived areas (McAndrew et al. 2012). The evidence above shows that breastfeeding confers a lower risk of diarrhoeal illness in *all settings* though morbidity and mortality is more severe in lower income countries.

Atopic disease

The other benefits to the child are a decrease in atopic disease due to the immunomodulatory factors in breast milk and by the avoidance of other allergens by exclusive breastfeeding (Gdalevich et al. 2001). Brew et al. (2011) found a slight increase in diagnosed asthma, though this may be due to reverse causation – mothers who suspect respiratory problems or who have a strong family history may be more likely to initiate breastfeeding and breastfeed for longer because of current advice. There are several difficulties in research into breastfeeding and atopy. Firstly, as well as the difficulties in classifying breastfeeding discussed below, there are also methodological problems with diagnosing and categorising atopic diseases (Brew et al. 2011). Wheezing, especially post-viral wheeze, is common in young children (Brew et al. 2011) as are infectious and chemical dermatitis. Children are not often given diagnoses of atopic diseases until later in life and therefore studies which

attempt to estimate incidence below about the age of five struggle with this categorical problem. Finally, asthma is more common in deprived socio-economic position groups, due to family smoking and local air pollution so, like many diseases of childhood, taking into account the other risk factors is essential when interpreting the evidence.

Maternal obesity

There is some debate about the size of the effect of breastfeeding on maternal obesity. The two seminal studies, briefly presented here are interpreted with caution as, of course, neither study can demonstrate causation and both studies are potentially confounded by socio economic status. But overall, given the reach of both studies, there does seem to be some evidence of benefit to mothers who breastfeed in terms of a reduction in obesogenic illness. Liu et al. (2010) in a cohort study of 52,731 women found that those who did not breastfeed had a 50% increased risk of type two diabetes in later life. Further, Bobrow et al. (2013) in their cross sectional study of 740,628 women, found that post-menopausal women had a 0.22kg/m² reduction in BMI for every six months they had breastfed.

Child obesity

Formula fed babies have, on average, an altered endocrine response with higher insulin responses and thus stimulation of fat deposition and the development of adipocytes (Beyerlein and von Kries 2011, Gale et al. 2012). The content of breast milk itself may help to limit obesity as it contains factors that inhibit adipocyte formation (Beyerlein and von Kries 2011), regulate growth hormones (Fewtrell, 2011) and it has a lower protein content (Beyerlein and von Kries 2011). In addition, there could be a 'programming' effect, both in terms of satiety response to the increased fat levels with the end of a breastfeed and in the infant's ability to eat to 'fullness' when breastfed (Beyerlein and von Kries, 2011, Gale et al. 2012). The authors of each study concluded that breastfeeding conferred a slight protective effect against cardio-vascular disease and that there was a weaker, but still significant, effect on obesity in later life. The discussion of diabetic risk alone was not conclusive. Overall

there is some evidence of a slight protection from later childhood obesity from being breastfed and some evidence of dose response effect from breastfeeding (Arenz et al. 2004).

Maternal cancers

Recent evidence has much strengthened the claims for the protective effect of breastfeeding on the maternal life-course risk of cancers, particularly breast and ovarian cancers. Victora et al. (2016) analysed 47 studies, which included nearly 50,000 patients, and determined that with every year a mother breastfed her lifetime risk of invasive breast cancer fell by 4.3% (95% CI 2.9-6.8). Similarly, the analysis of studies on ovarian cancers showed an even greater protective effect of 30% (95% CI 25-36) over the life-course. Further, Islami et al. (2015) showed in their meta-analysis of 27 studies (36, 881 patients) that the protective effect of breastfeeding is particularly strong (OR 0.90, 95% CI 0.82-0.99) for hormone receptor-negative breast cancers, which more commonly affect younger women and are more likely to be fatal than receptor-positive cancers. This is crucial information for our patient group in maternity care, given their age.

It is of great importance that, as well as conclusive evidence of overall benefit, the 'dose response' effect of breastfeeding is also now well demonstrated – that it is important not just that women breastfeed, but that they do so for extended periods of time. In the UK we have low breastfeeding rates overall but particularly low rates of continued breastfeeding after beginning solid foods (<1% by six months McAndrew et al. 2012). Understanding the reasons why this might be so is at the centre of any public health intervention to increase the duration of breastfeeding for all mothers.

Psychosocial benefits

There is increasing interest in attachment theory (Bowlby 1977) in early infancy and later child behaviour and mental health. The NSPCC intervention “Minding the baby” (Sadler et al. 2013), designed to promote attachment and bonding between young mothers and their babies, is currently being piloted in the UK and is a good example of this. Breastfeeding is thought to assist in attachment of the dyad by both keeping

mother and baby physically close so that the mother is more 'sensitive' to the infant's communication and by a demonstrable relationship with the mother's risk of postnatal depression (Dennis and McQueen 2009). However, it is not clear if the latter is because of early cessation of breastfeeding in mothers who develop postnatal depression, rather than a protective effect of the breastfeeding itself (Dennis and McQueen 2009).

A longitudinal study (Oddy et al. 2010) based on a pregnancy cohort of 2900 women, followed for 14 years, found that a shorter duration of breastfeeding (defined as less than six months, if at all) might be predictive of adverse mental health outcomes through to early adolescence. Similarly, an observational study of 152 mothers to assess attachment found that breastfeeding mothers were more 'sensitive' to the infant's cues (Britton et al. 2006). This has implications for young mothers, who are more at risk of both mental health problems themselves and of behavioural problems in their children (Shaw et al. 2006). However, as discussed later, this may be because of the wider socio-economic factors that cause women to become parents at a relatively young age (Link and Phelan 1995). There is a particular risk of reverse causality in observational studies into the effect of breastfeeding on behaviour and mental health (Kramer et al. 2011). In summary, there is no definitive evidence that breastfeeding has later psychological benefits for infants that could not be attributed to the cultural and individual factors that predispose women to formula feed.

Healthcare costs

From an economic perspective in public health, a recent report published by UNICEF (Renfrew et al. 2012) sets out the economic case for interventions to increase breastfeeding. The team used 25 systematic reviews, many of which are discussed above, to cost the harm in feeding infants with formula milk from birth. They found that prevention of disease by an increase in breastfeeding rates to achieve 45% breastfeeding exclusively to four months could save the NHS £17 million for each annual cohort of mothers. This saving reflects the reduced costs of treating gastrointestinal (including the severe necrotising enterocolitis), respiratory tract infections and otitis media (Renfrew et al. 2012) and does not include longer term

health benefits for mother and child which potentially could also represent a huge saving for the NHS. The global picture is even more compelling; Victora et al. 2016 concluded that if breastfeeding to WHO guidelines was achieved at a near universal level then globally over 823,000 deaths in the under fives could be prevented and 20,000 deaths from breast cancer averted.

Conclusions about the health benefits of breastfeeding

A fully evidenced view of the benefits of breastfeeding should be a prerequisite to any research that investigates breastfeeding. Infant feeding is an issue that provokes strong emotions and has a strong socio-economic gradient. Claims for benefits of breastfeeding are increasingly based on the best possible evidence which is vital if we are to overcome some of the stigma and tribalism associated with feeding modalities. We now have this evidence for some outcomes, such as risk of morbidity from diarrhoeal illness and reduction in cancer risk over the life-course, but other claims (such as increasing IQ or preventing atopic disease in a baby with no family history) are not as yet so robustly supported.

Secondly, it may be that in some circumstances the mother's choice to feed a child infant formula may be made for both psychosocial reasons (Hoddinott et al. 2012) and because of infectious disease or other pathologies. Whilst we aim for a much greater number of mothers breastfeeding their babies, and doing so exclusively to six months, there will always be a number of women for whom formula milk is the preferred choice.

Methodological difficulties with research on infant feeding

In the context of this primary research it is worth briefly noting the challenges of research into breastfeeding. Understanding the methodological difficulties is important to understanding the research context and also helps to make explicit the lack of understanding of exactly how infant feeding is experienced by young mothers.

There are several main methodological difficulties with researching infant feeding. The first is a problem of the many and varied ways of defining breastfeeding for example, ideal, exclusive, non exclusive, mixed feeding and use of expressed milk are all used, (Labbok and Krasovec 1990, Thulier, 2010) which leads to common categorical errors. There is an increasing drive towards consistency as Thulier (2010) reports, but it does make some of the existing research hard to compare. Duration of breastfeeding is typically very subject to recall bias and even purposeful obfuscation as women may feel that their mothering practices are being called into question (Labbok and Krasovec 1990).

Secondly, there are issues with the evidence of definite clinical significance to the proxies used - for instance, a single weight measurement in teenage years is not an accurate prediction of later cardio-vascular disease (CVD) risk in the life-course (Gale et al. 2012). However, as a well-controlled cradle to grave study is still not available, until the Millennium Cohort Study (Centre for Longitudinal Studies, 2000) reaches adulthood, the more reliable outcome of CVD mortality is unavailable to us.

Thirdly, and perhaps more insurmountably, there is very little gold-standard quantitative evidence on the health benefits of breastfeeding as we are reliant on observational studies as it is not feasible to randomly assign infants to breastfeeding or non-breastfeeding (Fewtrell 2011). For ethical reasons it is unlikely that there will ever be a randomised and double blinded controlled trial (RCT), as randomising to formula feeding would not be acceptable and obviously a woman would know if she were breastfeeding. Therefore, use of the next tier of evidence, such as observational cohort studies, is necessary for all meta-analyses (Fewtrell 2011).

Finally, in the UK the problems raised by the social gradient in breastfeeding are of great importance. Social status is both difficult to fully account for and also is not always given the consideration it deserves in bio-medical research on breastfeeding. Several of the studies (for example, Hoddinott et al., 2009) discuss the difficulty of controlling for socio-economic status in a support efficacy study (of any methodology) as more affluent women are more likely to access breastfeeding support. This is a further reason why young mothers are not well studied in terms of

breastfeeding behaviours and attitudes; they are hard to recruit and retain through the normal channels of breastfeeding promotion (Arai 2003).

The social epidemiology of infant feeding in the UK

Two successive Infant Feeding Surveys (IFS) (Bolling et al. 2007, McAndrew et al. 2012) in the UK have shown that breastfeeding is lowest amongst the most deprived groups of women (McMillan et al. 2009, Bolling et al. 2007). Prior to the IFS, Dattani et al. (2007) used census data from 2001-2002, to examine the relationship between teenage conceptions and deprivation in the UK (Dattani et al. 2007) and outcome (live birth, still birth, termination of pregnancy (TOP) and miscarriage) by ward. As expected, the rate of conception was highest in the most deprived wards, by Carstairs scores (Carstairs and Morris 1991), and the percentage of conceptions leading to a TOP was lowest in these areas. Further, in absolute terms, young mothers remain the group with the lowest level of breastfeeding initiation and a much steeper gradient of cessation by six weeks than older mothers of similar socio-economic position (Bailey and Clark 2008, McAndrew et al. 2012). Although deprivation is the most closely correlated risk factor for conception in young women, the clustering of pregnancies in certain urban areas is not fully explained by the local deprivation statistics (McCulloch 2001). Further research of other local factors and the cultural and moral norms in which these mothers are situated is necessary to understand the local rates of pregnancies and subsequent parenting decisions. The public health issue of breastfeeding is just a part of the picture of deprivation as it relates to teenage pregnancy as a whole.

The Infant Feeding Survey (IFS) in 2010 (McAndrew et al. 2012) found that 91% women who completed further education initiated breastfeeding, compared to 63% of women who left school at 16 in the UK. This inequality is more apparent in younger mothers, of whom only 46% initiated breastfeeding. Further, not only do young mothers have the lowest rate of initiation of breastfeeding, they also have the highest attrition rate by 6 weeks (McAndrew et al. 2012).

McMillan et al. (2009) in the “Looking at Infant Feeding Today” (LIFT) study, examined women experiencing material deprivation and their feeding patterns. The study was a retrospective descriptive study of 449 women in Leeds and Bradford, though not specifically teenagers. They found that breastfeeding is affected by deprivation across all ethnic groups. Similarly, the research by Smith (2010) examines the intersection between family and environment in teenage pregnancies in Kinston-Upon-Thames (Smith 2010). She compared the Index of Multiple Deprivation (IMD) for the areas of residency of her participants with the data from the study and personal demographics. Women who lived in areas of lower IMD scores (therefore less affluent) were less likely to be with their partner by the time the baby was born and had a higher number of risk factors for poor pregnancy outcomes and infant morbidity (Smith 2010).

The reasons for the higher pregnancy risks and lower breastfeeding rates are multifactorial and complex. As mentioned above, the reasons why younger women get pregnant and stay pregnant are often the same factors that put them at risk of such poor outcomes (Smith 2010) and limit breastfeeding (Dykes et al. 2003). Deprivation, at area level, is part of the picture but there are important individual factors too. For instance, at 16 weeks, 4% of mothers with the lowest education levels were exclusively breastfeeding compared to 13% of mothers with the highest education levels (Bolling et al. 2007).

The health benefits of breastfeeding are therefore lost to those subject to the greatest health inequalities throughout their life-course (Shaw et al. 2007, Black et al. 1980) - those who would most need them (Freese and Lutfey 2011). Low breastfeeding rates are therefore a “major health inequality for teenage mothers and their children, additional to the existing risks of social exclusion and deprivation” (Condon et al. 2013 pg. 2 paragraph 1). Improving these rates, whilst supporting young mothers in their choices and goals, is therefore a key health goal for maternity staff. As discussed below in the following section on UK interventions, promotion of breastfeeding at the level of the individual, using midwifery public health advice and lay/peer supporters, has not had a great effect in this group. We need to understand

why formula feeding is the preferred modality of feeding, which this study aims to investigate.

Evidence for interventions to increase breastfeeding rates in the UK

Initiatives aiming to increase breastfeeding in the UK encompass various different strategies. Firstly, the NHS has adopted the 'Baby Friendly Initiative' (BFI 2010), which focuses on the training of support staff and making hospitals more breastfeeding friendly. There have also been social marketing campaigns, such as the 'Be A Star' (Be a Star 2008) poster and social media initiative, which featured young mums looking very glamorous and breastfeeding their babies, as below. There are also many local initiatives, through Sure Start centres and community groups to provide peer-support for breastfeeding for all mothers (Dyson et al. 2008) (see Appendix 1 for initiatives local to this research).

Figure 1: The Be A Star Campaign (Collaborative Change Ltd. Image used with permission)



The largest and most well-known intervention to increase breastfeeding rates is the “Baby Friendly Initiative (BFI)” by UNICEF (United Nations Children's Emergency Fund) (UNICEF 2012), which operates internationally with health care providers, local government and academic institutions to implement policies and practices that

support breastfeeding, such as rooming in and standardised training and accreditation for health care professionals. The pertinent Cochrane Review (Dyson et al. 2008) finds that practical and comprehensive support like the BFI does improve breastfeeding rates internationally but an observational study of women delivering in UK maternity hospitals which implemented the BFI scheme found that the use of the scheme improved initiation but did not have a significant impact on rates of continuation thereafter (Bartington et al. 2006). However, the BFI guidelines which were introduced in 2012 (UNICEF 2012) aim to address this by including recommendations to support the mother and baby relationship and communication.

Renfrew et al.'s (2012) meta-analysis of RCTs and quasi-RCTs compared additional breastfeeding support and promotion interventions to the standard midwifery led care in the UK. They found that all forms of extra support extended the duration of breastfeeding and that personalised and in person interventions were even more likely to be effective. However, Hoddinott et al. (2011) discuss the fact that many of the interventions that seem to have an effect on a global scale do not necessarily improve breastfeeding rates in Britain. They conclude that in the UK, a cultural predilection towards formula feeding is entrenched in many communities and that both the current interventions and research into those interventions are too focused on one specific facet of breastfeeding support. For example, most targeted interventions focus on support offered during postnatal health care provision, rather than looking at infant feeding choices and social support mechanisms throughout the whole childbearing experience.

Hoddinott et al. (2011) argue that research into interventions which encompass the whole breastfeeding journey, a journey that starts in childhood and extends through to becoming a grandmother in its widest conception, is key to developing and testing complex interventions. Complex health interventions are interventions which have several interacting component, and typically include health service provision changes; personal support and treatment interventions; and community based strategies to promote healthy behaviours (Craig et al. 2006). A meta-analysis by Sinha et al. (2015) also makes this point – that interventions that are complex, sited

in multiple locations and involving health care systems, local environment and the home and family are much more likely to be effective in promoting both the initiation and duration of breastfeeding. Focusing specifically on young mothers, the systematic review by Sipsma et al. (2015) also calls for more theoretically driven, complex intervention studies that, crucially, must include the families and communities of the young mothers. My PhD primary research aims to capture both the complexities of the journey young mothers take from pregnancy to weaning in the context of their own lived experience, including both the home and their interactions with health care systems in order to address some of the uncertainties around breastfeeding promotion with this particular group.

It is outwith the scope of this review to examine each intervention in detail as this primary research is designed to investigate the experiences of young mothers and infant feeding, not the success or failure of specific interventions. However, a more in-depth look at the intervention most commonly used to target 'hard to reach' groups (Arai 2003) such as young mothers, is useful when discussing the evidence around the context and community of breastfeeding. Essentially, in a discussion of the culture of breastfeeding it is relevant to discuss the one intervention that is primarily driven by the perception of cultural barriers to breastfeeding – peer support. Peer support is either provided by a trained peer supporter (i.e. not a health care professional but a mother who herself has breastfed employed to support others) or by more informal and voluntary breastfeeding groups and the conscious creation and support of local breastfeeding communities (Raine 2003).

The peer support movement is based on the theory that the negative attitudes of a community towards breastfeeding significantly affect local breastfeeding rates (Raine 2003). Therefore, community based interventions that include positive reflections of breastfeeding, from women with similar backgrounds, are expected to ameliorate this in areas with a predominantly bottle-feeding culture (Scott and Mostyn 2003). The fact that areas with a predominantly bottle feeding culture are synonymous with areas of deprivation, poor nutrition and poor access to all kinds of health care,

means any analysis of cultural impacts upon health cannot be considered without situating it in the wider context of the health effects of poverty (Wilkinson 1997).

Peer support based intervention to promote breastfeeding began to be popular in the early 2000s and the second Cochrane Review (Britton et al. 2006) into the subject showed a positive effect on breastfeeding rates. The intervention fitted well with contemporary ideologies about breastfeeding, such as the discourse on 'natural' feeding (Dykes 2005b) and the growing understanding of breastfeeding as situated in a socio-political sphere as well as a bio-medical one (Raine 2003, Scott and Mostyn 2003, Mahon-Daly and Andrews 2002). However, since then a rigorous and clustered randomised controlled trial (Hoddinott et al. 2009) has found no significant effect of the implementation or increasing of provision in breastfeeding group based peer support in all areas – group based peer support increased breastfeeding rates in some trial sites, but breastfeeding rates actually declined in others. Hoddinott et al. (2009) suggest that the cultural context to which breastfeeding promotion interventions are applied are paramount to understanding why this scheme does not work in some areas.

The evidence as a whole is not definitive, and further research clearly needs to be done. The later qualitative study by Hoddinott et al. (2012) illuminates the elements required for success or failure and concludes that not all support is equal. Success is both context dependent and relies on many inter-related variables, including the personality of the peer supporters themselves.

There are other areas worthy of investigation regarding interventions to increase breastfeeding rates, such as; whether peer support has any impact on public perceptions of breastfeeding at large, and the media's impact on public perceptions of breastfeeding (Protheroe et al. 2003). Breastfeeding promotion that utilises motivation and emotional support (Dykes et al. 2003) rather than authoritative knowledge is also of much relevance to this discussion and is explored further below in the literature review.

In conclusion, although the evidence can be supportive of the efficacy of peer and community based support, at least in some contexts, there are still factors that we do not fully understand. Further, the proliferation of these interventions has raised questions about our approach to supporting breastfeeding mothers. The cultures of motherhoods and women's agency in responding to public health advice need to be understood in all their complexity to discover why breastfeeding rates remain low in young mothers of low socio-economic position despite these targeted interventions. The high cessation rate in the community is demonstrably caused by more than physical difficulties and techniques and a greater understanding of the cultural setting in which women continue (or not) as breastfeeding mothers is key to providing appropriate support (Hall Moran et al. 2007, Dykes et al. 2003). This study aims to further the socio-cultural understanding of the contexts of breastfeeding, for the group that has the lowest breastfeeding rates in the UK; young mothers.

1.3 Overview of the current literature on young mothers and breastfeeding

I approached this review and synthesis of the extant literature using a two-stage process. Firstly, I performed a systematic and comprehensive search using the strategies described below. From this I identified primary research papers that were concerned with young mothers' experiences of motherhood, young mothers' experiences of infant feeding and other axes of social deprivation and breastfeeding. Below, I provide a narrative review of this more general literature on young mothers' experiences in order to situate the study in the current understandings of infant feeding. There follows a meta-synthesis of the fifteen primary research papers that were directly focused on young mothers and breastfeeding. The meta-synthesis was produced to robustly identify relevant themes for discussion and to highlight potential avenues for further exploration.

The literature in the narrative review is interdisciplinary, no discipline criteria were used and the resultant literature is taken from anthropology, sociology and applied midwifery research. The literature selected for the broader narrative review was both

primary research and meta-synthesis and meta-analysis. A thematically organised critique is presented, looking at the issues that most commonly occur or are considered of utmost importance by the various studies. This review provides both background to the proposed doctoral research and potential avenues for further exploration.

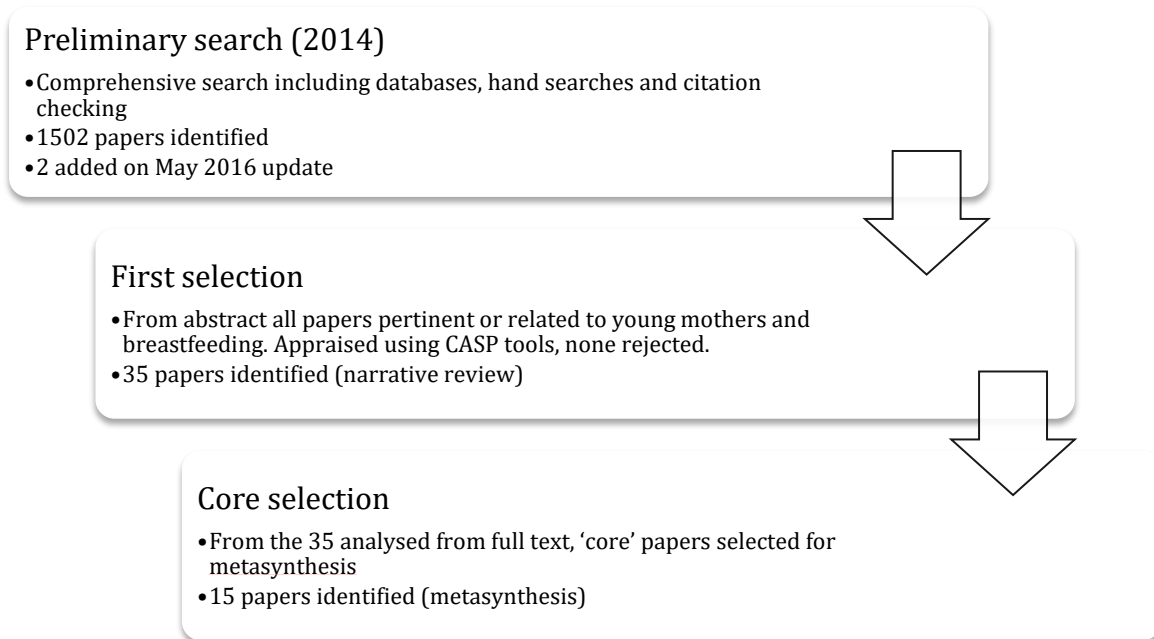
Search strategy

The literature search was guided by the question: *What are young mothers' experiences of infant feeding?* The literature search was performed in April 2012 then updated in April 2015 by performing the same process as below bounded with the dates '2011 to present'. A comprehensive electronic search strategy was used, followed by journal hand searches and citation checking. There is no date range applied to the studies - any research that is still relevant to young mothers and infant feeding was included. Eight databases (see Appendix 2) were systematically searched and in addition the search engine Google Scholar, and the Sheffield University library catalogue (Star) were used, yielding 1502 results (after removing duplications) in total from the database search operation. A final update was performed in September 2016 adding two new papers (Sipsma et al. 2015, MacVicar et al. 2015). Please see the PRISMA chart in Appendix 2 for the full details of the systematic search.

The same search terms were used for all the database searches but the search strategy differed depending on the interface supported. For instance, MeSH terms and command line searches were used where possible. Details of the search strategy are presented in Appendix 2.

Sifting for relevance

Figure 2: Literature screening process



Inclusion criteria were primary research (of any methodology), which examined any aspect of the infant feeding behaviours and demographics of young mothers in the UK. These inclusion criteria can be found in Appendix 3. Papers that were more generally about teenage conceptions/births were also included as they provide important epidemiological/demographic information and elucidate aspects of socio-economic deprivation that has an immediate bearing on infant feeding behaviours. Lastly, some papers about breastfeeding and mothers of any age experiencing health inequalities and/or of low socio-economic position were included, to provide insight into the circumstances within which young mothers may be making feeding decisions. This wider literature on breastfeeding is relevant as it relates to the framing of young motherhood and conceptual tools used to describe their experiences. This selected literature, 35 papers in total, that indirectly relates to young mothers and infant feeding, is included in the narrative review below to site the proposed study within the more general literature on breastfeeding. The data were extracted from the papers by a process of tabulating themes then examining each theme in turn and grouping similar themes for discussion; such as experiences of the different people who might provide breastfeeding support. This is the same

process of data extraction that was used for the meta-synthesis, an example of which can be seen on page 48).

Narrative review method

I used the method of narrative review by Green et al. (2006). As noted by Green et al. (2006) the purpose of a narrative review is not to provide evidence for one intervention or care recommendation, but to give an up to date summary of the literature as a whole, to stimulate debate and identify possible gaps in the existing knowledge. The following metasynthesis (section 1.4, this chapter) is intended to be a systematic and robust view of the pertinent literature, whilst this section is simply to provide an overview and some context to both the metasynthesis and the following primary research. The narrative review method was a detailed reading of the 35 papers selected from the systematic search as detailed above. Themes were tabulated and loosely grouped into similar ideas and discussions. Care was taken to maintain the context of the paper; for example the location and demographics of the participants were noted to ensure that results were not transferred or generalised beyond their limits. The four main themes, trusted supporters, making pragmatic feeding choices, moral aspects of infant feeding and authoritative knowledge and self-knowledge were identified by the frequency of discussion within the literature. After this the relevant theory was incorporated for discussion, for example Jordan (1997) was used as a seminal writer on authoritative knowledge in women's health.

Results of the narrative review of the wider literature

The literature on breastfeeding of the past decade has shown overall development from a knowledge/skills focus (for instance, Protheroe et al. 2003) to some analysis of local systems of support and issues with access (Arthur et al. 2007, Ingram et al. 2008). Newer work on the choices of mothers and the cultural and moral framework in which infant feeding occurs (Condon et al. 2013, Hunter and Magill-Cuerden 2014) has emerged in the past decade. This narrative review discusses papers in relation to their contributions to some of the major themes in the literature, beginning with the pragmatic debate around the people who support breastfeeding and the practical

reasons why women choose to breast or bottle feed. The review then delves deeper into the moral and politicised debates in infant feeding.

Trusted supporters

A cross-cutting theme in much of the literature was highlighted by this narrative review; that of the role of the family and/or the trusted advisor in young mothers' feeding decisions. This is directly investigated by McInnes et al. (2013) in their serial qualitative interview study of women of low-socioeconomic position. They found that the support and feedback from 'significant others', which could be a partner, other family, health care professionals, the mother herself or the baby, was strongly influential in feeding decisions. McInnes et al. (2013) frame women's feeding experiences in a holistic way; the decisions women make in infant feeding are about themselves and the wellbeing of their families. Public health messages of the healthy ideal of breastfeeding are only a small part of what the mothers must consider in making feeding choices (Sipsma et al. 2015).

A theme in many of the papers (for example McInnes et al. 2013, Smith et al. 2012) was the subject of grandmothers. This is of particular relevance to research into migrant families from cultures where the nuclear family is not the prevalent model of family life (Kessler et al. 1995). Ingram and Johnson (2004) piloted a feasibility study in Bristol, using mixed methods, to assess the impact of including fathers and grandmothers in breastfeeding education. They found that involving the near kin greatly increased the breastfeeding rates. However, the issues of family discouragement of breastfeeding, such as those raised by Henderson et al. (2011) were not covered and the normative expectation to bottle-feed goes unproblematised in their study.

Higginbottom et al.'s (2006) qualitative study in South Yorkshire and London looks at the experiences of motherhood of young women. The study focussed on teenage pregnancy and not on breastfeeding per se, but is useful in the framing of young motherhood in a more positive light than is usually the case. The study reported that the young women found an increase in self-esteem due to the pregnancy. Overall,

they saw the pregnancy as having more positives than negatives, which is a theme that Higginbottom et al. (2006) note is not generally recognised in other research. Also of interest is that, despite most young mothers being the children of single parents, they mostly found much family support for the pregnancy, especially from their own mothers, which is again in contrast to the image of the socially isolated teen seen in other studies (Smith 2010; McCulloch 2001).

Ingram et al. (2008) explore the barriers to accessing breastfeeding support experienced by black and minority ethnic women (BME) and young mothers. This is a qualitative study on the experiences and reasons for cessation among varied groups. Young mothers constitute a small part of the overall study and the reporting of focus groups does not go into the young mother experiences but concentrates more on their opinions of service provision. However, it is a useful study that offers some comparison between groups who are marginalised. Ingram et al. (2008) found that teenagers wanted to be educated separately (with peers, not with all mums) and that most young women found fear of exposure, and conflicting advice as well as other family members wanting a 'stake' in feeding the baby to be the biggest barriers to breastfeeding. All of the mothers found specific individual support/link workers of one kind or another to be the most valued method of support.

Lavender et al. (2005), Mead et al. (2005) and Thompson (2010) all assess current support systems for teenagers especially, and a common thread is that the services are very personalised (case-loading, easy access, individualised) and are all specific for the age group. Lavender et al.'s (2005) qualitative audit of a 'breastfeeding guardian' project whereby a specialist midwife was employed to support the young women from a teenage clinic exclusively with breastfeeding is a novel approach to the support of teenage mothers and seemed to work well. Their findings on the barriers to breastfeeding that teenagers faced were common ones (disruption to previous life and tiredness) they also found some previously unmentioned benefits (like getting rid of unwanted visitors!). Interestingly the breastfeeding midwife also became a main source of information about contraception, perhaps because of the temporal relationship between breastfeeding needs and resumption of a sex life.

They also found that the teenagers were without exception proud of any breastfeeding they had been able to offer their babies and were committed to the breastfeeding process. In this set of literature, we see that services that are both targeted (so easy to access) and sensitive to young mothers' experiences can be beneficial to young mothers.

Thompson's (2010) review of her antenatal clinic for teenagers in Liverpool is an insightful case study of specialised service provision over the last 10 years. Although not specifically about breastfeeding it offers a very insightful look into the many facets of teenage parenting and maternity care. Particularly it focuses on the impact of material deprivation and access to care (the clinic runs a 'drop in' so that those women who are dependent on others for transport and money can still attend) and the importance of a good role model in mothering. Further, the issues with loneliness and isolation of young mothers are discussed, particularly in relation to the role the midwife can fulfil being a person of reassurance and familiarity during the pregnancy. Here, the midwife remains in the authoritative role but is seen as benevolent and supportive. The framing of the young mothers is of them as a deprived group, irrespective of other circumstances, but the intervention is delivered with enough sensitivity to seem to support the young women's mothering.

Making pragmatic feeding choices

Hoddinott et al.'s (2012) recent qualitative study of women's feeding experiences examines the tensions and contests of feeding choices for women of all age groups (Hoddinott et al. 2012). The study discusses the rational and emotive choices women make when they encounter problems in infant feeding. *"Immediate family well-being is the overriding goal rather than theoretical longer term health benefits"* (Hoddinott et al. 2012 pg. 1). This is a cogent description of the idealism of exclusive breastfeeding at tension with the realism of most women's lives. For many mothers, both time and support can be in short supply, in a society that is not always accepting of a baby's feeding demands. This understanding is crucial to explaining why attrition rates are a problem across the population: less than 1% of all women are still exclusively feeding by six months (McAndrew et al. 2012).

Time, freedom of movement and engagement with normative social behaviour (such as drinking alcohol) all have to be negotiated by breastfeeding mothers, and in areas where breastfeeding is not the norm this can be very problematic (Dewan et al. 2002, Schmied and Lupton 2001). In the general literature on breastfeeding, there is still little consideration of the cost of breastfeeding (McCarter-Spaulding 2008); it is a mode of feeding which is almost exclusively done by the mother and which requires a huge amount of time and physical energy as well as restricting other activities. It is important to consider the feminist aspect of breastfeeding in the discourse. For example, in the seminal work in the field by Maher (1992), she discusses that there is a cost to breastfeeding, in both social and economic terms for women. This is further developed by other authors (Quinlan et al. 2005, Tracer 2009) who describe the cost of breastfeeding in relation to food and time in low-income countries. The cost of breastfeeding, including a discussion of the socio-political gender inequalities in infant feeding, is discussed more thoroughly below in the meta-synthesis (section 1.4).

The papers by Sipsma et al. (2015) and MacVicar et al. (2015) both discuss the importance of complex interventions, both practical and emotional, to support women to breastfeed. They also both call for further research into such complex interventions, which will aim to further understand why the pragmatic choices that women make, often result in formula feeding.

Moral aspects of infant feeding

The biomedical discourse of breast milk as a more nutritious food for babies than its artificial substitutes is difficult to disentangle from the discourse of breastfeeding as a morally superior act that demonstrates 'good motherhood' (Dyson et al. 2010). Further, constructions of natural behaviour versus scientific rationality are often used in discourses around infant feeding by mothers, researchers and healthcare professionals especially in the justifications of feeding choices (Murphy 1999).

Dyson et al. (2010) present a mixed methods study on the infant feeding behaviour of disadvantaged teenage mothers, examining the moral dimensions of the feeding

decision using the theory of planned behaviour (Ajzen 1991). They elicit the young women's views about breastfeeding as morally inappropriate and describe how moral norms can be an overriding cause of feeding decisions. For instance they find that some teenagers think it is not *morally right* to breastfeed, not just that it can be difficult.

Ryan et al. (2010) also examine the moral work in women's narratives of infant feeding decisions, and Murphy (Murphy 1999, Murphy 2000, Murphy 2003) and Racine et al. (2009) also discuss women's negotiation of these discourses. The discourses of the old dichotomy between maternal self-sacrifice and the selfish 'bad' mother are an intrinsic part of the social pressure and social sanctions around infant feeding, so much so that choice of infant feeding is in part defining of class, adequacy of parenting and a measure of love for one's child. However as Dyson et al. (2010) find, both methods of feeding can be perceived to be the virtuous choice depending on the circumstances. How these choices are couched in terms of class and virtue and how the medical and wider community constructs the concept of the rational choice in this politicised and moralised zone is still not totally clear.

Keenan and Stapleton's (2009) qualitative work on demand feeding in Sheffield looks at constructions of babies' agency in the feeding relationship, and how the behaviour of the child in relation to food and the (often covert) attempts by the mother to ameliorate the effects of demand feeding on family life begin to construct a child's identity and the maternal relationship. They looked at the typified self-sacrificing role of the mother in the feeding journey, and concluded that the decision to breastfeed is not a choice but an expected and normative behaviour. They also show the development of the infant-mother relationship through breastfeeding to weaning. They also look closely at women with food/weight related problems such as obesity and diabetes to understand the effects of a 'more mindful' or unhealthy personal relationship with food on the feeding of a baby. They conclude, "*Childhood identities are constructed and mediated through food and feeding encounters*" (Keenan and Stapleton 2009, pg. 29). This research also aims to frame the baby as a key agent in breastfeeding experiences and also to view the mother as an actor

embedded in her social and family life; with other concerns and duties that are not just those of motherhood.

Authoritative knowledge and self-knowledge

Brigid Jordan (1997), a pioneer in the anthropology of childbirth, reapplied the concept of 'authoritative knowledge' to the interactions between women and their carers and the wider bio-medical discourse. Jordan (1997) defines the application of the concept thus; *"the power of authoritative knowledge is not that it is correct but that it counts."* (Jordan 1997 pg. 58, paragraph 3). Much of the literature on young mothers and breastfeeding implicitly (Lavender et al. 2005, Mead et al. 2005, Thompson 2010, Dewan et al. 2002) and sometimes explicitly (Arthur et al. 2007, Bailey et al. 2004) deals with this tension, in part because the balance of power between young mother and health care professional is so much more marked than between other parents and their carers. Young mothers are seen as more in thrall of control by authority (including their parents) as they are in part 'still children', (Bailey et al. 2004).

This subject of sources of knowledge is covered by Dewan et al. (2002) and also Brown et al. (2011) which is discussed further in the meta-synthesis that follows. Dewan et al. (2002) produced a survey study comparing the knowledge and attitudes of teenage mothers and older mothers in a Liverpool clinic. The study is limited (by the authors' own acknowledgement) by the lack of qualitative insight into the issues around exposure and embarrassment and other psychosocial factors. It does provide, however, a good example of the interactions between knowledge and attitudes and the lack of the former in young mothers. They found that young mothers are less likely to intend to breastfeed and were less aware, or able to articulate the 'benefits' of breastfeeding than older mothers. They also found that young mothers were less likely to have witnessed any breastfeeding among their significant others and wider social circles than older mothers (Oliveira et al. 2016).

Arthur et al. (2007) and Bailey et al. (2004) explicitly discuss the barriers to breastfeeding inherent in the power relationship between the young women and the

health care system. Both suggest a change in care provision for young women, so that they could attend separate, more personal clinics both in the pregnancy and for help with breastfeeding. The qualitative study by Arthur et al. (2007) of teenage mothers' experiences of the maternity services in Bristol found that the biggest barriers to young mothers engaging with maternity services were lack of specialist services and difficulties negotiating the system. Most wanted separate classes and care mostly because of feeling very visible and judged by the older mothers. Specifically in relation to breastfeeding all of their young mothers ceased breastfeeding early, most citing lack of knowledge and pain as reasons. They all felt unsupported in their breastfeeding attempts, which was a continuation of feeling dismissed and judged by staff.

A qualitative study by Bailey et al. (2004) looks directly at the power imbalance and disincentives to accessing care for young mothers. The study reiterates the general themes of the importance of tailored, separate care for young mothers but also discusses themes of isolation and power in the young mothers' experience. They identify that the gap is wider between the health care professional's 'symbolic' power than it is with other mothers and that interventions must recognise this. They conclude that the biggest problem in all aspects of young pregnancy is the lack of access to services, both practically and in terms of the experience the women have when they do attend (Sipsma et al. 2015, MacVicar et al. 2015).

The only RCT evaluating an intervention to influence teenage mothers' infant feeding choices in the puerperium (Wambach and Cohen 2009) suggests that it is not necessarily a lack of education or information that leads women to choose to formula feed; the educational intervention increased the breastfeeding duration in those who initiated but did not significantly improve initiation rates or exclusive breast-feeding rates. This suggests that there are other constraints on breastfeeding decisions that increased knowledge of *how to breastfeed* will not solve.

Conclusion to the wider narrative review of the literature

The four main themes of the narrative review give an account both the practical, emotional, moral and interpersonal dimensions of the infant feeding experience for young women and women of lower socio-economic position. The main themes of trusted supporters and making pragmatic feeding choices chronicle the practical and interpersonal dimensions of the breastfeeding experience, whereas the main themes of moral aspects and authoritative knowledge discuss the frameworks of power, and morality within discourses of motherhood as they relate to infant feeding. The review presented here is a brief overview, designed to introduce the topics currently debated in the field to date and also to give a general outline of the research gap, discussed in detail in the metasynthesis, which this primary research aims to fill; that of the lived and interconnected infant feeding experience of young mothers.

As we have seen, breastfeeding is a not a neutral choice in terms of cost to the mother and this study aims to frame the discussion of *how* to increase breastfeeding to take account of women's feeding work as a gendered issue. This reframing is key if we are to fully understand the barriers many women face in achieving the duration of breastfeeding that they want. This thesis focuses on the intersection of the moral discourses of young parenting with the practical dilemmas of infant feeding. It will also explore the conflicts between the culturally normative expectations of infant care with the public health discourse of breastfeeding. Further, this research aims to investigate some of the intersecting aspects of self identity that young mothers negotiate, to try to further understand how the dynamic, lived experience produces a group who find bottle feeding to be the 'right' choice in most cases.

1.4 Meta-synthesis of 15 key papers

In addition to the narrative review of the wider literature above, I produced a meta-synthesis of the primary research which *directly* related to young mothers and infant feeding in order to clearly and robustly identify areas for further research. As above, the systematic search (see section 1.3) yielded 15 studies meeting the core inclusion criteria of English language, primary research (of any methodology) about young mothers' experiences of infant feeding. There were 10 studies with a qualitative

design, two of quantitative design and three mixed-methods studies. Because the core search criterion was studies concerned with 'experience' it was expected that the majority of the results would use qualitative methodology. The studies were not selected for country of setting, but they are all from high-income English speaking countries, the UK, Canada, USA, and Australia. Whilst there are differences of culture, law and health care provision which are discussed in the findings below, the socio-cultural environment in which women become young mothers is similar enough that most of the findings could be considered directly applicable to the UK context.

The papers spanned three decades, from 1996 to 2014, with the majority from the late 2000s. The aims of the studies were broadly similar in that they all aimed to explain and explore the ways in which young women experienced breastfeeding and breastfeeding support. Some of them specifically focused on the barriers to breastfeeding (Nesbitt et al. 2012, Ingram et al. 2008, Radius and Joffe 1998). Some papers also focussed more on the understanding of how young mothers' breastfeed; for instance, duration and exclusivity (Brown et al. 2011, Spear 2006, Ineichen et al. 1997). There were also four papers that included an examination of the experience of professional support (the *efficacy* of support was not part of this review) (Smith et al. 2012, Noble-Carr and Bell 2012, Condon et al. 2013, Dykes et al. 2003). The papers that met the inclusion criteria were from wealthy countries though often focussing on the deprived areas within these countries. Research sited in any country was reviewed as there is a social and age gradient in breastfeeding in most developed countries. Seven studies were in the UK, four studies were in the USA, two studies were in Canada and two in Australia. A summary of the studies, location, methods and results can be found below in table 1.

Quality assessment

All 10 qualitative studies and the qualitative arms of the three mixed methods studies were subjected to the Critical Appraisal Skills Program Qualitative Checklist (CASP 2013) to assess quality. The two survey studies and the quantitative arms of the three mixed methods studies (also survey data) were assessed for quality using the Boynton and Greenhalgh (2004) guide to questionnaire and survey research. All of

the 15 studies met these quality criteria thresholds; none were rejected as a result of this quality assessment process.

Table 1: Summary of and data extraction from the 15 papers in the meta-synthesis

Author, Year and Country	Aims	Design and Methodology	(In-vivo) themes extracted and analysed
Hunter and Magill-Cuerden 2014 UK	Explore the ways in which a small group of UK adolescent mothers conceptualise their decisions to breastfeed and experience breastfeeding in their communities.	n=15 16-20 years old. Qualitative, interviews or focus groups. Postnatal single interviews/FG. Recruited from parenting groups.	<ol style="list-style-type: none"> 1. Stigma of young motherhood has an effect on bf as mothers feared sanctions and tried harder to perform good motherhood 2. Feeding in public is an issue and private as public with an emphasis on the morality of breast exposure. 3. Paucity of support for bf in their social networks. Tension caused to relationships by bf. 4. Need for approval and forming identity as adults, part of bf.
Condon et al. 2013 UK	To explore teenagers' experiences of the breastfeeding promotion and support delivered by health professionals.	n=29 13-18 years old. Qualitative interviews and focus groups of both pregnant and postnatal (up to two years after birth) women.	<ol style="list-style-type: none"> 1. Bf is not normal to the young mothers social group though it is portrayed as normal by professionals. 2. Lack of support for bf beyond the initial few days. 3. Feeding in public was a problem.
Nesbitt et al. (2012) Canada	To examine the facilitating influences and barriers to initiating, and continuing breastfeeding, as perceived by adolescent mothers in the area.	n=16 15-19 years old. Qualitative semi-structured interviewing in the infants first year. Recruited from clinics and centres via respondent led methods (posters).	<ol style="list-style-type: none"> 1. Bf had an impact on social and intimate relationships. 2. Bf risked public breast exposure. 3 Availability of social support effected bf. 4. Physical demands were a reason to stop bf. 5. Knowledge of breastfeeding practice and benefits affected bf. 6. The maternal perceived sense of comfort effected bf.

<p>Noble-Carr and Bell 2012 Australia</p>	<p>To gain an understanding of how, when and where younger mothers want and need to receive breastfeeding information and support.</p>	<p>n=24 17-25 years old. Qualitative focus groups. Recruited from local services and groups. All three focus groups were postnatal. No ethics sought!</p>	<ol style="list-style-type: none"> 1. Bf is not normal (cultural norm) 2. Mothers influenced by their partners and family. They also used online/social media support. They attached great importance to informal support networks but did not often seek professional advice. 3. Advice and support were generally perceived to be unavailable or misunderstood. They concluded that information needs to be simpler and timely (given in pregnancy then good, consistent support in the postnatal period). 4. Stigma around young motherhood. 5. Many others felt isolated, especially in hospital.
<p>Smith et al. 2012 USA</p>	<p>To understand the factors that contribute to the breastfeeding decisions and practices of teen mothers</p>	<p>n=5 14-17 years old. Qualitative prospective semi-structured interview study. 3 interviews, one antenatal, one after birth and one two weeks after ceasing to use human milk – tracked for this weekly by phone. Recruited from a YWCA teen parent-mentoring program.</p>	<ol style="list-style-type: none"> 1. Milk expression extended the duration of receiving human milk. 2. Family influence was important. 3. Bf in public was an issue. 4. HCP's were quick to introduce formula and there were 'mixed messages on bf'. 5. Pain and dislike of the physical experience was an issue. 6. Negotiation of multiple roles and family dependency. 7. The mothers lacked bf knowledge.

Brown et al. 2011 UK	To examine factors associated with breastfeeding initiation and duration in young mothers.	Mixed Methods. Retrospective questionnaire between 6-24 months after birth (n=138) and semi-structured interviews (n=10). Recruitment from mothers groups, online forums and nurseries.	<ol style="list-style-type: none"> 1. Mothers who bf at birth were less likely to believe that bf was inconvenient, embarrassing, and not normal and that breastfeeding was better for the baby's health. 2. Bf duration was not associated with how 'important' and healthy the mums thought it was – all the mothers believed breast milk was better, regardless of mode. 3. Bf mums were more likely to seek information from hcps and formal sources and less likely to ask their families for advice after birth. 4. Bf mums were more likely to be surrounded by people who had breastfed their babies. 5. Duration of bf was extended in those who went to antenatal and postnatal classes. 6. Bf in public was not perceived as a problem
Dyson et al. 2010 UK	Examination of the psychosocial factors influencing infant feeding decisions in young pregnant teenagers.	n=71+n=17 16-20 years old. Mixed Methods of quantitative survey (n71) (predictive factors for bf initiation and duration using the Theory of Planned Behaviour) and qualitative focus groups (n=17). Recruited from a larger study (the LIFT study).	<ol style="list-style-type: none"> 1. Teenagers were four times as likely to intend to formula feed than women aged 20 or over in the total LIFT sample. (also see Infant Feeding Survey). They found that this was predictive of behaviour. 2. The variable of 'moral norms' was the most significant variable for predicting behaviour. 3. The qualitative element also found moral norms to be very important to feeding decision-making. 4. Feeding in public and sexuality of the breast was a barrier to bf.
Wambach and Cohen 2009 USA	To examine the breastfeeding experiences of urban adolescent mothers.	n=23 14-18 years old. Qualitative study using focus groups and interviews. Recruited from two specialist obstetric clinics in the postnatal period.	<ol style="list-style-type: none"> 1. They identified phases of decision making with either positive or problem influences: Prenatal decision making, initiation, continued bf and weaning (in this context ceasing to bf for formula). 2. Babies were perceived as being hungry and many mothers thought they had insufficient milk. 3. The mothers found bonding to be an important part of bf. 4. Bf was hampered by the need to return to work or school. 5. Professionals often advised formula feeding.

Ingram et al. 2008 UK	An exploration of the barriers to exclusive breastfeeding for 6 months in BME and young mothers and strategies for overcoming these barriers	n=22 (but the teens were a subgroup of n=5). Qualitative study of focus groups in the postnatal period. Recruited via the specialist midwife, a youth worker and mother and baby groups.	<ol style="list-style-type: none"> 1. They experienced conflicting advice between health care professionals (hcps) and between hcps and their families. The attitudes of their families' were very important. 2. Feeding in front of men was an issue. Feeding in public was an issue. 3. The mothers wanted more advice about breastfeeding and they wanted groups just for young mothers.
Spear 2006 USA	To examine the bf experiences and related behaviors of adolescent mothers after discharge from the hospital.	n=53 14-19 years old. Mixed methods using quantitative and qualitative telephone interviewing in the years after birth. Recruited from a birth center.	<ol style="list-style-type: none"> 1. The quantitative data showed a gap between intended duration of bf and actual bf, early weaning to solids and a generally positive experience of bf. 2. The qualitative data showed issues with pain and frequency of feeding, wanting more information about pumping, conflicting advice given by hcp's and a desire for more support after leaving hospital. 3. Stigma about being a young mother was an issue in infant feeding.
Nelson and Sethi 2005 Canada	To discover the phenomenon of breastfeeding as experienced by teenage mothers	n=8 15-19 years old. Qualitative (Grounded Theory) study. Recruited via health care professional referral.	<ol style="list-style-type: none"> 1. The core finding was that bf mothers must continuously commit to bf. 2. The mothers wanted more support but faced the same problems as older mothers. 3 Bonding was an important issue for the young mums. 4. Some negative encounters with hcp's 5. Bf in public was an issue.
Dykes et al. 2003 UK	To examine the support needs and holistic care and experiences of adolescent mothers	n=24+n3 13-19 years old. Qualitative study using focus groups (n=24) and semi-structured interviews (n=3) in the postnatal period. Recruited via the specialist midwife or parenting groups.	<ol style="list-style-type: none"> 1. Feeling watched and judged. 2. Lacking confidence, tiredness and discomfort were all issues. 3. The young mothers found that professionals expected them to formula feed and they sometimes found it hard to access professional help. 4. In hospital they found that midwives were often too busy to help. 5. Sharing accountability; family were the most important support. 6. The behaviour of the baby was a factor in decisions about bf.

<p>Radius and Joffe 1998</p> <p>USA</p>	<p>To assess the benefits and barriers accruing to breastfeeding as perceived by pregnant adolescents.</p>	<p>n=254 12-19 year olds. Quantitative questionnaire study whilst pregnant. Recruited from prenatal clinics and an adolescent parenting program.</p>	<ol style="list-style-type: none"> 1. 19.3% intended to breastfeed. 78% said breastfeeding would be 'embarrassing'. The outcomes correlating with intent to breastfeed were that they were less likely to think that breastfeeding make you feel 'rundown' and made your breasts 'ugly'. Those who intended to breastfeed were also more likely to value the benefits of breastfeeding. 2. Bonding was important to 90% (love of the baby) of the respondents but bf mums were more likely to think that the baby would love them more and that bf would make them feel important. 3. The respondents thought that they would loose Medicaid benefits if they breastfed (USA). 4. d. Mothers who intended to bf though bf mothers get more sleep!
<p>Ineichen et al.1997</p> <p>UK</p>	<p>To elicit the breastfeeding attitudes and behaviors of teenage mothers.</p>	<p>n=55 Teenagers and young mothers. Quantitative questionnaire. Recruited via a teenage pregnancy magazine.</p>	<ol style="list-style-type: none"> 1. Breastfeeders were more likely to be older (18.4 years rather than 16.5 years). 2. They made the decision on mode later than the national average. 3. Reasons to breastfeed were health benefits, bonding, cost and convenience. 4. Partners could be hostile to breastfeeding. 5. Difficulty in either 'getting out' or feeding in public.
<p>Benson 1996</p> <p>Australia</p>	<p>To explore the adolescent experience of breastfeeding and motherhood.</p>	<p>n=18 13-18 years old. Qualitative study following the participants from early pregnancy to 6 months old. Recruited via a maternity unit and a young parents centre.</p>	<ol style="list-style-type: none"> 1. The mothers anticipated disapproval for being a 'young mum'. They thought that they were expected for formula feed by the professionals they met. 2. Breastfeeding was hard – easiness was very important in making decisions. 5. Family was very influential, as was being part of a breastfeeding community. 6. Sleep was very important and was seen as a barrier to breastfeeding.

Meta-synthesis methods

The meta-synthesis was performed using the framework provided by Walsh and Downe (2005), which is discussed in detail below. A summary of the 15 studies design and findings can be found above (page 41, Table 1).

In the initial step of the meta-synthesis each paper was analysed for its major themes and key concepts (Walsh and Downe 2005), see the example in table 2 below. These concepts were then tabulated, see the results in figure 3 (page 50) to give an overview of the frequency of common themes as below. Only three themes were found by just one study which were: 'performing good motherhood' and 'achieving adulthood' found by Hunter and Magill-Cuerden (2014), and the 'negative impact of fathers on breastfeeding' (Ineichen et al. 1997). Apart from this, the findings were broadly similar.

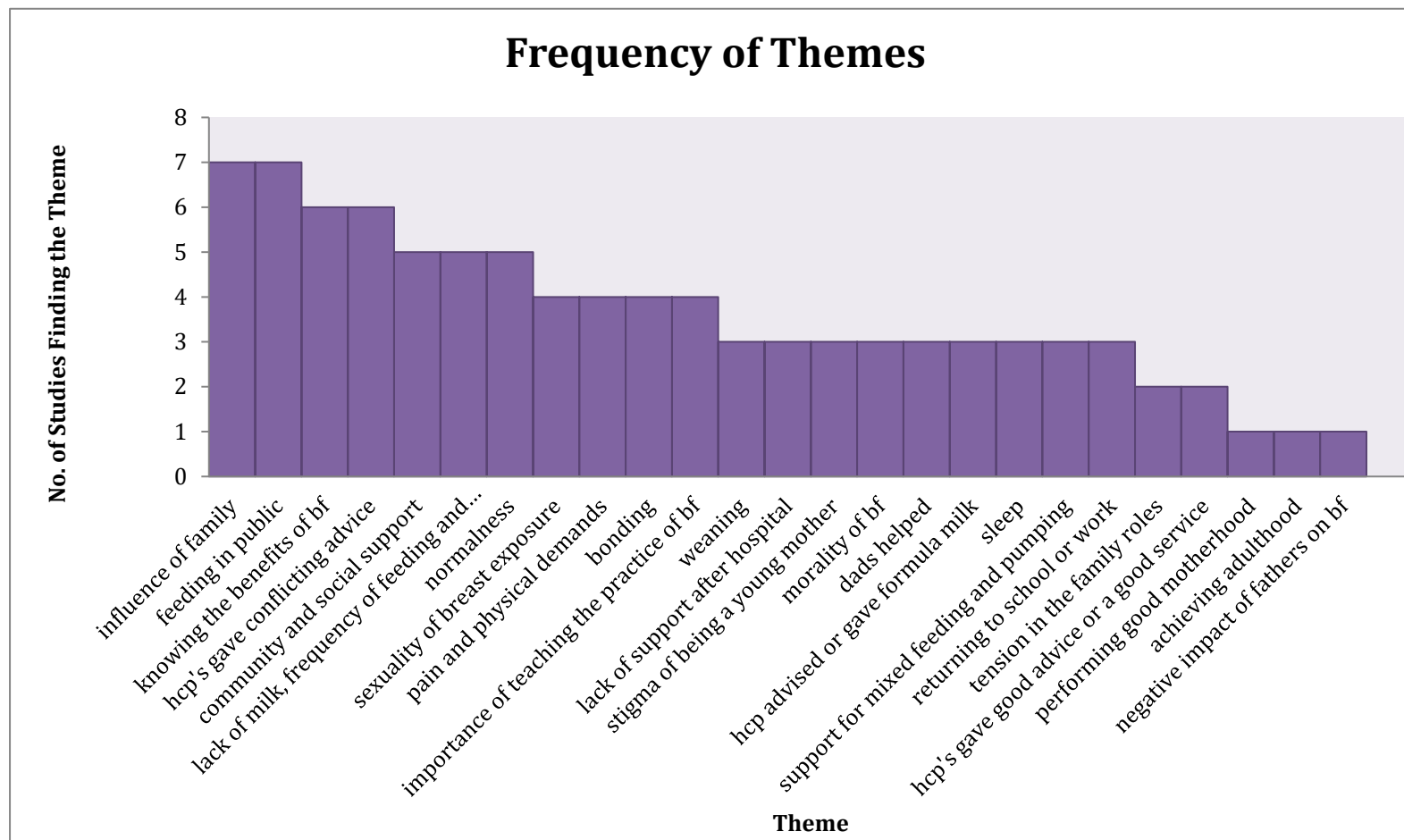
There were many themes that were reported across several studies. The most common findings were the 'influence of the family' (Hunter and Magill-Cuerden 2014, Nesbitt et al. 2012, Wambach and Cohen 2009, Brown et al. 2011, Radius and Joffe 1998 and Ineichen et al. 1997) and the embarrassment and difficulty with feeding in public (Hunter 2013, Nesbitt et al. 2012, Noble and Carr 2012, Condon et al. 2013, Ingram et al. 2008, Nelson and Sethi 2005, Ineichen et al. 1997), each reported in seven out of the 15 studies.

Table 2: Example of data extraction from a core paper in the meta-synthesis, at the stage of relating it to the emergent themes.

Benson, S., 1996. Adolescent Mothers' Experience of Parenting and Breastfeeding – A Descriptive Study. <i>Breastfeeding Review</i>, 4(1), 19-26.			
In vivo Theme	Data sample (p= primary s=secondary)	Theme, relations and considerations	Overarching theme
Anticipation of disapproval	p: "I don't want to become one of these people I see on TV about teenager mothers, they talk about them as if they are nothing." s: "The anticipation of disapproval was so pervasive that when teenage mothers met acceptance they found it worthy of comment".	<ul style="list-style-type: none"> • Stigma • Achieving adulthood <i>Relates to findings of stigma and the desire to have specialised teen services.</i>	<ul style="list-style-type: none"> • Moral and emotional • Influence of others
Mixed experience of health professionals	p: "But that's how it were, you felt like you were on your own." p: "It was just wonderful. The nurses... they were really good." s: "Many had pleasant memories of being helped, supported and guided by the staff."	<ul style="list-style-type: none"> • Hcp conflicting advice • Lack of support after hospital • Hcp advised formula <i>Relates to findings of diverse experiences of hcps. However, this study was in a dedicated teen centre and therefore more positives may have been encountered.</i>	<ul style="list-style-type: none"> • Influence of others
Conspicuous, self-aware and egocentric	s: "This feeling of specialness and heightened body awareness explains the ambivalent feelings expressed when asked their view of public breastfeeding." p: "If I'm walking round the streets and he is hungry – well I make him suffer! I never do it in public."	<ul style="list-style-type: none"> • Feeding in public • Community and social support • Sexuality of breast exposure <i>This relates to others work on fear of feeding in public, though notably dissonant to Brown et al. 2011. However this latter was (the only) retrospective on mothers who had successfully fed for an extended duration. The mechanism of adolescent specific body anxiety is novel. Further the Australian context is potentially a less 'threatening' climate to bf in than the UK.</i>	<ul style="list-style-type: none"> • Physicality • Moral and emotional
It's got to be easy	p: "I said to Mum the first time I put him on, (I had sore,	<ul style="list-style-type: none"> • Pain and physical demands 	<ul style="list-style-type: none"> • Physicality

	<p>cracked nipples and everything), I said to Mum, I'm not doing this, I'm putting him on the bottle."</p> <p>s: "Ease of doing things seems to be a standard used to gauge whether or not an activity is worth while".</p>	<ul style="list-style-type: none"> • Lack of support after hospital • Influence of family <p><i>This is a novel take on the theme of pain and physical demands, Benson (1996) argues that difficulty it is particularly a disincentive for adolescents.</i></p>	
The influence of culture and family	<p>p: "I fed for a couple of days after I got home, but I didn't feel comfortable and he kept whingeing. Mum suggested, you know, about putting him on the bottle."</p> <p>s: "These adolescents respected their mother's advice as that of an expert."</p>	<ul style="list-style-type: none"> • Influence of family • Community and social support • Pain and physical demands • Tension in the family roles <p><i>This is coherent and similar to others findings. Grandmas (of the baby) are a particularly significant influence across the 15 papers.</i></p>	<ul style="list-style-type: none"> • Influence of others
Sleep, Sleep, Sleep	<p>p: "When I got out of labour they brought Karl in to me and didn't let me sleep."</p> <p>s: "Mothers whose babies had achieved a sleep pattern that included a long sleep at night were at pains to tell of this. It was an achievement of inordinate pride."</p>	<ul style="list-style-type: none"> • Sleep • Pain and physical demands • Lack of support after hospital <p><i>Sleep is mentioned in several other papers and when it is discussed seems to be of overriding importance to the participants.</i></p>	<ul style="list-style-type: none"> • Physicality

Figure 3: Frequency of themes in the meta-synthesis (hcp = Health Care Professional)



The second phase of the analysis was to determine the relationships and the dissonance between the studies' findings (Walsh and Downe 2005). This was done by taking each in vivo (the author's exact statement of findings) theme in each study in turn and comparing it to the others. This analysis enabled a look at each of the themes that were common, providing both nuance to the concepts and validation to the findings. The in vivo themes were grouped into 25 specific themes (see figure 3, page 50 and then into three overarching themes as in Table 2 (page 48). This process was performed in turn for each paper. The three overarching themes were the influence of others; physicality and moral and emotional domains. These are discussed in detail below.

I analysed relations between themes and findings and critically examined the dissonances and similarities. This "*compare and contrast*" (Walsh and Downe 2005) exercise either furthered the understanding of young mothers' experiences of infant feeding, or highlighted a gap in the research. Themes and findings that were similar were grouped to provide a breadth of understanding across the studies. The themes and findings that were contradictory across studies were then interrogated to uncover the meaning of these dissonances. Some dissonances were contextual, in that they related to time, site or population. For instance, some of the American literature (for example, Wambach and Cohen 2009) found that returning to work or studies was a key factor in decisions to formula feed, whilst the studies set in other countries did not find this. Maternity leave is very short in America and this may be why the USA studies alone found this to be a key issue.

There was also some dissonance in the interpretation of commonly found themes, for example whilst seven studies found that the participants discussed feeding in public (Hunter 2013, Nesbitt et al. 2012, Noble-Carr and Bell 2012, Condon et al. 2013, Ingram et al. 2008, Nelson and Sethi 2005 and Ineichen et al. 1997) six of these found that feeding in public was a barrier and a source of embarrassment to the young mothers, whereas Brown et al. (2011) found that the participants did not have a problem. This may be

because the vast majority of the participants in this study (Brown et al. 2011) had already ceased to breastfeed (the data was collected at 6-24 months after birth) and may be subject to recall bias or because the participants who had successfully breastfed had worked to overcome embarrassment at feeding in public.

Further, incidents of dissonance allowed me to identify areas for further research. For example, three UK studies found that women felt let down after discharge from hospital (Condon et al. 2013, Ingram et al. 2008, Spear 2006); because there was little continued support for breastfeeding after the immediate post-partum period. Conversely, six studies, including two of the former (Noble-Carr and Bell 2012, Condon et al. 2013, Ingram et al. 2008, Nelson and Sethi 2005, Dykes et al. 2003) also found that health care professionals (hcps) were often considered to give impractical, conflicting or unhelpful advice and/or that health care professional advice was rarely sought. This suggests that the relationship between a young mother and her health care provider was influenced by more than the services on offer and the health care professional herself.

The third step in the production of the meta-synthesis was to examine the themes which were drawn out by the above compare and contrast exercises and to develop new insights by reading across the findings to produce a "*synthesis of translation*" (Walsh and Downe 2005). Broadly, the findings of the meta-synthesis were grouped into three main categories or overarching themes. The first was the influences of others on breastfeeding; who and what influence the mother and how and when their input is important. The second overarching theme was the physicality of breastfeeding, pain, sleep and physical work. The third overarching theme was the moral and emotional domains of breastfeeding, all of which are discussed in detail below.

The influence of others on breastfeeding.

This overarching theme of the influence of others is about the types of interactions and the people with whom they occur, that present support or challenges to young mothers as they journey through infant feeding from birth to weaning. Significant others, such as partners and family members are often cited as being influential in infant feeding decisions (Condon et al. 2013, Nesbitt et al. 2012, Smith et al. 2012, Nobble-Carr and Bell 2012, Brown et al. 2011, Dykes et al. 2003, Benson 1996). However, the health care professionals, initially the midwives, do also have an impact on infant feeding decisions (Nesbitt et al. 2012, Smith et al. 2012).

Brown et al.'s (2011) mixed method study on the attitudes and knowledge about breastfeeding of young mothers showed that being part of a family and peer group in which breastfeeding is natural and normative is strongly associated with breastfeeding initiation and particularly with continuance. They also found that mothers who bottle fed used family as a resource of knowledge more than women who breastfed. The latter group tended to turn to professionals and books for sources of information. (Brown et al. 2011, Benson 1999).

Moving out from the immediate family to the peer group, Brown et al. (2011) used mixed methods to examine factors associated with breastfeeding initiation and duration in young mothers. Brown (2011) recruited mothers 24 years and younger. They asked 138 mothers to complete retrospective questionnaires then interviewed 10 mothers who breastfed for six months or more. Their sample contained more mothers who initiated and continued to six months than the national average (83.3% initiated, 27.6% continued). Although the mothers who initiated breastfeeding were less likely to believe that breastfeeding was inconvenient or that bottle fed babies were more settled, there was no difference in the perception of the difficulty of breastfeeding between the groups. Mothers who breastfed were less likely to use 'lay' sources of advice.

Examining the role of the professional more closely, Dykes (2003) found that the young mothers experienced being stereotyped as bottle feeders because of their age. However, in the other studies (Dyson et al., 2010, Brown et al., 2011, Condon 2013) the young mothers generally perceived the midwives and other health care professionals as being strongly in favour of breastfeeding and often censorious of their decisions to bottle feed. This dissonance may be due to different research approaches but it may be that different health care professionals promote breastfeeding whilst others assume that young mothers will bottle feed. This is an important finding of the meta-synthesis as it demonstrates the complex and often ambiguous relationship of the young mothers with the health care system. This ambiguity is an area that requires further investigation.

The physicality of breastfeeding

This theme encompasses the practical and biophysical demands of breastfeeding such as pain and pumping and also the environmental issues such as finding somewhere to feed. This discussion is positioned in the theme of support and supporters because practical difficulties with feeding mean that the mother is likely to utilise support to overcome them, if such support is available. There is also some discussion of embodiment and sexuality, which was a relatively sparse area of enquiry in the literature, usually confined to the sexual exposure of feeding in public rather than a rich examination of the interplay of sexuality and infant feeding.

Four authors (Hunter and Magill-Cuerden 2014, Nesbitt et al. 2012, Smith et al. 2012, Benson 1996) found that the pain and physical demands of breastfeeding were the main cause of cessation of breastfeeding or were overriding themes in the young mothers' experiences. The kind of support they encountered in such 'pivotal points' of pain and physical demands (Hoddinott et al. 2012) would often make the difference between continuing to breastfeed or starting formula. The complex relationship between the

practical, and the interpersonal aspects of breastfeeding will be explored further in this study.

Moral dimensions and emotional domains of breastfeeding

Dyson et al. (2010) examine the psychosocial factors influencing infant feeding decisions in young pregnant women (study described above). They found that there is a perception that breastfeeding is morally inappropriate for the young women in that they fear sanctions for breastfeeding and self-censure their own motherhood. A normative culture of bottle-feeding is pervasive among this group of mothers and Dyson et al. (2010) discusses the production and maintenance of moral norms in infant-feeding (Dyson et al. 2010). They find that many modes of feeding can be perceived to be the virtuous choice depending on the circumstances. How these choices are still couched in terms of socio-economic position and 'virtue' and how the medical and wider community constructs the concept of the rational choice in this politicised and moralised zone is central to the analytic framework of this study; the lived experience of the self encountering the wider social norms and influences.

“Breastfeeding was viewed as a morally inappropriate behaviour by most of these teenagers, with formula feeding being perceived as the appropriate behaviour”. Dyson et al. (2010) page 144. 1st Column, paragraph 4.

Dyson et al. (2010) found that the norm of bottle-feeding (and the work to defend and legitimize bottle feeding to professionals) was a key part of the young mothers' experiences of infant feeding, even to the extent of group censure of the young mothers who wanted to breastfeed. The young mothers (six in all who started out with the intention to breastfeed) sought to defend themselves and their value as future mothers in their choice. One participant found that people thought she was lazy for breastfeeding (as you don't have to get up in the night to get a bottle). The researchers also found a lot of sensitivity about the young mothers' identity in 'good motherhood' – not least

because social services were seen as a threat to their ability to keep their children. The authors here emphasise the importance of cultural context in understanding behaviours and norms - young mothers are often subject to more surveillance than older and better resourced mothers. Making sure your baby is getting 'enough' food is sometimes a necessary, defensible practice for this group of mothers who are watched closely by institutions, such as social services, that many of them have reason to fear (Dyson et al. 2010).

There are also moral issues around the sexuality of the female breast. Dyson et al. (2010) found that breastfeeding in public was the most contentious issue (generated the most emotion). The relationship between the sexual, maternal, public and private body is not a clear one for any woman and especially so for this group of mothers who have to work harder and guard more carefully their fragile identities as mothers. Dyson et al. (2010) found, in the main, breastfeeding in public to be culturally inappropriate - to the extent of some quite aggressive language such as "*slap it out*" and "*sick and twisted*", (Dyson et al. 2010 pg. 146 2nd paragraph). Even if it were not seen as amoral, it was certainly seen as dangerous in exposing the maternal body to unwanted and perhaps even unperceived sexual attention, voyeurism and perversion. It is also worth noting that the home environment, which is often not under the young mothers' own control if it is their parents or partners' house, can also be a public space. They may not be able to command any space they like to feed and often feel forced into more 'private' spaces within the house, such as bedrooms and bathrooms (Dyson et al. 2010).

Brown (2011) concludes from her qualitative data, in common with Dykes (2003) and Dyson et al. (2010), that self-esteem and pride in breastfeeding - so that they were willing and able to meet external challenges - were strong themes in the women's accounts. An internal and external validation for their feeding was part of a positive and non-conflicting motherhood. The reverse of this is Murphy's (1999) description of the interactional work the women had to do when they felt their decisions would draw censure. I used a theoretical

framework from the more general literature on breastfeeding to interpret this finding on moral work. In Murphy's (1999) longitudinal qualitative interview study, women (she implies that this was done subconsciously) used strategies to 'defend' their decisions to formula feed their babies by claiming that they were *unable* to breastfeed. This defence takes two forms; outright dissembling of true intentions or a covert attempt to get the 'permission' to bottle-feed from a professional. Murphy (1999) illuminates this experience by applying a framework from the "sociology of deviance" (Murphy 1999 pg.187 abstract), to explain how women deal with the challenges to their behaviours as they defend their moral decisions and their identities as good mothers. Few women are totally unaware of the public health messages about the benefits of breastfeeding and the role of an uninformed mother is not consistent with a model of mothering virtue. Therefore, most women sought to excuse a deviation from the expected behaviour of breastfeeding by either stating that other loyalties demanded that they bottle feed (such as allowing fathers and grandmothers to play a part in infant feeding) or that they could not physically breastfeed (Murphy 1999). In summary, women in her study sought to defend themselves against implicit or explicit criticism by claiming that their actions were the only appropriate ones in their situation.

Infant feeding is thus situated in an "*irreducibly moral*" (Murphy 1999, pg. 187 Abstract) domain with implications for the physical and emotional well being of the young women and their families. With morality come sanctions when moral boundaries are transgressed and thus the moral work of breastfeeding can be greater when the mother is not situated in a community that regards it as the normative choice. The ways in which young mothers *negotiate* the moral domain - the meanings of resistance and compliance to certain authoritative narratives have not previously been studied - but without this a fuller understanding of why breastfeeding rates remain very low in young women of low socio-economic position cannot be achieved. This research was designed to generate a deeper understanding of the moral meanings in infant feeding decisions for young mothers; how these shape both their

experiences of early motherhood, the support they are given and what support would be most effective in addressing these issues.

Conclusion to the meta-synthesis

The qualitative literature in the synthesis appears to separate itself along two levels of analysis. The 'deep' analysis, for instance Dykes et al. (2003) and Dyson et al. (2010) that centre around creations of identity, moral frameworks and explicit and implicit cultural forces and representations. The other studies, Brown et al. (2011) Ingram et al. (2008) and Condon et al. (2013), describe the practical importance of support (both professional and lay) for their young mothers - in breastfeeding initiation and continuance, and the problems with feeding in public. However, this support is usually discussed as a barrier or aid to professional practice rather than as a representation of a construction of a moral and embodied identity as a mother.

Three overarching themes captured the issues most pertinent to the mothers' infant feeding decisions and provided a greater understanding of why breastfeeding rates remain relatively low for this group of mothers. The theme of the influence of others illuminates how networks of community influence young mothers. This is often juxtaposed with their relationship to the professionals who care for them and with the powerful discourses of medicine and socially acceptable constructions of motherhoods (Jordan 1997). That advice and support is more useful and effective when the relationship of the mother to supporter is close is well supported by the literature (Dykes et al. 2003; Dyson et al. 2010; Brown et al. 2011). However there is a dearth of research on the wider experiences of professional support; we do not know how young women of low socio-economic position negotiate the conflicting norms of infant feeding and therefore why and how there is resistance to the medical imperative to breastfeed.

The second theme of the physicality of breastfeeding represents commonly found barriers to breastfeeding represented in the literature on breastfeeding

as a whole, namely pain, tiredness and difficulty mastering the skill of breastfeeding. Whilst this topic is relatively well researched, how such physical difficulties interact with the other domains and specifically how they relate to young mothers' experiences is as yet unclear.

The third theme of moral and emotional domains is best exemplified by Dyson et al.'s (2010) finding that young mothers find it morally inappropriate to breastfeed at least in certain circumstances (Dyson et al. 2010). There is an element of active resistance to the high profile public health message of "*breast is best*" (Stanway and Stanway 1983) within these communities where the creation of one's identity as a good mother excludes breastfeeding – it is not a "*normal thing*" (Condon et al. 2013, title). Furthering the understanding of this resistance and of the moral norms and embodied experiences which underpin the feeding journey in situ are vital to develop effective ways of supporting and working with young mothers - even if these projects begin to be more about valuing the young motherhoods rather than traditional midwifery advice.

The themes uncovered by the meta-synthesis are thus analysed to produce new insight and to reveal the gap in evidence of young women's lived experience in negotiating the contested terrain around infant feeding and wider constructions of motherhood. The conclusion of this meta-synthesis of the relevant literature is that we do not fully understand how young women interact with these multiple influences and social expectations. This research therefore aims to develop deeper insight into the lived experience of the young mothers. In particular, their constant narration and creation of themselves as good mothers and how this affects and is affected by breastfeeding will be examined.

Research Focus

From these themes, a need for further research on the meanings young mothers of low socio-economic position give to infant feeding practices and

how these meanings are part of a developing mothering identity for the mothers becomes apparent. If the public health goal of significantly improving breastfeeding rates in young mothers of low socio-economic position (and thus ameliorating some of the extant health inequalities) is to be met, an understanding of the young mothers' agentive, lived experience within infant feeding is essential. This experience will be seen through the frame of the narrative self, as discussed in detail in the methods chapter and the discussion chapter, below.

The above review and meta-synthesis found the following gaps in our understanding of young mothers' infant feeding practices. Firstly, from the available research we do not know how young women of low socio-economic position negotiate the conflicting expectations of supporters.

Secondly, within the young mothers' communities where the creation of one's identity as a good mother can exclude breastfeeding – it is not seen as a “normal thing” (Condon et al. 2013). Furthering the understanding of the moral norms which underpin the developing feeding practices in situ are vital to develop effective interventions in working with young mothers by building resilience to breastfeeding challenges (Hoddinott 2012).

Lastly, there is a good understanding of the practical barriers to accessing breastfeeding support and recommendations for improving support services that are more accessible and sensitive for young mothers. However, the wider practical barriers, such as issues of privacy both within and without the home, are not fully understood in relation to young mothers particularly. What exactly these practical difficulties are, and exactly whether and what help the young women want with breastfeeding, needs to be better understood.

The aim of this research is to fill the gap with a more contextual examination of what the young mothers prioritise, whom they listen to and *why* formula feeding seems to be a preferred choice. The lived experience of young mothers will be described in a way that accounts both for overarching social

inequalities as well as the personal and embodied experience of the young mothers themselves, as Hunter and Magill-Cuerden (2014) have done for young motherhood in general. Therefore the research questions below were developed to investigate these phenomena.

1.5 Research questions

Aim: To investigate and understand the lived experience of breastfeeding in particular, and all infant feeding in general, among mothers under 20 years of age.

Research Question:

How do young mothers experience breastfeeding and infant feeding?

Secondary Research Questions:

1. What and who influences the decisions young mothers make about infant feeding?
2. How do young mothers encounter, understand and respond to professional and lay discourses and practices of infant feeding?
3. What practical difficulties do young mothers encounter when breastfeeding?
4. How does breastfeeding affect the work of the narrative self?

Broader research objectives:

1. To capture and describe the whole journey of infant feeding from pregnancy to weaning onto solid food to investigate the dynamic nature of living an infant feeding experience.
2. To inform the discussion of young mothers and breastfeeding in reference to the lived experience and wider socio-economic influences that play a part in

an infant feeding journey. To develop a theoretical model(s) of understanding young women's experiences of motherhood from this reframing.

3. To share the findings of this study with the local Teen Link midwives and to contribute to the understandings of young mothers' infant feeding behaviours via academic and midwifery practice publications.

Chapter summary

We know that young mothers must negotiate practical, emotional and moral challenges in infant feeding (Hunter and Magill-Cuerden 2014, Dyson et al. 2010 and Dykes et al. 2003). We also know that the influences of their families and peer group may be of importance in making infant feeding decisions (McInnes et al. 2013, Brown et al. 2011, Dykes et al. 2003). From the wider literature we can see that breastfeeding is lower in deprived areas, where the majority of teenage conceptions occur and that socio-economic position must be taken into account when discussing infant feeding. However, it is important that we better understand the complex interplay of these influences and look at these from the woman-centred perspective of the lived experience of the young mother herself. The current literature describes many of the influences, as above, but stops short of a coherent integration of the whole infant feeding journey for young mothers. This research aims to contribute to this holistic understanding and aims to describe what practical and moral negotiations the young mother needs to do in order to breastfeed. This research also seeks to explicate the cultural imperative to formula feeding by examining the meanings of infant feeding to young mothers. By achieving these objectives, this research will inform further investigation and clinical practice to better support and serve young mothers who want to breastfeed.

Chapter 2: Methods

2.1 Section 1: Methodology

Introduction

This chapter provides a discussion of the methodologies underpinning the research project and a detailed overview of the methods used in the study. The first section (2.1) discusses the ethnographic methodology - both the rationale for using some ethnographic methods and the implications for the findings of using these methods. This section also discusses the use of Ricœurian theories of narrative identity (1991) to define the subject of this research - the narrative self. This section concludes with a brief discussion of the feminist lens through which the work is seen and in which paradigm the conclusions are sited.

The second section (2.2) is on the specific methods used. Sub-section 2.2.1 gives an overview of the study design and describes the participant safeguards in place. The next two sub-sections (2.2.2 and 2.2.3) present a detailed description of the participants' journey through the study. The fourth sub-section (2.2.4) describes the use of Thematic Network Analysis (Attride-Stirling 2001) to analyse and structure the data to produce the thematic and theoretical findings. Sub-section 2.2.5 is a brief description of the patient and public involvement (PPI) activity undertaken to inform the design of the study. This included gaining opinions on the acceptability of methods of participant recruitment via midwives and data generation methods such as voice recording. This sub-section also describes the second phase of PPI whereby a young mothers group (which did not include the participants) and a group of teen link midwives were asked for their opinions on the emergent themes and implications for practice and research. The final sub-section details the ethical and confidentiality procedures undertaken.

Ethnographic methodology

The research questions generated from the literature review are open-ended inquiries into the lived experience of the young women through the infant feeding journey. Further, in the critical literature review above I question normative assumptions about the worth and portrayal of young mothers in UK society in order to re-site the enquiry in a holistic setting; that of lived experience of young mothers and their families. As Holloway and Walker (2000, page 49, paragraph 5) state, qualitative methodologies are suitable, *“where the researcher wishes to explore new interpretations to challenge existing explanations”*. Such an exploration is obviously only possible with qualitative methodologies, but ethnographic methodologies were chosen over, for example grounded theory methodologies (Strauss and Corbin, 1990) for several reasons.

Firstly, the theories under exploration, for example the construction of the 'good mother' and its effect on breastfeeding (Hunter and Magill-Cuerden, 2014) were already being considered before the research began as the extant literature was detailed enough to pose such questions. Unlike a grounded theory approach, the methodology was not entirely inductive, so an ethnographic methodology was more suitable (Clifford 1986).

Secondly, the focus of the research is the cultural context of the predilection to formula feeding. This focus is seen through the lived experience of the young mothers, as it would be in phenomenological research design (Giorgi and Giorgi 2003), but it also opens out to a wider view, situated in part in the public health perspective, encompassing both the personal (for example the physicality of breastfeeding) and wider cultural (for example the public disapproval of breastfeeding openly) mechanisms which seem to lead to formula feeding. As below, the methodology here used is only semi-ethnographic, elements of phenomenological analysis (Reid et al. 2005, Smith et al. 2009), that of the actor as a creator as well as a narrator of their own biographical stories, are at the heart of this work. Indeed, Ricœur (1991,

1992) theory is from the hermeneutic tradition, the epistemology most often associated with phenomenological theory (Palmer 1969). However, Ricœur (1991, 1992) did contribute a novel understanding to this tradition, that of 'Philosophical Anthropology' (Ricœur 1988) and it is in this nuance and combination of hermeneutic anthropology that this work really belongs.

Ethnography is the qualitative research methodology most commonly associated with anthropology. Ethnography is both a research methodology and the finished piece of research itself (Hammersley and Atkinson 1995). It is a tool to examine the interaction between culture and behaviour, and to study a specific research question in depth with a small number of participants (Hammersley and Atkinson 1995).

Ethnography is also an inherently reflexive and self-critical set of techniques (Clifford 1986). It is acknowledged that objectivity is often unattainable in ethnographic research and, unlike quantitative methodologies; it is not necessarily even of importance (Krumeich et al. 2001, Mason 2002). An ethnography is an understanding, one understanding perhaps, of culture as a process and as a contested and changing space, inhabited by constantly changing authors (Clifford 1986). As Clifford (1986) discusses, all ethnography starts from the understanding of cultural relativism (there is no final or absolute judgment on culture) and all findings are at best partial truths. He describes the art of ethnographic writing as "*true fictions*" (Clifford 1986, page 6, line 28). Further, through engagement and interaction, you can 'try out' emergent knowledge in practice which is the reflexive and iterative process at the heart of ethnography (Spradley 1979). This approach enabled me as a researcher to arrive at rational judgments about what seems to be going on while still recognizing that I was interpreting the world through a semi-ethnographic lens.

As stated, my approach to the current primary research is not ethnography per se. Firstly, I was not embedded within the culture of interest; I moved in and out of the mothers' lives over the year long period of data generation.

Secondly, there were specific research questions grounded in an identified public health need (the increase in breastfeeding rates in this group). This meant that the data generated was focused on these questions and the whole lived experience was seen through this lens. However, this research used many ethnographic techniques, such as participant observation (Clifford 1986) and ethnographic interviewing (Spradley 1979). The study design for "Young Mothers' Negotiations of Infant Feeding" is therefore based upon ethnographic principles, but differs from 'classic' ethnography in that the researcher did not 'live among' the participants (Clifford 1986) for an extended period but rather, for practical reasons, took the role of the visitor who came and 'hung out' with them.

This semi-ethnographic methodology follows in the footsteps of Dykes (2005a), a midwifery researcher who is a leading figure in the use of ethnographic methodology in maternal and child health. I also draw on the work of Lupton (2012) who examines medicine as a cultural product of society rather than an idealized empirical method. Further authors such as Davis-Floyd and Sargent (1997) and McCarter-Spaulding (2008) examine childbearing and breastfeeding by using this method of analysis to draw out the themes of power and gender within their research. The research was situated within this paradigm and will examine the relationships between women, their immediate society and their health care professionals as it applies to infant feeding, with a consideration of their practical, embodied and agentive life world at the centre of the analysis.

Participant observation and the ethnographic interview

A key element of ethnographic research is participant observation. Participant observation is done by a researcher embedded within the field of study, who participates in cultural life and practices in order to understand, then represents the informants' ideation of their world and the meaning that they use to understand their lived experience (or 'life world') in an ethnography (Clifford 1986, Hammersley and Atkinson 1995). Ethnographic participant

observation is of particular relevance when the topic under scrutiny is the collective social world – that is the shared understandings of meanings (Clifford 1986). In order for the ethnography to be considered authentic, it is important that the researcher considers how their own perspective and framework of interpretation of what they see may influence their work (Krumeich et al. 2001). My own reflections on my professional (as a midwife) perspective may be found in chapter 7 and a brief discussion of the framework of interpretation below.

The ethnographic interview is perhaps misnamed. The word 'interview' suggests a question and answer format to gain information and possibly make an assessment – for example a 'job interview'. The ethnographic interview is much more of a 'chat' (Spradley 1979). As Spradley (1979) describes it:

"The ethnographic interview as a speech event... shares many features with the friendly conversation. In fact, skilled ethnographers often gather most of their data through participant observation and many casual, friendly conversations." Spradley 1979 pg. 58.

This passage almost perfectly illustrates my experience of the research. Of course, the young mothers were informed of the fact that this was a research study and given information sheets written in an accessible way, which were thoroughly discussed. However, when one of them asked me, half way through the third interview we had together, when we were going to start the proper research, I realised that her opinion of 'what research was' might be different from my own. She was expecting a questionnaire, she told me, like the market researchers in town who stop you and ask you what kind of nappies you buy. I realised then that the interviews were so informal and so unstructured that they did not feel like interviews to this participant, and perhaps this was true for most of them. I did of course ask questions, pick up on interesting things and ask for more details, but it was a two way process, a conversation, which, at least in subsequent interviews when they were more used to me, did not feel like an examination.

The limitations of ethnography mean that it is the beginning of the process to produce evidence-based care, so further applied qualitative research or quantitative research is usually desirable for translation into practice (Donovan 2006). However, it is invaluable for exploring new subjects or under-researched phenomena and is therefore a suitable approach for this research for two main reasons. Firstly, there is very little previous work on the subject, so open-ended qualitative methods such as ethnography are ideal for broadening a limited knowledge base (Donovan 2006). Secondly, the subject matter - women's experiential and emotional responses to infant feeding and the attitudes of their peers - requires an open approach which enables women's voices to be made audible (Krumeich et al. 2001).

Analytical framework – the narrative self

I designed this research as a longitudinal and ethnographic study because I wanted to capture, analyse and theorise from the starting point of the self as a self-creation by narrative. Starting from the hermeneutic anthropology of Paul Ricœur (1992) I constructed the 'self' of the young mother, the subject of my enquiry, as self made through the constant narration of her identity. This means that as the physical and named self (*idem*) exists in the world, it moves through time and changes. What makes this *idem* a 'self' is the stories of selfhood that connect it to the past, present and future. The classic metaphor for this concept is the Ship of Theseus, which sails around the seas, being repaired and planks replaced when necessary. The crew may also change, and perhaps the sails too. But even when none of the original bits, planks and ropes remain, it is still Theseus's ship.

I can use myself to illustrate the same point: To make the physical self that is called Phoebe be me, I have to identify with the Phoebe of yesterday and have expectations about the Phoebe of tomorrow. I must tell a story of that yesterday Phoebe and how she got into today and how she may get into tomorrow, and for all of the days. This story becomes very complex, as I

weave together what I did; rationalise about why I did it, understanding my actions and interactions and my impact on the world. This is the *ipse* identity.

This sounds very philosophical but for the purposes of producing theories to inform public health interventions and research from this study, it is in fact very useful. Using a Ricœurian analytical framework of the self allows extrapolation from the individual participants' narratives towards models of how and why young mothers, on the whole, choose not to breastfeed. By defining the self, we can move beyond it. Therefore, in terms of health and nurturing practices of young mothers; if the self is a relational creature, one made, remade, negotiated and storied through interaction, then the genesis and possibility of change of health behaviours must also be considered in a relational and narrative way (Ricœur 1991).

For these reasons, the data generation undertaken in the normal context for the participants (in all cases the family home) was a way to understand the constructions of the self. The data collected was the narrative production of the self, through the young mothers' interactions with their immediate surroundings and through their descriptions of their interactions with more remote agencies and people.

The implications for this application of theory is discussed in chapter 7 but it also provides here an epistemological justification for the methodologies used, as a focus on the self as conveyed by narrative is the essence of Ricœurian theory. More traditional public health methods of qualitative data generation, for example semi-structured interviews, would not have suitably answered the questions asked. For example, the question of 'why do you now choose to formula feed?' is too limiting. A more theoretical problem is instead posed 'what is it about your constant creation of a mothering identity that seems to lead to formula feeding? This latter question is only answerable using ethnographic interviews offering a rich description and by using Ricœurian theoretical frameworks of the creation of the self.

The feminist lens

This work is underpinned by feminist theory, in that it accounts for gender in explaining some of the cultural phenomena under investigation. In practice this means that the results will be interrogated for the impact and interplay of gender with other personal or pragmatic axes of influence on the young women and their infant feeding behaviours.

Lupton (2012) points out that from a Foucauldian perspective the visible emotional and physical work of becoming a mother often obfuscates the old, but ever present, existing *gendered* relationships. For instance, using technology we measure, monitor and test babies from the moment they are born – and by extension their mothers and their mothering behaviours. If a baby fails to gain weight to a set standard the mother's feeding practices will be examined and other modes prescribed. In my experience, the most common complaint from new mothers about feeding support, is that they received contradictory advice from health care professionals about breastfeeding, (especially in cases of slow weight gain) but this is not always visible in the literature here reviewed (section 1.3 and 1.4). Within the literature the young women are often seen as making the 'wrong' choice either through ignorance or a lack of self-determination (see for example, Ingram et al. 2008). The fact that contested ground of infant feeding is a power struggle and that the medicalised guidance is sometimes contradictory needs to be further understood in relation to the specific impact on young women's experiences.

Lupton (2012) also discusses the ways in which the medical profession creates deviance. In this context, it shows how we also create the 'vulnerable' in maternity – the saintly midwives and paediatricians 'rescue' the babies of those whose motherhood does not conform, does not meet the measured and measuring targets of early infancy. Thus there is the risk of creating the 'neglectful' mother, the 'inadequate' mother in interventions in infant feeding (Lupton 2012). Further, as in the work of Maher (1992) the literal cost of

breastfeeding, the time and need for increased calorific intake cannot be ignored when discussing breastfeeding. Whilst Maher's (1992) work focuses on a low-income setting. This work stems from and further investigates the ways in which these gendered 'costs', of time, bodily autonomy and emotional work impact upon young mothers' experiences of infant feeding.

In these ways, the approach and the results of this work are filtered through a feminist perspective. This approach is a needed contribution to the understanding of the experience of breastfeeding in the UK as I believe that the obfuscation of these gendered issues is in part why we are seemingly failing to enable and support breastfeeding (Hoddinott et al. 2011). This may be particularly in vulnerable groups of women, who may have fewer resources than a more affluent mother.

Reflexivity in this work

As in the reflexive introduction, as a mother I have had almost entirely positive experiences of breastfeeding, in a context in which these positive experiences were all the more important because of other problems during pregnancy and birth. Further I am an affluent and educated professional and had my daughter in my early 30s, although I grew up in a highly deprived urban environment. In this sense, my perspective on the young women's experiences will always be one of sympathy rather than empathy; I care and respect the young mothers' experiences, but I do not really know what it is like to live them. As Kanuha (2000) points out, a close personal relationship to the experiences in question can sometimes be useful in a nuanced and rich understanding but it can also detract from the ability to see the wider context in which this experience occurs. As this is an ethnographic study, with a public health perspective underpinning both the rationale for and use of the research, the ability to care about the emic perspective whilst being able to appreciate the etic viewpoint is a delicate balance, which I hope my 'close but not too close' personal experiences will contribute to.

Secondly, as an experienced midwife I have a clear bias towards the role of healthcare and the involvement of health care professionals in the support and promotion of breastfeeding. The aspects of my professional role which had implications for the research are section discussed further in section 7.4, but in terms of the methods chosen my midwifery identity was key both to the recruitment and design of the study. Due to the well documented difficulty in recruiting and retaining young parents to research programs (Arai 2003) it is unlikely whether my recruitment strategy would have been successful without the ability to approach and work with the midwives to recruit the participants as afforded by my insider status (Kanuha 2000) as a midwife. Indeed, the immense amount of time and intensive effort taken to recruit and retain the participants who were part of the study meant that even with this advantage it was a difficult task.

My professional identity does also imply, however, that the aspects of experience that relate to the interactions with healthcare professionals may well have been given a more visible place, both by the young mothers view of me as a health care professional and by my own focus on the topic. I kept detailed reflective journals throughout the data generation and was at pains to analyse and make clear my own perspective on the data, as this is discussed further throughout chapter 7. Overall I feel that the focus of this study has been the holistic experience of the young mothers, and the aspects of the results which do discuss the role of healthcare are appropriate and necessary. This is because the intent of this research is to inform future interventions that may be of use in this group, therefore it is important to include the emic perspective on health care as well as the wider lived experience.

The theory of commensality

I use commensality here as an anthropological term (as in Mauss 1954) indicating not just those who eat together but also the ritual of obligation that creates and sustains a group (in the UK context the group is the family). This theory places the act of sharing or giving food in a central place in the

maintenance of group dynamics, in which roles are reiterated and bonds are strengthened (Kerner et al. 2015). A good example of this in Britain is the traditional Sunday lunch. The ritual of the family coming together to share a meal that (usually) the mother has cooked and meat that the father has carved; symbolising the domestic nurturing and sustaining mothering role and the providing and apportioning role of the father (Kerner et al. 2015). This concept is primarily used in the analysis chapter (chapter 7) to discuss the ways in which infant feeding becomes a key part of the family's process of accepting the new baby.

2.2 Section 2: Methods

This is a qualitative study with ethnographic methods and I carried out all the data generation. The data generation was effectively a continuous process from recruitment up until the final interview as the baby was weaned onto solid food. The following four short sections are an overview of the study, followed by a detailed description of methods and safeguards.

2.2.1 Overview of Methods

Preliminary phase

Three Public and Patient Involvement (PPI) sessions were carried out before recruitment began. One of these was with the specialist Teen Link Midwifery Team and the other two sessions were during Antenatal Classes at the hospital. The PPI sessions were useful in gaining opinions about the proposed research and in finalising methodological decisions, such as what social network site was the most likely to be used, where the data generation should take place and how much the honorarium should be. A full discussion of the PPI phase and of the collaborative elements in the study overall, can be found in 2.2.5 below.

Recruitment phase

Participants were recruited via the Teen Link Midwives in Sheffield and were purposively sampled. The sample was of mothers who were reasonably well and stated an interest in breastfeeding and in discussing infant feeding. A subsequent exclusion criterion was serious illness of their babies but, thankfully, this did not occur for any of the 10 participants. Full inclusion and exclusion criteria can be found in Appendix 3 For the purposes of answering the research questions it was vital to recruit mothers who considered breastfeeding and who then succeeded or changed feeding modalities, as it is a close and rich description and understanding of these journeys that creates

insight into the low breastfeeding rates of young mothers. Whilst there is undoubtedly much insight about wider cultural attitudes to formula feeding to be gained from mothers who make the decision to formula feed before the birth of their babies, this was outside the scope of this study.

Data generation phase

There was an initial entrance interview to discuss the research and gain written and informed consent. Initial data was collected at this interview, asking for the participant's general thoughts about infant feeding and also basic demographic information. The interviews lasted around 30-60 minutes. At this meeting, a plan of engagement was drawn up between the researcher and participant so that data generation locations and timings were best suited to the participants' needs and availability. This was, in all cases, their own home, though for most of the participants several visits (sometimes up to four) were required to secure one data generation episode.

There was subsequently a six-month period of participant observation (again all in their own homes as none of them attended any infant feeding groups or parenting classes) and 2-3 more interviews per participant, until weaning began at around 4-6 months of the infant's life. All interviews were recorded with a tablet computer using voice recording and participant observations and sketches were made using a notebook and pen both during and immediately after the visits and interviews. The template for the unstructured interviews and participant observations can be found in Appendix 4 along with a sample of field notes.

A small (£50) honorarium was given in vouchers for a local shopping centre as a token of gratitude for taking part in the research. The amount and type of vouchers used was decided by the young mothers at the initial PPI consultations.

Participant involvement in production of the results

Data analysis was concurrent to the generation and was discussed at the end of the final interviews. The final interview (when the baby was about 6 months old) was arranged to jointly reflect on the infant feeding journey and the mothers' experiences of the research. Twelve months after the study finished I attempted to contact the participants to share the final results of the work, although all of them had changed their phone numbers. I did manage to engage some of them on Facebook. They were generally pleased with the findings but no specific comments were made. The research findings were also taken back into the community for other young mothers and the Teen Link Midwives to discuss in a final PPI exercise.

2.2.2 Recruitment methods

Sampling

The sampling frame was young pregnant women who were under the care of the Sheffield 'Teenage Specialist Midwifery' service. The scoping exercise identified two clinics in which to make initial contact. The clinics were chosen because they were the busiest in Sheffield (i.e. were in the areas with the highest under 20 years old conception rate); were different in terms of ethnic diversity (one was in a mostly white British area, the other in an area with a high proportion of South Asian families) and were run by midwives who were supportive of my research. The inclusion criteria (Appendix 3) were explained to the midwives and this was revisited when first contact with the participants was made, by asking for their postcode, year of birth and also asking, "have you been well in this pregnancy?" to elicit disclosure of any serious morbidities. Mental capacity was not formally assessed but a discussion with the midwife caring for the young woman was had in each case, to gain a

second opinion of the suitability and ability of each participant. None were excluded as a result of these discussions with the participant or midwife.

Recruitment

The participants were recruited from two clinics run for young mothers in Sheffield by purposive sampling techniques according to the inclusion and exclusion criteria. I made frequent visits to the midwives at their clinics and team meetings to discuss the research further and to answer their questions, keeping the research visible in their extremely busy and demanding jobs. The recruitment was done by the Teen Link Midwives, who asked the young mothers if they would like to take part and gave them the patient information flyer (see Appendix 5) with a short verbal summary of the research. The potential participants were asked to contact the researcher directly, or, if they would prefer the researcher to contact them by telephone to arrange an initial interview.

The stated plan in the research protocol was to recruit up to 10 participants. This is a manageable and appropriate number of participants for an in-depth, longitudinal qualitative study, similar to other comparable studies (Hunter and Macgill-Cuerden 2014, Smith et al. 2012, Nelson and Sethi 2005). No plans were made to stagger the recruitment as it was imperative that all possible participants could be included due to the difficulty in recruitment and retention of this group (Arai 2003). However, in practice and mainly due to this difficulty, the data generation was spread over a full year, with five months between the birth of the first and the last baby.

Purposive sampling took place over the first five months of the research program (November 2013- March 2014). The sample size was expected to be 6-10, based on similar previous studies (for example, Dykes 2005a), and the final number of women who took part in the core ethnographic research was 10. Although two subsequently withdrew from the study after birth having only completed the initial interview. Permission to use the existing data was

obtained from both the participants who withdrew. They both said (during a telephone conversation) that they had decided to formula feed and therefore "didn't want to talk about breastfeeding any more."

Every woman who expressed an interest was phoned to discuss the project and to arrange an initial interview if this was then appropriate and desired. Only two women declined to initiate a first meeting, both because they said they were too busy. One woman who was interested in the study was not recruited because of social services involvement. Once 10 interested participants were recruited and plans of engagement formulated, I asked the Teen Link midwives to stop recruiting. The number recruited was designed to be enough to provide a depth of data, but without exceeding the researchers capacity to collect data at the relevant points (as above), nor placing undue demands on a participant's time. Since data generation was slightly staggered by the different gestations at recruitment (between 30-40 weeks), and the extensive recruitment phase (five months) the data generation was spread over 12 months. Gestation was not specifically included in the criteria but because of the third criteria 'expresses an intent to breastfeed' they were all in the third trimester at the initial interview as the Teen Link Midwives generally started to discuss infant feeding at the 30 week appointment.

Assessing socio-economic position

Given the important socioeconomic differences in breastfeeding rates and young childbearing, this study aimed to focus on the experiences of young women of low socioeconomic position. The term recognises that socio-economic position is both contextual and dynamic – people's lives change and the values applied to aspects of their lives are also mutable. There are elements of practical and economic inequalities (poverty) described by socio-economic position, as well as cultural and status related aspects to the term (Shaw et al. 2007).

Within discussions of health inequalities, definitions of the kinds of inequality experienced by an individual or group are essential but these are often confused by the interwoven and interdependent nature of axes of inequality. There are particular problems assessing socio-economic position for this group of mothers. They are unlikely to have had careers prior to motherhood because of their age and, therefore, income and previous occupation is a less useful marker than for other groups. They may also be too young to have completed higher education so educational attainments are not as predictive as in other groups. With this in mind, sampling was designed to recruit women from lower socio-economic positioned families, as the clinics approached were both in high deprivation areas.

Assessing socio-economic position was done by using the IMD for respondents' postcodes. Sheffield has almost three times as many people living in the most deprived national decile (125,000 people) than in the least deprived decile (47,000 people) (Hollingworth 2011). The address they are resident at might well be their parents' address and will therefore not be as meaningful as in other groups, and of course there are individual variations within IMD areas (for example I live in a 4th Quintile area but I am a well educated professional). However, it is a proxy that should be consistent in the

age group of interest (16-20) and is more accurate than using classifications based on profession or education for this group. Therefore, socio-economic position was assessed by using the IMD multiple axes of deprivation, supplemented with other details (for example parents' work status) where necessary.

2.2.3 Data generation methods and schedule

The data generation was fluid and continuous, as is normal in the ethnographic method (Hammersley and Atkinson 1995) but the original guiding plan for data generation is set out in the table below. The entrance interview was also used to collect data on the participant's thoughts on feeding prior to birth, and her understanding and attitudes towards breastfeeding.

Table 3: Data Generation Schedule

Time point	Interviews	Participant Observation
30-40 weeks of pregnancy	Entrance interview and demographics	PO at home with the family.
< 4 weeks post-natal	Unstructured Interview	PO of community midwife visit or health visitor and the family.
2-5 months post-natal	Unstructured Interview	PO at home with the family.
4-6 months post-natal	Exit Interview, including respondent validation	PO of weaning practices at home and social events.

I recruited 10 young women to the study, undertook 10 antenatal interviews, five final interviews and three participants made every single one of the scheduled meetings. The initial proposal had been for 6-10 participants and in

the end 10 were recruited and eight were retained, although not all of them completed every interview. Data saturation, when no new themes were emerging from the data collected (Saumure and Given 2008) was achieved during the third to last final interviews, but I completed the following two final interviews, as this was also an opportunity to gain participant validation of the results and to say goodbye.

The meetings were difficult to obtain, though this did not appear to signify participant desire to discontinue with the study. I repeatedly offered each participant the opportunity to withdraw. The honorarium was not dependent on any particular numbers of interviews and each participant who did remain in the study seemed genuinely happy to see me. The problem seemed more to be a matter of organisation and often they were running late. In all, I completed 25 interviews and participant observation opportunities. Special attention was given to ensuring data generation within the neonatal period (the period with the steepest drop in breastfeeding rates) as the vast majority of women who convert from breast to formula feeding have done so by six weeks (McAndrew et al. 2012).

Participant observation was used as a method of data generation (see Appendix 4) as it enables data generation from unspoken activity and gives a glimpse of the daily actions and interactions that create her lived experience (Hammersley and Atkinson 1995). Detailed field notes were taken at every encounter, both during and outwith the interviews while still present in the home, and an example can be seen in Appendix 4. The data from the participant observation: daily family life and events, and two home appointments with health care professionals (a health visitor and a midwife) with whom the young mothers were involved, was used to provide depth to the narrative data from the interviews, by giving context to the mothers' stories and revealing the unspoken work around the care of the baby. This was done by transcribing the relevant episodes as memos and marrying these to the participant interviews so that when the initial coding was performed the

context and unspoken nuances of the episode could be taken into account when interpreting the meaning. Most often the observational data served to reinforce and contextualise data from the interview. However, in a few instances, such as the theme of the feeling of 'weirdness' when breastfeeding which none of the participants could adequately verbally express, the field notes and participant observations were used as data in their own right. This is discussed in depth in the results chapter (chapter 7, section 7.2)

This dual and contemporaneous method of data generation (Mason 2002) provided some authenticity to the data collected and gave me insight into the lived experiences. For instance, the interaction of Jessie's baby with his grandma supported Jessie's description of her mother as primary carer. When he was hungry he looked to her for food and she made him a bottle without any words being spoken between her and her daughter.

The final interviews also provided some respondent validation of the themes, as did subsequent Facebook contact. There was not much detailed critique of the work but all the main themes were acceptable to the six participants who were able to give me feedback.

2.2.4 Data analysis methods

In order to structure the analysis, both for ease of planning and to be more transparent in my methods, I used the Thematic Network Analysis (TNA) (Attride-Stirling 2001) method to organise the data. TNA does not analyse the data per se, but is a way of coding, organising and identifying emergent themes in a systematic way. Further, this improves the internal validity of the results by employing systematic and repeatable methods.

Briefly, there are three stages of TNA:

1. Lowest-order premises (Attride-Stirling 2001) are codes that take basic themes directly from the text. These are often called **basic themes**.

2. Categories of basic themes, whereby the direct themes are organised by emergent themes and groups are built that can demonstrate or describe more abstract and theoretical principles. These are **organising themes**.
3. Super-ordinate themes (Attride-Stirling 2001) are the main descriptions, metaphors and theories developed from the text. These are **global themes**.

As applied to my data, the methods of analysis were thus:

1. Coding of basic themes

I used MaxQDA software (similar to NVIVO) to read every transcription thoroughly, and assign a code to each section. Some of the codes were in-vivo (e.g. 'having a little break'), some were more general (e.g. Family) and some were quite abstract (e.g. Agency of the baby).

To make coding more standardised, pragmatic categories were used based on the subject under discussion rather than interpretative understanding; using 'literal indexing' (Mason 2002). Each transcript was coded soon after the interview was completed. Then, when all the data generation was complete, the transcripts were all re-coded in light of the new codes developed by later transcripts. This was done iteratively until no more new codes were being created. A final check was done to ensure all codes were used consistently and exhaustively for all texts. Some codes were merged and some were broken down into two or several different codes as further data nuanced the different themes at play. There were 1936 coded segments of text that were categorised into 122 Basic (pragmatic) themes.

2. Identifying organising themes

The transcripts and the participant observations were collated for each participant. The codes were then compiled into groups of themes for those individual participants with some thought to the 'overriding' features of that

participant's narrative. Memos of lexical (the repeated use of particular words, such as 'bonny') and semantic (repeated or strongly emphasised meaning) analysis were written for each coded section of text. This process also led to the writing of the Vignettes in chapter 3. Thus the transcripts were analysed to "identify the underlying patterns and structures" (Attride-Stirling 2001 392 paragraph 1).

Some of the organising (interpretative) themes developed were broad and general. For instance, Family Practical Support contained both references to practical help and issues of 'common knowledge' within family relationships; two very different facets of the relationships, but with a common root in the 'living with' of the families. Other themes were very specific but were either very important to some of the participants or were commonly cited by many of them over time. For instance, 'mothers' eating habits' were often mentioned by many of the participants when discussing milk production or the change the baby had made to their lives. Fig. 4 (page 85) below is an example of how the basic themes from step one formed the organising themes of the Agency of the baby.

The participant observation data was included at this stage to either validate or raise questions about the narrative data. The participant observation gave me both contextual information about the family and who was often around. It also was very useful in forming themes around the importance of items, for instance prams. There was no instance of direct contradiction between the narrative and observational data but there were nuances of tension in family relationships that were much easier to elucidate because observation was used.

Figure 4: Basic themes within the organising theme 'The Agency of the Baby'.



3. Creating coherent global themes

The next step of analysis involved rereading and tabulating the coded sections of the basic themes across the participants, (inter-participant analysis) to ensure that the organising themes were meaningful to the data as a whole. Next, the organising themes were grouped into the global metaphors of the research; in this case, the immediate context (family and self), the external context (the 'outside world') and the babies and the milk (the dynamic role the baby plays). Thus three thematic networks were described by the data and then theoretical analysis was informed and formalised. Fig. 7-9 below show the three thematic networks with the global themes and their subordinate organising codes.

Figure 5: Global theme of the immediate context

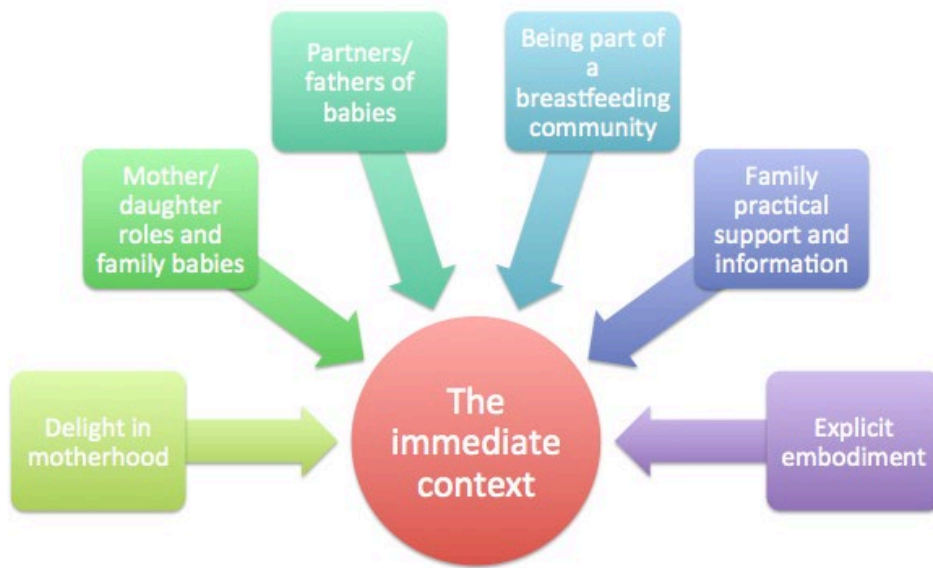


Figure 6: Global theme of the external context

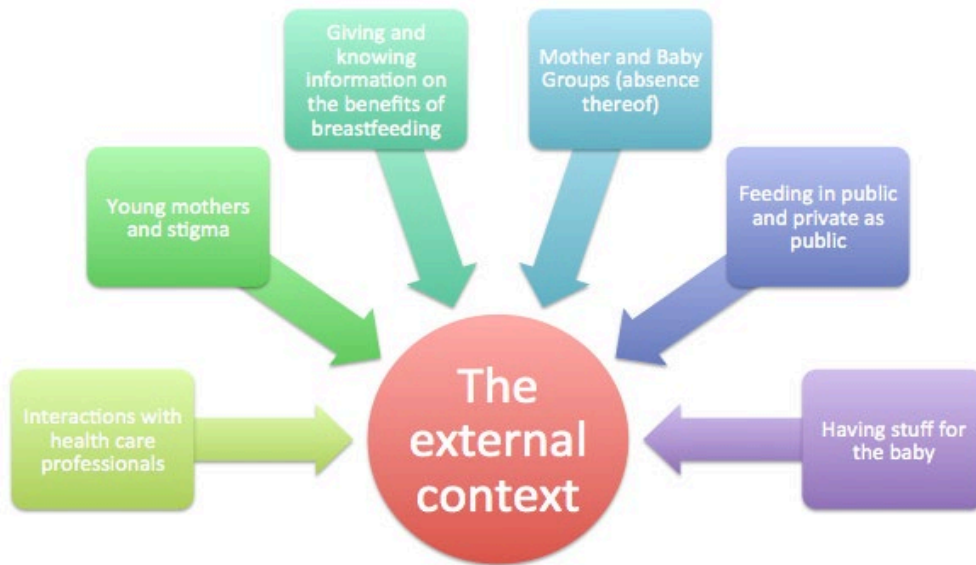
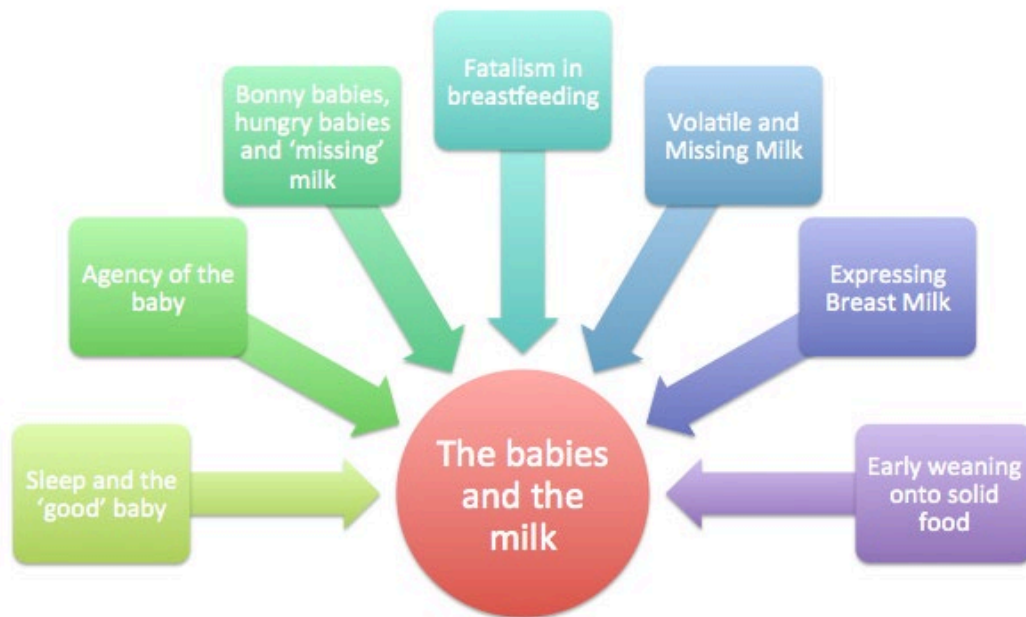


Figure 7: Global theme of the babies and the milk



Transparency in data generation and analysis

Throughout the process of generation and analysis, in keeping with this research forming a doctoral thesis, the results and codes were discussed at length with the supervisory team. The first supervisor also inspected a selection of the transcripts and the codes originating from this in order to enhance the internal credibility (Silverman 2010) and also to support me to improve my data generation process and interviewing technique as part of the research training aspect of a PhD. Ideally a more thorough second researcher analysis would have made the study more robust, but within the financial and time constraints of a PhD this was not feasible.

Difficulties with research methods

As discussed in section 7.4 the initial research protocol had included plans to use social media to generate data (Facebook) and to attend mother and baby groups to gain more varied participant observation opportunities. However, as discussed in detail in section 7.4, none of the participants were happy to grant

me access to their social media posts until the very end of the study. Further, despite several of them expressing an interest in attending mother and baby groups, none of them did so this opportunity was not possible. This does limit the scope of the directly observed data generation entirely to the family home. However the finding that this is the most important context for mothers infant feeding practices, that what happens in the home will overwhelmingly dictate feeding decisions, is important in its own right, as discussed extensively in chapter 4.

2.2.5 Patient and public involvement

Patient Public Involvement (PPI) in research is now an integral part of health care research (Mathie et al. 2014) and is usually defined as research undertaken with members of the public as partners in the process. This involvement can vary from just initial consultations to hone the research questions, to full participatory research, in which lay people play a part in designing, implementing and analysing research.

The collaborative ethnography model, at the extreme of participant involvement was both interesting to me, with my background in grass-roots social activism, and eminently suitable for the subject in question (Lassiter 2008). However, I found that the confines of PhD research, both in terms of resources (time), process (upgrade prior to recruitment) and issues of authorship (academic credit), made it impossible for this model to be used. I have tried to carry over some of the principles and techniques into the research where possible, including developing research schedules with the participants at the outset, and planning feedback and participant review sessions when the thesis is written. As described here, from the outset, I also planned PPI sessions as an initial collaboration with young mothers.

PPI exercises took place August-November 2013, whereby groups of young mothers (accessed through an antenatal group run by Sheffield Teaching Hospitals) were asked for their opinions on the proposed methods and on the subject itself. The purpose of this exercise was to avoid potential harm or inconvenience to the participants. It was also useful to reduce the methodological difficulties of the research by a greater understanding of what is generally acceptable to young mothers in Sheffield. For instance, the group was asked how much they think an honorarium should be and what kind of vouchers would be most useful. More emotive information was also sought such as how acceptable a request to do interviews in the young mothers'

home may be. No details of the participants of this group were taken and all information generated was non-attributable.

A pragmatic approach of 'dropping in' to antenatal classes was necessary as this group of mothers are often difficult to engage, primarily because they often lack the resources and support to travel to and attend sessions on time. The PPI phase was guided by good practice guidelines for PPI engagement activities (Joint Health and Social Care Regulators Patient and Public Involvement Group, 2010), and always included one or more key professional (youth worker, midwife etc.) for the support of the young women.

The PPI questions were primarily formulated from the development of the Research Protocol with the exception of the final question (6) that was put in to allow free comment on the planned research.

Several attempts to run PPI sessions were made, between September and October 2013. On three of these occasions (all planned care episodes, such as midwifery clinics and antenatal education sessions) no young mothers attended their appointments. At one of the unattended clinics I asked a group of midwives and student midwives the PPI questions and this stimulated quite a heated debate. I had not planned to include midwives in the PPI phase as it was the participant perspective I was trying to gain, but it seemed appropriate to do *something* when they had kindly invited me in and it turned out to be quite an illuminating discussion, as below. Only one planned PPI session garnered any contributions from young mothers. At an antenatal class, five pregnant young women attended with three of their grandmothers, two of their mothers and one partner. To avoid confusion, the patients are referred to as 'pregnant young women', their own mothers are 'mums' and their grandmothers are 'nans'.

I began the session with a brief introduction to my research, asked everyone if they were happy to participate, and gave them a copy of the Participant information leaflet (see Appendix 5). I then asked the questions below and

received the answers listed. We also had a general discussion about breastfeeding.

1. Do you think asking to visit people at home is acceptable? What do you think I should do to make sure I am not in the way?

All of the pregnant young women said that home was a good place; it was comfy and you didn't have to get ready to go out. One young mother added that she worried that people would be judging her when they came round and that she really valued it when people seemed to have an *"open mind"* and when they *"treat me like an adult"*

2. Where is a good place to meet someone if not at home?

Two of the pregnant young women said that they wouldn't like to talk about feeding in a cafe and another suggested the GP surgery if home was not possible as it was *"near your house"*.

3. Who else in a mum's life do you think influences her choices on infant feeding?

All of the midwifery team said the young woman's own mum, very emphatically so. They thought that it was often the mums 'choice' about how the baby was fed.

All of the pregnant young women remained silent on this point (possibly to avoid upsetting the relatives they had brought with them). One grandmother said that she thought she would only help if she were worried; *"It depends how the baby develops, doesn't it?"* One of the mums said she thought the dads had a big say in feeding *"if they were around"*.

4. How much is a good 'thank you' and what kind of vouchers are best?

A midwife suggested Boots vouchers as then they could be spent on baby or mother.

The initial suggestions from the pregnant young women were Boots, Mothercare and Superdrug. Mothercare was then discounted by the group because it is *'too expensive'*, and then a pregnant young woman suggested a Meadowhall voucher, *"because you can use it in any store you like"*. They all agreed that this was the best idea. They all thought more was better, but no one was willing to give a number. I suggested the range of £20-£50 pounds (what was possible within the budget) and they all said £50.

5. Do you have any other words of wisdom on asking mothers about feeding their babies?

One mum said that it was really important in the early days to remember how exhausting having a small baby can be, and to limit demands and be understanding at this time. One pregnant young woman said the research sounded really interesting and she thought 'mums like her' would like to talk about their experiences.

A student midwife, who was a young mother herself at 18, discussed her own experiences. She related, with funny impressions, her journey through the maternity system. The first doctor she saw said, patronisingly (she was acting it out) – *"how did we get into this mess then?!"* She said that no one expected her to breastfeed with her first child and so she felt that it was inappropriate to ask for help. She didn't know how to 'do it' so she gave up after a week, as she worried her daughter was losing too much weight. She breastfed her subsequent two children (both born in her thirties) and was a breastfeeding peer supporter before she began her training.

The senior midwife then commented that *"young women just don't see breastfeeding as a way to feed a baby – it's not rejected, it's just not an option. It's not seen as a way to feed a kid and not something that is ever*

done. Like they don't think you need to talk to a baby. They are unaware and not exposed to it, so they don't do it".

She went on to say: *"they are not 'in touch' with their bodies, they don't have good sex and they don't feel that the foetus is part of them – smoking is something they do – not the babies"*. She said that saw her job as an opportunity to help the young mothers make positive changes, not just in health but also in education and employment. She discussed how having a baby can be a real motivator to 'do something with your life'. All of the other midwives and students agreed with this, and the student midwife who had been a young mother said that this had certainly been true for her.

When asked how to elicit opinions of young mothers on breastfeeding, all of the midwives, with the exception of the most senior, immediately started discussing breastfeeding promotion; this is how the question is always framed for them, because it is their job to increase breastfeeding rates. There was also discussion on the division between "what they think up at the hospital" and what is actually true in practice. They thought the guidance they were given by the breastfeeding team was of less use with young mothers than with older caseloads.

Conclusion to the PPI phase

The exercise was of practical use in establishing the acceptability of the research as a whole, likely acceptable meeting places and the honorarium. Theoretically, it also resonated with the findings from the literature review in that the stigma associated with being a young mother was keenly felt and seen as an obstacle to be expected, but overcome.

It is interesting, and reassuring, that the discussion very quickly became an issue of reframing the ideas about young pregnancy as a whole for the midwives and for the young pregnant women. The idea that the best outcome for a young mother is not to be one is still very prevalent (Department of

Health 2010) and the midwives' and the young pregnant women's comments were a reaction against this perceived prejudice. The discussion also concluded with the dissonance in breastfeeding idealism and realism for young mothers. Both groups expressed that it can be theoretically seen as right, but is not always seen as morally or practically possible. These ideas were similar to the ideas found in my literature review of breastfeeding being 'not normal' and 'difficult' (Condon et al. 2013, Dykes et al. 2003, Dyson et al. 2010).

2.2.6 Consent, confidentiality and ethical approval

Confidentiality

Interviews and participant observation were recorded (voice recording and notes made) using a small tablet computer with the participants' immediate consent and pen and notebook. Transcriptions were made of the voice recordings and the original recording permanently deleted. The transcriptions and further analysis were stored on an encrypted and password protected laptop, and on the University server.

All data collected was tagged with pseudonyms only, chosen by the participants themselves and the key was kept in one password protected file on the University server. Data were collected in accordance with the Data Protection Act 1988. The one caveat to assurances of anonymity was the overriding professional obligation to disclose information to social services and/or the police if a child or vulnerable adult are in immediate danger. This was discussed with each participant and was an item on the consent form. None of the participants raised such concerns during the study.

Consent process

All initial contact to ask if the participant was interested in taking part in the research was made by the midwives. Permission to call the potential

participants was gained in full before the researcher made any contact. Full informed and written consent was obtained by the researcher immediately prior to the initial interview. Consent is an on-going process and the participants were informed at every meeting that they could withdraw at any time, without needing to give a reason, and that this would not have any negative impact on their care or other service access.

Full informed consent for the participants was achieved by the following steps and checks:

1. A participant information flyer was given to all potential participants from the community clinics by the teenage pregnancy specialist midwives, at the midwife's discretion (see Appendix 5).
2. Full informed consent was taken with a standard consent form (Appendix 6) before the first interview and a copy of the more lengthy Patient Information Sheet (Appendix 7) was discussed and again given to the participants. The consent form was signed by the participants and the PI.
3. Only participants with a good command of spoken English for whom there was no question of their capability to consent and who were over 16 years old were recruited.
4. Access to medical records was not sought by the researcher.

Issues of consent for any people other than the mothers who contributed data were handled as follows:

1. Participant observation of the family setting was part of the data generation, to provide context to the data from the core participants. Therefore, comments and questions from other people inevitably became part of some of the transcripts where they formed a conversation with the main participant.

2. As the researcher I always introduced myself to every member of a group or family and the purpose of the study was made clear with verbal consent gained from everyone.
3. No personal or demographic information was sought from any of the other people in the group; they were not identifiable even to the researcher except as their relationship to the participant (e.g. 'mum').
4. When a friend or a family member chose to take substantial part in an interview or participant observation then the standard written consent was requested using the same process as for a core participant, as above. This was only subsequently done in one instance by Tom, the partner of Marley, who was present at every interview and contributed as much as Marley did to the narrative of Paige's feeding. However, many of the participants had family members who came and went throughout the participant observations and interviews.

Ethical approval

Full ethical approval was granted by the HRA NRES committee (Berkshire B 13/SC/0567^[L]_[SEP]136435 See Appendix 8) on 24th October 2013 with an amendment to the social media platform (Facebook rather than twitter due to participants' preferences) on 13th March 2014. Full approval from the local Hospital Trust's Research and Development office was also granted.

Chapter summary

This chapter has set out the design and the underpinning methodology and epistemology that informed the study design and the production of the results. Qualitative research informed by ethnographic methods was used to describe and understand the lived experiences of young women and infant feeding. The relevant recruitment and ethical considerations have also been discussed at length to provide assurances of the wellbeing of the participants.

The following four chapters (chapters 3-6 Results) discuss the data and the research findings in the global categories produced from the Thematic Network Analysis (Attride-Stirling 2001) as detailed above. The final chapter (Chapter 7 Discussion and Conclusions) build upon these chapters' methodological foundations and the results of the study to draw practical and theoretical conclusions from the research.

Chapter 3: Background to the research findings

Introduction

This chapter presents an introduction and background to the research findings that are comprehensively discussed in chapters 4-6. The chapter opens with a brief précis of the demographics (3.1) of the participants, describing their socio-economic position and living arrangements.

The second section 3.2 Vignettes of the participants is an introduction to the participants themselves, using vignettes which are written as far as possible in their own words. For each mother and her family there is a short synopsis of her living arrangements, taken from the participant observation and a brief history of her infant feeding journey taken directly from the transcribed texts.

Demographics of the participants

All but two of the participants lived in a 'high deprivation' postcode (IMD quintile 5). Marley had very recently moved with her family from the 5th IMD quintile to the 1st, to make room for the new baby. Marley's parents were both working in semi-skilled jobs. Scrump lived with her parents in an IMD 2nd quintile postcode. They were all 16-18 years old, of varied ethnicity and religion. All but one was having their first baby; Kiara had a little girl, Skylar, who was 2. Half were in education when they became pregnant, two returned to education after the birth of their babies during the duration of the research. All of them either already lived with or moved back in with their own mothers before the birth, though all planned to leave again when the child was older. All of them knew what gender baby there were going to have from the antenatal scans. All but one of them started to breastfeed. The range of breastfeeding (including expression) was three days to 18 weeks, though all

gave some formula as well within the first week. The range of age at weaning onto solid foods was from 8-24 weeks of age. A tabulated overview of the young mothers' demographics and self-reported durations of feeding breast milk and age of weaning can be found below in table 3. With the exception of Scrump, who exclusively fed expressed breast milk until Victoria started solid food, and Newmum who exclusively breastfed, all of the young mothers who breastfed also gave their babies formula milk from hospital onwards.

Table 4: Demographics of Participants (SVB = Spontaneous Vaginal Birth)

Participant	Ethnicity	IMD (quintile)	Education at booking	Occupation	Single A/N?	Single 5mths?	Duration of bmilk	Weaning to solids	Type of birth
Deedee P1	African	49.35 (5)	A levels (current)	Student	no	no	12 weeks	15 weeks	SVB
Alfie P2	African- British	63.99 (5)	College >1 year ago	Carer	no	unknown	0 days	?	SVB
Jessie P3	Slovakian	52.82 (5)	College (<1 year ago)	none	no	no	8 weeks	14 weeks	Ventous
Marley P4	White British	5.67 (1)	School >2 years ago	none	no	no	2 weeks	10 weeks	SVB
Yasmine P5	Afro- Caribbean	54.09 (5)	School >2 years ago	none	no	unknown	1 day	?	SVB
Kiara P6	White British	35.99 (5)	School >2 years ago	mother	yes	no	7 days	8 weeks	Home SVB
Scrump P7	White British	12.27 (2)	BTEC (current)	Student	yes	yes	24	24 weeks	SVB
NewMum P8	Pakistani	63.94 (5)	School (current)	Student	yes	yes	18	18 intended	SVB
Pinky P10	Caribbean- British	45.24 (5)	School (current)	Student	no	unknown	2 weeks	18 intended	SVB
Ash P11	Caribbean- British	75.23 (5)	School <2 years ago	Unemployed	yes	yes	6 weeks	18 intended	SVB

3.2 Vignettes: meet the participants

In this chapter, preliminary to the main findings of the study, I would like to introduce the participants. The intention is to give some context for the decisions the mothers made and the experiences they had. They are individuals, some have strongly expressed ideas while others are less willing to put across their own points of view. Here, in their own words, are their journeys from pregnancy to becoming a mother and weaning their babies. Other voices can be heard here too, the significant people in the mothers' lives, whose thoughts and habits play a part in the decisions the mother makes. These 'significant others' are usually, though not always, the grandparents of the babies. All of the names are pseudonomised, chosen by the participants themselves, and any identifiable data has been changed.

Table 5: Schedule of meetings for data generation

Participant	Antenatal int	Neonatal	Postnatal	Weaning	No. interviews
P1 Deedee	35 wks. preg	unavailable	unavailable	16 wks	2
P2 Alfie	31 wks preg	withdrew	-	-	1
P3 Jessie	37 wks preg	2 wks	9 wks	18 wks	4
P4 Marley	39 wks preg	4 wks	10 wks	16 wks	4
P5 Yasmine	40 wks preg	Withdrew			1
P6 Kiara	40 wks preg	unavailable	5 wks	15 wks	3
P7 Scrump	33 wks preg	2 wks	8 wks	20 wks (phone)	4
P8 Newmum	40 wks preg	4 wks	unavailable	no contact	2
P9 Pinky	37 wks preg	unavailable	unavailable	no contact	1
P10 Ash	40 wks preg	2 wks	4 wks (phone)	no contact	3

Deedee and baby Nyah

Deedee is 18 and this is her first baby. She was a student at a local college before she had to leave due to her pregnancy. Deedee breastfed Nyah for over three

months though she introduced bottles at birth and used mixed feeding with increasing amounts of formula over time. She ceased breastfeeding at 15 weeks.

Although Deedee eventually rented her own flat, she still preferred to meet me at her mum's home. She said that the flat was very small and crowded, not properly decorated and had no fridge or other basic necessities. Deedee has a nurse visit every two weeks, which will continue until her boy is two. The nurse is part of a project called the Nurse Family Partnership (NFP) intended to support positive parenting skills and health behaviours in young mothers.

I visit Deedee at her mother's house, a two bedroom council house in the middle of a large and deprived estate (IMD 5th quintile). Her older sister has two children and lives locally. The house is in a state of disrepair, with paper peeling off the walls, and no carpet in the hall or stairs. We sit in the small front room and chat. She speaks first about her reasons for wanting to breastfeed.

Deedee says: "I'm definitely going to breastfeed, you know, I want to try that first... So I wanna give breastfeeding, and then if that's not going to work or I'm not going to have enough milk, then maybe I will just give a bottle. I'll see how he goes on, I really don't know." (Antenatal interview, Deedee and Phoebe present).

The next time I see her, she has breastfed for three months with some formula too and has just weaned him onto food. Here she discusses her experiences and her reasons for introducing formula milk on the first night after she was born. She discusses feeling lonely in hospital and then goes on to say; *"He just wanted to be fed constantly, for like three hours, so cos I just didn't think it was really doing much, so I asked for a bottle that night." (Weaning interview, Deedee, Nyah, Deedee's mum and Phoebe present, formula feeding Nyah who is 16 weeks old).*

She carried on breastfeeding once she was discharged from hospital and here explains her routines.

"I did both so I were like, at night time I did breast, but in the day time I'd do bottles... So then I carried on doing it until he was about three months, and then I just wasn't

eating enough so it weren't filling him up so he'd want a bottle after. So I just stopped all together." (Weaning interview, Deedee, Nyah, Deedee's mum and Phoebe present, formula feeding Nyah who is 16 weeks old).

She then explained how her decision made her feel and the difficulties she has faced.

"But because obviously we don't have much money and we don't have a fridge because the fridge broke, so we ended up having, I didn't eat enough to be able to feed him myself. That's part of the reason I didn't really want to talk about it, it's really upsetting when he's crying for a bottle and it's so easy to just feed him by breast. It's just like it weren't doing nothing for him, so it kind of really upset me that I couldn't look after my child and all these other people could and they don't choose to. It really annoyed me." (Weaning interview, Deedee, Nyah, Deedee's mum and Phoebe present, formula feeding Nyah who is 16 weeks old).

Throughout our meetings she discusses bonding and how much she enjoys being a mother. This is well summed up when she says: *"It's kind of nice though, isn't it, to know that there is just this little person that loves you more than anyone else." (Weaning interview, Deedee, Nyah, Deedee's mum and Phoebe present, formula feeding Nyah who is 16 weeks old).*

Alfie and baby James

Alfie is 18 and this is her first baby. She left school when she was 16 and has been caring for and living with her Nan-nan (maternal grandmother) ever since. Alfie has a boyfriend, the baby's father, but I have not met him. Alfie has a named midwife but she does not have any additional support.

I visit Alfie at her Nan-nan's house. She lives in a deprived area of Sheffield (IMD 5th quintile) and the street is hard to find as most of the road signs have been torn down. Like many people in Sheffield, the back door is the normal entrance to the house and the front door is blocked up with furniture and piles of belongings. The house is a

semi-detached two-bedroom house on a crescent of similar houses all with good-sized gardens. The garden is well kept; Alfie later tells me that she enjoys gardening.

Alfie called me a few weeks after the baby was born and said that everything had gone well but that she had decided not to try breastfeeding when he was born, and therefore she would like to withdraw from the study. We had a brief chat and she seemed quite happy with her decision to bottle feed him and still very excited to be a mother. She said that she didn't know why she had changed her mind, just that it 'felt right' to bottle-feed him immediately after she gave birth.

In our first interview they discussed her expectations of breastfeeding:

"Alfie: If I can breastfeed, I'll breastfeed, if I can't then I'll bottle feed. (P: OK!) But I might do both." (Antenatal interview, Alfie, Nannan and Phoebe present).

Alfie's Nan-nan echoed this sentiment a little later on:

"Nannan: It is a good thing, don't get me wrong, to feed them on the breast if you can, it is a good thing. But if you can't..." (Antenatal interview, Alfie, Nannan and Phoebe present).

Alfie withdrew from the study after baby James' birth, so her subsequent experiences about infant feeding are missing.

Jessie and baby Lee

Jessie is 18 and this is her first baby. She was studying at college, before she left to have her baby. She hopes to return to college when Lee is a bit older. She was born in Eastern Europe and has lived in the UK since she was nine years old. Her partner lives with her and she tells me he is a very supportive father to their son. Her parents support her a lot, and every time I visited her at least two other members of her family were there. She had her own council flat when she was pregnant, but moved back in with her parents before Lee was born. Her parents live in a deprived area of

Sheffield (IMD 5th quintile) in a very well kept and well-furnished council house. Her flat is on the corner of the same road.

Jessie breastfed her son exclusively from birth, apart from one bottle of formula given in the hospital by a Health Care Assistant. She weaned him off breast milk and onto formula feeding at 7 weeks. She told me that this was on the advice of her GP. She then weaned at 14 weeks, with pureed homemade food, baby rice and yoghurt.

At my first visit, at her mother's house, she tells me of her plans for feeding Lee. *"I'm definitely going to breastfeed, you know, I want to try that first. The family experience was, my sister was saying that it was a bit painful for the first times, but then after that everything's fine. So I wanna give breastfeeding, and then if that's not going to work or I'm not going to have enough milk, then maybe I will just give a bottle. I'll see how he goes on, I really don't know. I've got milk at the moment! As well, when I was about six months, so it seems that I've still got milk, so we'll see if it's going to get better. Because now it's like, watery, but my midwife says that when you get to nine months it's supposed to be milky, like a bit more thick, so we'll see how it goes on."* (Antenatal interview, Jessie and Phoebe present, Jessie's mum often coming in to offer food).

At our second meeting, at her house, she recounts her early experiences of breastfeeding in hospital.

"So, the midwife that was there, she just told me just to try with the breast and see how it goes on!... I was trying my best to put him on breast and always trying to get him so like, my nipples get to normal again, so that's alright. It's fine really now!" (Neonatal interview, Jessie, Lee, Jessie's mum and sister and Phoebe present, breastfeeding Lee who is two weeks old).

She then tells me how much she loves him and how she is finding the breastfeeding difficult but that it is worth it for his sake. *"I don't know, this love is like so, so, so, I can't explain it (laughs).... So, it's alright for him, and he's health, we'll just do it, it don't matter! I am thinking of giving him the bottle, not now, but in 3 or 4 months,*

when he's going to eat then he'll have the bottle as well, so he's more full than just breastfeeding. So he will have the bottle, definitely, because I want to go out sometimes! (laughs)". (Neonatal interview, Jessie, Lee, Jessie's mum and sister and Phoebe present, breastfeeding Lee who is two weeks old).

At our third meeting, she has just ceased breastfeeding and is exclusively formula feeding him, with plans to wean soon. She explains to me why she made this decision, after he had a period of vomiting frequently. *"We've seen the doctor and he gave him Gaviscon, and they've [GP] told me to stop breastfeeding him. So I started with the bottle." (Postnatal interview, Jessie, Lee, Jessie's mum, grandma, aunty and Phoebe present, formula feeding Lee who is nine weeks old)*

At our last meeting she reflects on her journey and talks about how proud she is of him, especially of his eating and development. *"He's 7kg's now! I'm really happy for that. That is getting in there, he's alright and everyone is happy with it. He's also had his two injections, so we have to get his other one next week I think. He's getting really well now, I'm so glad that I've got him!" (Weaning interview, Jessie, Lee and Phoebe present, Jessie's mother often coming in to offer food, formula feeding Lee who is 18 weeks old)*

Marley, Tom and baby Paige

Marley is living with her parents and her boyfriend, Tom, the father of the baby. She is 17 and this is her first baby. She was at college before she got pregnant and has firm plans to return to finish her course when Paige is old enough. Tom and Marley's father are both welders at the same company. They live in a wealthy neighbourhood (IMD 1st quintile) in a privately rented house. The family has just moved from another area of Sheffield, (IMD 5th quintile) to make space for the baby. Marley tells me that her mum and dad are supportive. Marley is an only child, although they wanted more, and they are very enthusiastic about the new arrival. The baby was planned and Marley and Tom have been together for several years. Tom is very proud and Marley tells me that he is a very *"hands-on dad"* and that he changes all of Paige's nappies.

Marley initiated breastfeeding in hospital but struggled when she arrived home, mainly with the frequency of feeding and the lack of sleep. She ceased breastfeeding and began to formula feed after five days. Tom and Marley then weaned Paige onto food at around 8 weeks of age. I also gained Tom's consent to be part of the study because he was present at every visit and interview and contributed a lot of data to the study.

At our first meeting, Marley told me what her family thought about the idea of breastfeeding. She wasn't breastfed as a child. *"Probably my mum would help me, I don't think the men would have a clue! I don't think my dad would want to be around for that. And Tom, just likes it, but the idea of breastfeeding just makes him (makes vomiting sound). It reminds me a bit like, I don't know, it's hard to explain (P: ok!). Everything's all new to him, so the breastfeeding's is like, makes him..... Tom: It freaks me out a bit."* (Antenatal interview, Marley, Tom and Phoebe present).

She also discusses her worries and expectations about breastfeeding. *"The problem, I think probably me just not being able to have, produce any milk for her. Ummm, but if I do I think it will be better, cos it's healthier for the baby."* (Antenatal interview, Marley, Tom and Phoebe present).

The second time we meet, we discussed how she felt coming home with the baby, and how this affected her breastfeeding. *"After I left the hospital I didn't really have anyone other than my mum and dad and Tom. But mum and Tom, they were really the only two helping me, no one else really said anything about it. They said they were going to send a breastfeeding woman round to help me do it and everything, but they never did."* (Neonatal interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is four weeks old).

She then talks about how the breastfeeding made her feel and how she worried about Marley's growth, which prompted her decision to start to feed Marley formula milk:

"Marley: When I was doing it, I was thinking, 'I don't want to do it', but I thought I'd keep trying because I was disappointed when I couldn't do it, because obviously of the bonding experience, plus it's a lot cheaper, as I've found out! (laughs). But, because I was so tired, being up most of the night because she weren't getting enough in, I thought it was best for both of us. I was too tired and needed to sleep.

Phoebe: I understand that. What was making you think she wasn't getting enough?

Marley: The amount she was feeding, she just never seemed full, and when she wasn't putting on enough weight, the second time she got weighed, I thought well, she's not getting enough. But then when I put her on the bottle she gained weight, so I thought that was the best thing.

Phoebe: When the midwife weighed her, what did she say about the feeding?

Marley: She didn't say it was like a concern because she was over the weight they say is ok, but she says, 'she needs to be eating more', and I was thinking 'eating more! She can't be eating more, she's on me 24/7!' ." (Neonatal interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is four weeks old).

At our last interview, she reflected back on the journey from pregnancy to weaning Paige. She talks elsewhere about how much she enjoys bottle feeding but finally said of the breastfeeding, *"I didn't really like it in a way. It felt weird. But I probably weren't doing it right."* (Weaning interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is 16 weeks old).

Yasmin and baby Kaylee

Yasmin is 17 and this is Yasmin's first baby. She lives in her own flat by herself in a busy but run-down central location (IMD 5th quintile) the flat is privately rented and all of her neighbours are university students, which she complains about as they are very noisy. The flat is very sparsely furnished, although clean and tidy. She left school at 16 with no qualifications and has no plans to return to education. She plans to move back in with her Nannan (grandmother) before the birth of the baby and will

give up her privately rented flat to do so. Yasmin expressed a desire to breastfeed antenatally. I spoke to her once after the birth of the baby and she had not initiated breastfeeding. There was not a great deal of rich data from Yasmin, but the following quote captures the key issues she discussed in relation to breastfeeding.

"I'm going to do it for the first bit. Even if I'm not always, I can take it out and give it him (expressed breast milk) in a bottle anyways."

Partner: Well that's alright, as long as he's getting breast milk!

Yasmin: (to partner, shouts) What do you think the pump is for? It's to take the milk out of the house!

Phoebe: Who will you ask for help with breastfeeding if you need it?

Yasmin: My Nannan and my mum, they live up by the Northern, only a phone call away. I'm moving back in with me nan-nan before the baby's here anyways." (Antenatal interview, Yasmin, her partner and Phoebe present)

As Yasmin withdrew from the study there is no further data about subsequent breastfeeding or infant feeding experiences.

Kiara, little Skylar and baby Cory

Kiara has a partner and this is her second baby. Her little girl, Skylar was about 14 months old when we first met. Kiara left school when she had Skylar without sitting any exams. She has a flat with her boyfriend but has moved back in with her mother until after the baby is born. She had a homebirth at her mother's house. Both her flat and her mother's house are in a deprived (IMD 5th quintile) and sprawling estate in Sheffield, quite a way from the town centre. She has Family Nurse Partnership involvement with her little girl and this continued when baby Cory was born.

Kiara intended to feed primarily by expression but initiated breastfeeding after birth and continued for a few days. She then ceased breastfeeding and moved entirely

onto formula. She told me that she had also exclusively breastfed Skylar for a similar period, but continued to mix feed for over a month. She tried to express milk with both children but didn't manage to sustain a quantity sufficient to feed them.

At my first visit she discusses feeding little Skylar, who is playing on my knee. *"She were a right hungry baby! She was wanting it like, every 10 minutes, so it was right hard wi' her. But, I stuck it out."* (Antenatal interview, Kiara, Skylar and Phoebe present).

Her mum (Nanna) comes into the sitting room and joins in the conversation. We are talking about when she had Skylar and how she felt about the support she got in hospital.

"Kiara: I asked if I could have a bottle to feed her, and they were like 'no' (Nanna and Kiara in unison:) 'Keep trying'. And then that's what were getting me even more stressed, because I knew that I didn't want, I did want to do it, but it were too hard, and they kept on pushing me and pushing me (Phoebe; right). So, they never ended giving me a bottle, I just had to stick it out."

Phoebe: In retrospect, was that a good thing or a bad thing?

Kiara: It were, but it was just hard, really hard." (Antenatal interview, Kiara, Skylar, Kiara's mum and Phoebe present).

I came to see her after Cory's birth and she told me about how much she had enjoyed being at home and how important it was to feel that her family surrounded her. *"I had a homebirth with him, it were good because I could just do what I wanted, I could go out for a fag and I had all my family there and stuff, it were right good."* (Postnatal interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is five weeks old).

She then continued to talk about how the feeding went in the week after Cory was born and how she made the decision to give him formula milk. *"I fed him, I tried, I didn't put him on bottles till he was three days old, because the student midwife what*

helped me deliver him, she gave me a lot more help by helping me to attach him and stuff, and she even got some other midwives to come out when he were a day old, to like help him try and latch on, but he wasn't having none of it, so they said it's best if I just put him on bottles. But then, a couple of days after I started him on bottles, I fell asleep wi' him, and he found his way to the boob and started to breastfeed... (but) now, no, because he just doesn't seem to be bothered by it any more." (Postnatal interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is five weeks old).

At our final meeting Kiara reflects on the journey and then she summarises the decisions she has made with both of her children. *"You just do what you think's best really, because I wanted to breastfeed him to give him the best, but then having to give him a bottle for his benefit, for the best!" (Weaning interview, Kiara, Cory, Skylar and Phoebe present, formula feeding Cory who is 15 weeks old).*

Scrump and baby Victoria

Scrump is 18 and this was her first baby. She lived with her mum and dad and older brother in a quiet residential area (IMD 2nd quintile) and she was no longer in a relationship with the father of the baby. Both of her parents worked full time. Scrump was doing a course at college and has a strong ambition to be a health care professional. She was still enrolled at college and plans to return to college at the start of the next academic year, when Victoria would be 4 months old. Every time I visited, we sat in the front room and her father always joined us for a while.

Scrump was very determined to breastfeed when I met her in pregnancy. She initiated breastfeeding, though did give two formula feeds in hospital, she says on the advice of a midwife. She found breastfeeding very difficult but really enjoyed expressing and thus continued to exclusively feed Victoria expressed breast milk until she weaned her at four months.

During pregnancy she told me of her feeding intentions. *"At first I were going to use a breast pump, and then I've just gone on to breastfeeding. Because it's just, it's a lot*

easier, I mean with me having three months off to be able to look after her, I've got that time with her, but if I were like back at college and back at work, I wouldn't be able to. It's just easier and cheaper to be honest." (Antenatal interview, Scrump, Scrump's dad and Phoebe present).

Scrump and her dad also tell me about the preparations they have made for the new baby.

"Scrump: I've got everything, cot set up and everything! We've got Moses basket, we've got everything!"

Dad: Spare bedroom looks like Mothercare!

Scrump: We've got car seat, we've got, I can't think of anything else I need, we've got 88 nappies already, half a million baby wipes! I can't believe how quick we got it all, because we've had it for about 6 weeks haven't we? I bought everything!

Dad: Pretty much, after Christmas, that's when we started getting everything.

Scrump: We got everything and that were it. We just had it. She doesn't need any more clothes, put it that way!" (Antenatal interview, Scrump, Scrump's dad and Phoebe present).

At my second visit, she relates her experiences of breastfeeding in hospital and explains how she has ended up exclusively pumping. *"I was expressing sort of before I got into hospital, because I used to make sure that I were producing milk at the time, and as soon as I had her, they were like 'do you want to feed her?' And I was like, 'yes!' put her straight on and fed her and that were it. I just knew I could produce milk, even before I had her. I enjoy feeding her my breast milk because I know she's getting all the right nutrients and that. She had a bit of a like, stomach ache about a week ago. She kept cramping up (mimes drawing knees up) and releasing, she were bringing a lot of milk back up. But that's when she put on the most weight, I mean she were going through bottles! So I think she were just being a bit greedy and taking everything. But she's not bad now. I can burp her at odd times,*

but dad's a good burper, I get him to do it. But sometimes when I do it, she brings it back up a bit. I did it last night and she brought it up, and I were like, 'mum you need to clean the couch!'. (all laugh). It's not my fault!" (Neonatal interview, Scrump, Victoria, Scrump's dad and Phoebe present, feeding expressed breast milk to Victoria who is two weeks old).

Scrump often talked about how delighted she was with Victoria and how much joy she gives her. *"She eats so much and she's so chubby, it's unbelievable! She's such a good baby, you couldn't ask for anything better." (Neonatal interview, Scrump, Victoria, Scrump's dad and Phoebe present, feeding expressed breast milk to Victoria who is two weeks old).*

At our subsequent meeting Scrump talked of her ambition to be a midwife, here she describes how she imagines her life with Victoria when she goes back to college.

"Scrump: It's strange, it's gone so quick and it's like she keeps changing and getting bigger and like, but she still fits in like all the first size, so I'm like aww, she's not big enough yet, she needs to get bigger! But like all her face is changing and it's like, awww. She just doesn't bother, everyone keeps saying ah, she's so content and so happy, she barely even cries, like even now, unless she's hungry or she's dropped her dummy that's about it. She has like a little whinge when I put her down, that's when I pick her up, but I so like, try and leave her when she's down, but I tend to end up picking her up anyway.

Phoebe: Why do you think you've got to leave her?

Scrump: I don't know, I just don't want to be picking her up all the time if you get what I mean. It's like, when I go to college full time in October, its like, I'll be putting her in nursery and she might not be getting picked up as much as I always pick her up. But. I'm a bit nervous about that. I don't want to put her [nursery] ... but I don't want her to see me as someone whose sat on't dole, I don't want her to think, yeah I'll be lazy, when she gets older I want her to know that she needs to have a job and needs to have a passion for something, not sat there not doing anything." (Postnatal

interview, Scrump, Victoria, Scrump's dad and Phoebe present, feeding expressed breast milk to Victoria who is eight weeks old).

Newmum and baby Ahmed

Newmum is still at school and lives with her father and her stepmother and siblings. The father of the baby is not involved in her life anymore and no reference is ever made to him. Newmum tells me that she is well supported by her school and plans to return as soon as her baby is old enough. This is her first baby.

I visited Newmum at her parents' house; they occupy a very small two-bedroom flat in a council block in a deprived area (IMD 5th quintile IMD). There are three adults and five children living in this flat (Newmum's younger siblings and Ahmed). The entrance to the flats is very grim, smelling strongly of urine with broken glass and smashed windows, graffiti covering the doors and walls. Newmum initiated breastfeeding in hospital, and was the only participant to never have given a bottle. She, alone of the participants, has a currently breastfeeding member of her family (her step-mother). She decided to wean at four months onto homemade food. At the first visit, we sit in her front room and she tells me about her plans for when the baby is here.

"I'm planning to breastfeed hopefully, like, I don't know if it's going to come out straight away and that's what I'm worried about. Because if I have to wait a couple of days I don't want my baby to go hungry. So I don't know what to do, like, if I'm giving him bottle milk and then I'm going to start breastfeeding after, I don't want to confuse the baby, like give them two different kinds of milk. But hopefully my family will support me with it and look after me." (Antenatal interview, Newmum, Newmum's step mum and two small siblings and Phoebe present).

She worries about breastfeeding but is fairly sanguine about the other aspects of becoming a new mother. *"I think it is going to be hard producing milk, because I don't, no one has told me about what's good to do to produce milk and stuff like that. I've heard that eating well and things, but other than that I don't really know how to*

do this or anything". ." (Antenatal interview, Newmum, Newmum's step mum and two small siblings and Phoebe present).

The next time I visit her, she tells me about her experiences in hospital. She was an inpatient for many days because of a suspected problem with Ahmed, but they are both well when I see her. *"The midwives like, really helped me out, like afterwards with my breastfeeding."* (Neonatal interview, Newmum, Ahmed, Newmum's step mum and two small siblings and Phoebe present, breastfeeding Ahmed who is four weeks old).

She later talks about expressing milk, which she has already tried to do, though Ahmed is exclusively breastfed at this interview. *"So I'll try and read about it (pumping), and if it's all right then.... So I can go to college while he's still having natural milk instead of, because it's got lots of sugar in, carton milk, hasn't it? Cos I don't want him to get used to the sweetness of the other milk and not have my milk, and I can have some. And I won't be worried, 'oh he's at home crying', if he's getting my milk."* (Neonatal interview, Newmum, Ahmed, Newmum's step mum and two small siblings and Phoebe present, breastfeeding Ahmed who is four weeks old).

Finally, she discusses feeding Ahmed in public, which she mentions several times as being a hard part of breastfeeding for her, especially since she tells me she already feels self-conscious about being a young mother. *"If I was out in town, if there is like baby changing rooms and stuff, but I couldn't do it just sitting at the bus stop or nothing! Or I could just, go to the disabled toilet or something, if he's desperate and I ain't got nowhere to go."* (Neonatal interview, Newmum, Ahmed Newmum's step mum and two small siblings and Phoebe present, breastfeeding Ahmed who is four weeks old).

Pinky and baby Joe

Pinky is 16 and this is her first baby. She is living at home with her mum and dad, older brother and her boyfriend is also casually living with them. The estate is

sprawling and deprived (5th quintile IMD). She left school before finishing her GCSE's and has no plans to return to education.

Pinky told me that she wanted to try to breastfeed when she was pregnant though felt very unconfident in it and subsequently did not initiate breastfeeding in hospital. She didn't have a postnatal interview with me, though we did chat on the phone, shortly before the study ended.

Her mother contributed greatly to the first interview and her daughter's views on breastfeeding seemed to be heavily influenced by her mother's experience. *"Grandma (of Pinky's baby): I tried, no I didn't even try with my first. Then I was adamant with my son Josh, that I were gonna breastfeed, breast was best and der der der, and I struggled for six long weeks. He wouldn't settle, he wasn't putting weight on, and it were just, you know, try mix feeding, give him some formula, and once he'd had formula he was just a different baby. He were settled, he were putting weight on. Trying to do breast and formula, it weren't happening, and then I felt guilty because I put him through all that for six weeks just because I've got this daft idea in my head... So I didn't even attempt wi' her (Pinky). I don't know, after that I were traumatised... I can't be doing with that again!" (Antenatal interview, Pinky, Pinky's mum and Pinky's partner and Phoebe present).*

A little later, I asked Pinky what her expectations of breastfeeding were; again her mother answered the question.

"Grandma: And it's like, for Pinky, is a bit funny with your eating aren't you? And what she eats. And I'm thinking, is she going to be able to produce enough milk, and when we spoke to Kath, the midwife and said, what formula should we get, should we have a box of formula in? And she said, well you've almost like, given up if you get a box of formula. I said, well, then there's like, it's a security blanket, if you, you know, it might be sods law that it's a Sunday night and he won't settle, and just gi' him a bit of formula. You've got to eat, ain't you? You've got to eat proper and be able to produce enough milk, and feed your baby." I repeated the question to Pinky and she replied:

"Pinky: I don't think I'll produce enough milk.

Phoebe: Even now you don't think that?

Pinky: No, but I'm just going to try." (Antenatal interview, Pinky, Pinky's mum and Pinky's partner and Phoebe present).

Pinky didn't formally withdraw but missed a subsequent meeting and then the study ended as data saturation had been reached several interviews previously. I phoned her to say goodbye and ask her how the feeding had gone, she said that she had breastfed for a few weeks but was now formula feeding as she felt the baby had been too hungry and wasn't getting enough from her.

Ash and baby Christopher

Ash is 17 and this is her first baby. She has moved continuously during the past few years, between a northern seaside town and big cities. She stayed with family or sometimes had a place of her own. She has come back to Sheffield to have her baby, as this is where her mum and Nan now live (though they too recently moved back). They all live within a few streets of each other in a very deprived area (IMD 5th quintile). Ash left school with a few GCSE's and has no plans to return to education. She is part of a close family of women and whilst she tells me this is important to her, there is also some tension, especially between her and her mother. All of her family apart from her Nan are currently caring for small children so she expects to give as much support as she receives. Every time I visited her, the entire matriarchy was in attendance; so many of their voices are also heard in Ash's story although she herself was both eloquent and forthright.

Ash told me that she was uncertain about breastfeeding at first, especially as she thought that she couldn't breastfeed if she was still smoking and found giving up hard. However, by the end of her pregnancy she was determined to try to breastfeed Christopher and had managed to stop smoking. She initiated breastfeeding at birth, though struggled in hospital due to feeling unsupported and 'mithered' (Yorkshire slang meaning 'harassed') by health care professionals carrying out care schedules.

She was mixed feeding the last time I saw her but wanted to return to exclusive breastfeeding.

Ash was living at her mum's house both during her pregnancy and until at least our last postnatal interview. Her aunty and cousin were also staying there.

"Ash: Yeah. I've got my own flat, but it's easier to stay here, for the first few days. I've got a lot of people around me then, ain't I."

Mum: That's why the cribs there. It's going upstairs."

Together the family discussed how they felt when Ash told them about her pregnancy. *"Mum: fucks sake, she's going to college and stuff, and then she tells me she's pregnant! But I was 17 when I got pregnant wi her, 18 when I had her, so I can't really say owt. Me mum was 17 when she had me, so it's like, just waiting for the next one next!"* (Antenatal interview, Ash, her mum, grandma, young aunty, younger sister and Phoebe present).

In our first meeting, her family related many tales of breastfeeding to Ash, discussing both the practical and physical difficulties of breastfeeding. The final story her aunty told, about a breastfeeding incident leading to the final breakdown of a relationship is quite tragic.

"Ash: I've bought some cow and gate formula milk, and I've bought six bottles and then some little cheaper bottles. But I don't plan on using them. I'm hoping to breastfeed, but I've got everything there just in case I can't. Or in case it hurts too much and I can't cope."

Nannan: It's really painful Ash."

Ash: I've heard it's like, umm painful." (Antenatal interview, Ash, her mum, grandma, young aunty, younger sister and Phoebe present).

At a later meeting, Ash discussed how hard feeding was in the hospital: *"I kind of got on with it myself. They helped me and was talking me through it. Then they just left me. The woman when I first give birth said, how are you feeding and I said, breastfeeding, so she was like do you want some help and she showed me how to do it, so first time I let her but then after I was like I'll try it myself. I think it were about twice where I struggled because he wouldn't latch on properly."* (Neonatal interview Ash, Christopher, her mum, grandma, young aunty, younger sister and Phoebe present, breastfeeding Christopher who is two weeks old).

Here in a paragraph is the entirety of Ash's journey through breastfeeding, in her own words at the last interview. She reflected on both the experience and the way she negotiated the challenges. *"It were, on a night time, I were getting really stressed out, and he could sense that I were getting stressed out, so he weren't feeding properly and like, he would be feeding but he'd do it for like, three hours and just not let go, and then um, I didn't think he were getting enough from it, so I bought the pump so I could like see how much I were producing and how much he were drinking and then after he'd had that first bottle he were fine on the boob and then he had another one, one night he stopped here and my mum got up for a night feed, and then after that he wouldn't go back on the boob. He wanted bottles all the time, so I took him off bottles completely and put him back on the boob. Bottles is easier so that I can get more support and more help, but it's more convenient breastfeeding."* (Postnatal interview, phone call between Ash and Phoebe, mixed feeding Christopher who is four weeks old).

Conclusion

These then, were the ten participants; young women, all with some family support and all experienced joy and pleasure in their new babies but faced some problems too, as all new mums do. They were mostly from low-income families and mostly lived in deprived areas, but some had more resources than others. Every one of them told me that there were difficulties with feeding and with other aspects of caring for an infant, though their own analysis of these struggles varied greatly both in depth and in the reasons they gave for these difficulties. Their journys into becoming

mothers, into creating a new self of whom they were proud, can be seen in their own descriptions of their lives above. In the following chapters, this narrative work of the self is analysed to provide further understanding of what breastfeeding and infant feeding as a whole, meant to these young mothers.

I was particularly grateful for the contributions of Scrump, Jessie, Marley and Ash to the study because of their eloquence and insight into their own feelings and experiences. The next chapters present an analysis of the themes across the participants, considering the similarities, differences and omissions in the data produced by their narratives and from my participant observations, to address the research questions identified above.

The following three chapters are structured around the three global themes produced by the Thematic Network Analysis (Attride-Stirling 2001): the immediate context (that of the family and self); the external context of the wider community; and the babies and the milk. These themes are presented discretely. However, within each chapter the organising themes are described with thought to how they mesh together to provide a holistic description of the lived experience of the young mothers.

The first results chapter is 4: the immediate context that describes the influences and relationships which make up the young mother's lived experiences and her internal and emotional experiences of infant feeding.

The second chapter is 5: the external context that deals with the themes relating to the wider community, public attitudes to breastfeeding and interactions with health care professionals.

Lastly, the theme of chapter 6 is the babies and the milk. This discusses the data from the narratives and participant observations that directly addressed lactation, the physicality of breastfeeding and the behaviour and agency of the baby.

Chapter 4: Results theme 1, the immediate context

Chapter introduction

This is the first of three chapters (chapters 4-6) that present the research findings. In these chapters I have adopted a descriptive, data-driven approach, seeking to paint a detailed picture of the young women's lives and experiences of being mothers, in keeping with the ethnographic tradition. In chapter 7, I return to the theoretical framework of Ricœur's (1992) narrative self, as well as prior literature, in order to contribute to more general discussions and to draw broader conclusions from the findings.

This chapter is concerned with the global theme of the immediate context. Much of the data was about this global theme and reference to the home and the family was frequently made by the young mothers. This theme is about how the young mother's journey, from teenager to young mother, takes place mostly in the family home. Within this home there are sources of support and safety, habits and cultural beliefs that the young mother is part of and which influence her. There are also tensions and conflicts that she must negotiate to create her mothering identity as well as to practically care for her baby. As with all three results chapters, the results are ordered by the organising themes that constitute the global theme.

The chapter begins by discussing the family and community in terms of how visible, or not, breastfeeding is. There is then a discussion of the practical help and support of their families that the young mothers rely on. The chapter then discusses how the relationships between family members and fathers impact upon a mother's breastfeeding experiences. The final section is a discussion of how the mothers experience the embodied and intensely physical experience of breastfeeding.

4.1 Not being part of a breastfeeding community

The young mothers did not have much exposure to other people breastfeeding, with the exception of Newmum and Jessie, both of who had family at home who had breastfed for a prolonged period within their lifetimes. Only three of them, Marley, Jessie and Newmum, told me that they had ever seen another woman breastfeed and only Newmum and Jessie had experienced a family member breastfeeding for more than a few days. Marley's cousin breastfed once when she visited them with a very small baby and Marley recounted how embarrassed her cousin had been.

Jessie's mother had breastfed all her children but Jessie did not clearly remember any breastfeeding from her childhood and her older sister had bottle fed her own children. All of the young mums had friends and relations with babies and they told me about what these women had said about their feeding experiences. Largely, these other mothers either exclusively formula fed their babies or they had storied struggling to breastfeed and then deciding to formula feed, to the young mothers.

"Phoebe: Have you got friends who've got kids?"

*Kiara: Yeah, but they've always had their babies on bottles, right from the start."
(Antenatal interview, Kiara, Skylar, Kiara's mum and Phoebe present).*

"Scrup: Well, my friend who's had her baby, I was talking to her about it and she went, she said that she started for the first week like breastfeeding and that, but she couldn't carry on, it were too painful and she said it were getting right hard, so she went on to bottle feeding." (Antenatal interview, Scrup, Scrup's dad and Phoebe present).

Issues with feeding in public have a whole section to themselves (in Theme 2 The external context) because they were both very prominent practical issues and narratives with deeply felt expression. However, it is worth mentioning here that the very-local community (neighbours, extended family and local pubs) are also part of the young women's infant feeding lived experience. Newmum told me a story about

her neighbour's advice to her, which she felt strongly, supported her decision to breastfeed Ahmed:

"Newmum: umm, also this one girl, she said to me, her son, she breastfed one of them, and the other one she was too ill to breastfeed, and she realised the difference because one of them was a lot stronger than the other one. She went. So I was like, ok. She lives down there. Cos I seen her, and she was like, cos she seen me with the baby so she was like, telling me some stuff." (Neonatal interview, Newmum, Ahmed, Newmum's step mum and two small siblings and Phoebe present, breastfeeding Ahmed who is four weeks old).

As above, there was little exposure to other women breastfeeding while the young women were growing up. Furthermore, most of the stories I was told about sisters, aunties, mums and neighbours breastfeeding were overwhelmingly negative. They were stories of failure, exhaustion, and lack of milk and of pain.

"Alfie's Nan: You could follow me, I didn't have no milk, although I'm big up there, I had no milk to feed." (Antenatal interview, Alfie, Nannan and Phoebe present).

"Deedee: Um, yeah she (my sister) did, but like with her son, because she's like, not a really good eater, she weren't eating enough she weren't, because he was literally on all the time, so she couldn't have her tea, she couldn't have her breakfast or anything because he was just always there." (Antenatal interview, Deedee and Phoebe present).

"Ash's Aunty: So I breastfed him, but I only managed to breastfeed him for three weeks, it were just because he were waking up every two hour to be breastfed so I thought I weren't giving him enough, you know, breast milk. So I didn't produce I didn't that much, so I thought do you know what, we'll try him on formula see how he takes it." (Antenatal interview, Ash, her mum, grandma, young aunty, younger sister and Phoebe present).

These young mothers therefore, with the exception of Newmum, lived with frequent reaffirmation that breastfeeding was hard and often did not succeed. Formula

feeding was seen as normal. Further than that, tales of pain and woe that were constantly storied between women created both a fatalistic and fearful attitude towards breastfeeding. This was not to say, however, that some family members were not also encouraging of breastfeeding, as we see below in 4.2.

4.2 Family practical support and information

All of the participants, regardless of their social situations, turned to their mothers (or in Alfie's case her Nannan) when they wanted advice. There was a notable absence of even *thinking* about asking anyone other than the immediate family for information in the young women's narratives. That they would turn to their immediate family for help is understandable, but most said that they would ask their family for advice on *breastfeeding* (not just infant feeding in general), even though they said they sometimes regretted the lack of an experienced breastfeeder in their family circle.

Alfie here demonstrates that she considers her family to be the important, and perhaps the only, source of knowledge and advice on infant feeding and babies in general. The last line is very telling, when Alfie asks her Nan's advice about whose advice she would ask!

"Phoebe: So when you're feeding him, who do you think you might turn to for advice?"

Alfie: Probably one of my family or something.

Nan: What?

*Alfie: Who would I turn to if I needed help (directed at nan). Probably my nan."
(Antenatal interview, Alfie, Nannan and Phoebe present).*

Similarly, Jessie especially stresses the importance of her mother in supporting her and teaching her to be a mother. Jessie seems very comfortable taking support and devolving responsibility to her family, with less tension between her own independence and her need for their help than some of the other participants. This

tension is further discussed in 4.3 Mother/Daughter roles, below. *"I'll probably... a lot of time with my mum, like loads of family time. They (her family) will be helping me and supporting me. So, probably just family, like help from each other, and they will show me how to do it all!" (Antenatal interview, Jessie and Phoebe present, Jessie's mum often coming in to offer food).*

Jessie's wider family are also really important to her, as they are to Scrupp and Marley particularly. At every visit, there were at least a couple of older women around, and usually some sisters and other children as well. Just before the second visit she had had Lee's 'birth party' and she showed me all the clothes and presents her extended family had brought for her. *"For him, like in my country what they do like, when you have a baby, they come round, see the baby, bring stuff like clothes and like one of them (indicates big hamper of baby stuff on the wardrobe). We had like, ten of them!" (Neonatal interview, Jessie, Lee, Jessie's mum and sister and Phoebe present, breastfeeding Lee who is two weeks old).*

Marley also turns to her relations, but despairs at the lack of breastfeeding skill in her family. *"My cousins tried to explain how to breastfeed properly, but cos she's got three now, and two little ones, she's not had time to breastfeed as much so, she hasn't had time to show me properly. But mum's going to try to show me as best she can (sighs)." (Antenatal interview, Marley, Tom and Phoebe present).*

Kiara discusses her family a lot less than some of the other participants. She spends a great deal of time with them, sometimes staying at her mum's and usually visiting every day. However, there does not seem to be the same level of reliance on her mother as with all of the other participants. This may be because this is her second child and she has already established her mothering capabilities before Cory's birth. Here we start to learn about Kiara's relationship with her own mother, and her mother's encouragement of breastfeeding, despite the fact that none of her own children were breastfed.

"Phoebe: How was she (her mum) with you breastfeeding your daughter?"

Kiara: She were fine, she said it were my choice, and she helped me through it, cos when I was in the hospital with Skylar she were wanting it so much, I were getting so tired. But my mum were pushing me, like to say, 'just try', so I did try! It worked, it lasted for four weeks!". (Antenatal interview, Kiara, Skylar, Kiara's mum and Phoebe present).

Kiara's words here demonstrate that she considers breastfeeding is to be difficult and uncertain; she is very pleased that she has managed to breastfeed for four weeks as it seemed very difficult to her.

Newmum's step-mum was still breastfeeding her much younger siblings whilst Newmum was pregnant, so for her experienced support for breastfeeding was always on hand. *"I'd ask my step-mum because she's been through it quite recently, so she knows about breastfeeding and stuff, because she just fed my sister for a bit long, so. I'd ask her."* Specific breastfeeding problems are dealt with in the same way *"like once I had really pained, you know when they've got too much and they're feeling really heavy and stuff, and she talked, and she went through the same thing. So she said, 'keep feeding him and then massage them' and stuff like that, so it doesn't happen again. Because she went through the same thing, so like she helped me. And understanding the pain, that's like, good!"* As for all of the young mothers, practical help with other childcare tasks was also very important to Newmum. *"Like my grandma and others are used to my family having babies, so they help out a lot. Like if I'm tired they would hopefully be there to feed him and change him and bath him."* (Antenatal interview, Newmum, Newmum's step mum and two small siblings and Phoebe present).

As for Newmum above, one of the most important roles the family played was in informal and ad hoc childcare. All of the participants said that having someone to take the baby, for example whilst they had a shower or slept, was really important to them. Deedee says, *"It's nice to have a break"* (Antenatal interview, Deedee and Phoebe present). and this was especially so in the immediate neonatal period (to 28 days) when the baby's feeding was the most demanding. This was also the period at which most of the young mums reported ceasing to breastfeed.

This theme demonstrates how the young mothers relied almost entirely on their families both for information about breastfeeding and practical help in taking care of the babies. Needing respite was a major factor for all of them. They all moved back in with their mothers (and in Scrump's case her father), at least in the first few months, partially to more fully access this support and advice.

4.3 Mother/daughter roles and family babies

This organising theme was separated from that of family support because it is about the way in which young mothers can sometimes feel ambivalent about family support. In all of the narratives there is tension between being both still a daughter and also a new mother. This ranges from Jessie, who is happy to be helped as much as possible by her mum; though has future hopes of independence, to Ash and Deedee who agonize over needing support, both emotional and practical because they want to forge their identity as mothers and as adults. This tension seems to stem from the dual identity of child whilst still living or mostly living in the family home and the new, weighty responsibility but also higher status of being a mother. This produces the baby as being a family baby, not just the mother's. As Scrump and her father demonstrate, with his house "*like Mothercare*", (*Antenatal Interview, Scrump, Scrump's dad and Phoebe present*). other family members are often in parental roles. This becomes relevant to breastfeeding as it is an exclusively mothering act that prevents other people from feeding the baby.

Further, feeding is seen as key to forming a relationship with the baby. Ash and Deedee too, want to promote their baby's relationship with other family members. As below, there is also pressure on the young mothers to 'share' the baby and that means sharing the feeding.

Here, Jessie describes her mum's relationship with her grandchildren and she also discusses her mum as the matriarch and main care giver for the family, a role she is seemingly comfortable with, though there are some suggestions that one day she would like to be more independent.

"Jessie: She can't get out from children! She can't get out, at night time if you were to go upstairs and see you would say, 'oh my god what happened?'. All the children (Jessie's nieces and son) went to sleep with her, even mine, and we put both girls with her! So she's like all night with them."

Phoebe: Do you always get up with him at night-time?

Jessie: No! Either my mum or my dad. Yeah, so that's good. At least I'm getting some rest." (Weaning interview, Jessie, Lee and Phoebe present, Jessie's mother often coming in to offer food, formula feeding Lee who is 18 weeks old).

Jessie often implies that her mum is the primary care giver and often the one who institutes change for Lee. For example when she is discussing weaning: *"The first time, my mum tried, because I was a little bit scared, and she tried and he really liked it, so she was like happy."* (Weaning interview, Jessie, Lee and Phoebe present, Jessie's mother often coming in to offer food, formula feeding Lee who is 18 weeks old). She goes on to say that her mum just has much more expertise in childcare and that she feels pleased about this but also forced to yield to her greater abilities: *"When you are by your own and he starts crying and you don't know what to do, like, what's wrong? What to do? But mum knows you know all the things, massages and things like that."* (Weaning interview, Jessie, Lee and Phoebe present, Jessie's mother often coming in to offer food, formula feeding Lee who is 18 weeks old). She has accepted her mother as another primary carer to Lee to the extent that, when she talks about her and her partner's plans to go to Slovakia for a family wedding, she thinks it would be better if Lee stayed behind for a few weeks with his grandmother.

She only once voices a desire for independence from her mother and family. Jessie here describes the tension she feels between wanting to have her own flat and time with her partner and the demands of her family. The family and her partner desire that she and Lee stay in the family home, because of practical and financial support but also because of a sense of 'family togetherness'. *"I don't know yet, I'm still waiting for my boyfriend. Because he wants to stop here, at my mum's, probably, like*

all the help and everything, so that's what he doesn't want, to go away straight away. So we want to stop here probably this year, and then we'll see what's going to happen next year. Probably we'll move house and then go to college. So I'm still up and down with that." (Weaning interview, Jessie, Lee and Phoebe present, Jessie's mother often coming in to offer food, formula feeding Lee who is 18 weeks old).

All of the participants had their mothers involved in some respect with their pregnancies and all of the participants had their mothers present at the birth. There is less tension between Marley and her mother than with some of the participants about who has the primary caring role for the infant. Marley seems to gladly accept her mother's expertise and even said that she often calls herself 'mummy'. *"Yeah, she's nan-nan, But she get's confused because she's used to saying 'mummy'... and she goes 'come to mummy, no, oh just come 'ere' (all laugh)." (Postnatal interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is 10 weeks old).*

Marley accepts that her mother also has a mothering role to her granddaughter and doesn't seem to complicate this with tension about her own mothering role. *"Yeah, I was an ICSI IVF baby so. I was a twin but mum had a car crash and my twin died. So I'm an only special child and now having a grandchild, it's just like a new little daughter to her in a way." (Antenatal interview, Marley, Tom and Phoebe present).* Her mother, like Jessie's, seems to be in charge of making some decisions for Paige, which Marley emphasises when we discuss weaning. *"And then mum says that when she is that age she's going to give her some chicken and some fish. As long as I don't have to cook, I'm fine!" (Weaning interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is 16 weeks old).*

It is not just her mother, the whole family is very invested in this baby and have moved house to accommodate Paige's arrival, she really is a 'family baby'.

"Phoebe: Are you living with your mum when she's here?"

Marley: We (mum, dad, Marley and her partner) got this, only just moved in here cos it's bigger for the baby, and then when she's about two or something we'll get our own place, hopefully." (Antenatal interview, Marley, Tom and Phoebe present).

Throughout the whole of the study with Scrump, there is very much a theme of her dad being the second parent to Victoria and still in the parental role to Scrump. Here they discuss the baby's arrival.

"Scrump: Victoria's due 8 weeks today! Only 8 weeks, then you've got a screaming baby to put up with (to dad). Or I have (laughs).

Phoebe: How many kids do you have?

Dad: 17 (indicates Scrump) and 19, he's just on his way to the gym at the moment. It's going to be fun when I have to get up at 6 in the morning again. Again (said with a smile)." (Antenatal Interview, Scrump, Scrump's dad and Phoebe present).

At the next interview, Scrump describes a really beautiful moment when she and Victoria fell asleep on the sofa, knowing they were safe because Dad was watching over them *both*.

"I know, other day when I weren't very well she was causing a bit of a fuss in her Moses basket, cos I were laid on the sofa, I said just put her in front of me and I ended up falling asleep with her sort of like laid in front of me, and you were watching us weren't you, so I was bang out not very well, and she ended up falling asleep as well." (Neonatal Interview, Scrump, Victoria, Scrump's dad and Phoebe present, feeding expressed breastmilk to Victoria who is two weeks old).

Similarly, in this off hand comment we see that Scrump really is still her dad's little girl. *"Dad: She used to suck her thumb. Still does, if she falls asleep on the sofa."*

However, at the postnatal interview Scrump expresses her struggle for independence and to assert her motherhood role over that of the daughter. Scrump has always lived with her mum and dad, unlike some of the others who had a

tenancy before they became pregnant. Here, as she talks about her plans, we see the tension between needing support and wanting independence.

"Phoebe: Do they want you to stay?"

Scrump: Yes! (very emphatic)

Phoebe: Do you want to stay?"

Scrump: I'd like my own place, I want to get used to being on my own and being in my own space and having to do like all the housework and get sort of used to it first, before when she's older and I have to move out. Otherwise I'll be here for years, I'll be here till she's about 12! (Laughs)." (Postnatal Interview, Scrump, Victoria, Scrump's dad and Phoebe present, feeding expressed breastmilk to Victoria who is eight weeks old).

Things are not quite the same for Newmum. Although she is very much in a daughter role to her father, her step-mum is in her mid-20's and therefore quite close in age to Newmum. They seem to have an amicable relationship, but although Newmum expects help from her stepmother, her own contribution to the childrearing of the family is also expected in return. *"I'm going to need help with looking after him. My stepmother will look after him. If I'm planning to go to college then she'll look after him.... The sleep will be all right because I'm used to like, waking up with the kids and everything, so it won't be that much different."* (Antenatal interview, Newmum, Newmum's step mum and two small siblings and Phoebe present). We see here that childrearing is a family occupation, the support is more mutual than it is for Scrump. Deedee and Ash were also sometimes carers for much younger siblings and Alfie was a full time carer for her disabled grandmother.

The reliance on family support is therefore ambiguous. Ash, as below, and Deedee seem to express this the most. For instance, there are several contradictions in Deedee's narrative that relate to the mediation of feeding in the role of other people in Nyah's life. Here she says that breastfeeding is essential to a successful bond with a baby. *"It's just about that connection, it's so special, it's just like, I'm keeping this*

baby alive! And then you're just giving them bottles. Anyone can feed a baby a bottle." (Weaning interview, Deedee, Nyah, Deedee's mum and Phoebe present, formula feeding Nyah who is 16 weeks old). She presents formula feeding as a negative, as a threat to her special status as Nyah's mother and it is diminished as a form of feeding in her words. However, shortly afterwards she contradicts herself, saying that one of the reasons she introduced bottles was "so other people had the chance." (Weaning interview, Deedee, Nyah, Deedee's mum and Phoebe present, formula feeding Nyah who is 16 weeks old).

Ash often explicitly described the tension between herself and her mother over who would be the primary carer for Christopher. Ash wants and needs her family around her but is also defensive over who gets to do things for her baby. They both seemed a little angry during this exchange.

"Phoebe: Is this your mum's first grandchild?

Ash: Yeah!

Mum: We...

Ash: (interjects) He's already spoilt by me though! As much as I can anyway!

Mum: We've got everything for him. (emphasis in the original)." (Antenatal interview, Ash, her mum, grandma, young aunty, younger sister and Phoebe present).

Although by the time I met them, the pregnancy was accepted by the family, many of the young mothers told me that there was a negative reaction to the pregnancy initially which gradually transformed into excitement by the time baby was due. This passage also demonstrates again the tension between Ash and her mum (and family) about needing help but also wanting to assume the parenting role for the baby.

"Mum: But I wasn't happy at first, we did have a few arguments about it. Ash: A few! You disowned me, and then one day they decided they wanted everything to do with

him! They were gonna take him away from me! My mum is on about kidnapping him! She's on about moving in wi me so she gets to spend every single day wi him, but at first, they were like, nah, don't want owt to do with him, don't want owt to do with you. laughs." (Antenatal interview, Ash, her mum, grandma, young aunty, younger sister and Phoebe present).

Therefore, breastfeeding or formula feeding becomes part of the delicate negotiation between the young mother as the primary carer but also needing, and wanting to include other members of the family. For instance, other people being able to feed Christopher is also really important to Ash. *"That's another reason why I wanted to express as well, so my mum can get to feed him and my sister and my nan." (Antenatal interview, Ash, her mum, grandma, young aunty, younger sister and Phoebe present).*

Similarly, for Marley, including Tom, who was a very attentive dad, feeding is the problem *"I think it's healthier for me as well. And we bond closer with each other. But then I worry that if, like if I'm breastfeeding and not expressing straight away, that Tom's not going to have as much bonding." (Antenatal interview, Marley, Tom and Phoebe present).*

Ash was very ambivalent about bonding with her baby for its own sake as well as 'including the family'. She tells me that there can be too much of a bond and worries that this will be a negative outcome of breastfeeding. She is also aware of the health benefits and both she and her family state them several times. *"But I've been adamant about breastfeeding though, because it creates a better bond, and it makes their immune system stronger and everything. So I'll be doin' that. But I don't want to be doing it for too long, cos his dad's not around so I don't want him to be too clingy and create too much of a bond." Later in the interview she also discusses that bonding with her will prevent other family relationships forming. "I'm going to try to stick to it for as long as I can, but I want others to feed him so that bond is not just me." (Antenatal interview, Ash, her mum, grandma, young aunty, younger sister and Phoebe present).* She reiterates both of these points, that too much bonding can be bad and will prevent other relationships, in the second interview: *"Cos he hasn't*

really got a dad has he, so I don't want him to be too clingy towards me and not have that bond with anybody else, cos I'm the only person feeding him." (Neonatal interview, Ash, Christopher, her mum, grandma, young aunty, younger sister and Phoebe present, breastfeeding Christopher who is two weeks old).

Clearly then, my respondents were both mothers and daughters within the family home. They acknowledged their need for their family's support but some also expressed a desire for independence and autonomy, that is perhaps part of being a teenager as well as being a young mother. Family togetherness was very important to the young mothers and most of the babies, perhaps with the exception of Deedee, were seen by everyone as belonging to the whole family. This has clear implications for breastfeeding promotion as an intervention aimed solely at the mother is less likely to succeed in this context. Bonding is important to all of the mothers, but this is something that they feel should happen with everyone and breastfeeding can challenge this, as only the mother can do it. Interestingly, bonding is also something that can be 'too much of a good thing' for its own sake, an issue which will be explored further in the Discussion chapter (chapter 7) as it relates to the embodied and sexual negotiation of breastfeeding.

4.4 Partners; the fathers of the babies

The absence of narrative about the fathers was very apparent, except for Marley who was always with Tom when I met them. The only stories told by most of the participants were negative, though six had partners when they were pregnant and four still had by five months after delivery. Apart from Tom there was no involvement of the dads with any kind of childcare, either observed or reported. Dads were very much on the periphery of the women's lives; they are nearly invisible in this study and there was little expectation among the participants that they would be of use. Jessie sometimes mentioned her partner, Peter, who lived with her and the family, and although she was never critical of him she said that he did not have any part in the daily care of Lee.

Nyah's father was rarely mentioned by Deedee, and when he was it was almost always in a negative way. They were still together, but Deedee spoke of herself or her mother in relation to any care Nyah might need. Here she describes the 'early days', which though beginning positively, quickly becomes a criticism of her partner. She says he was helpful at first but then he *"Kind of got tired"* so didn't help so much. She then discusses his immaturity *"They (men) are still kids themselves really."* (*Weaning interview, Deedee, Nyah, Deedee's mum and Phoebe present, formula feeding Nyah who is 16 weeks old*).

Scrupp did not talk about the father of the baby much in the first two meetings, except to mention that he was present at the birth. During our third meeting she was fuming about his behaviour. This anger was because he, or his family, had been sending her solicitor's letters demanding contact. She felt this was unfair because she had tried to get him involved before, but found that he was not interested.

"But it's been a bit hard due to, with like, her dad playing up and that. At first he didn't, he had a bit of contact wi her, then stopped having contact wi her, then had a bit more contact, like I took her down. Then we registered her last week, we couldn't get an appointment, and he's not gone on the birth certificate, he's been in and out all the time, so I turned round and went you're not going on. So he were like, fine, I don't want to see her again, I'm never seeing her again, I was like, fine! It's water off my back, you've not seen her for four weeks anyway. He'd seen her once in four weeks during that time, and then at the weekend I got a letter from mediation for him to see her and I'm like, well that's a shock!.... I turned round, I'd happily take her down to see him, but he don't want to see her but I know it's his mum pushing him, he's not. He don't want owt to do wi her. He's never really known how to settle down or focus on anything, and I just don't think he wants owt to do wi her, he's too much of a I want to do, this, that, t'other for myself type of a person. So." (*Postnatal Interview, Scrupp, Victoria, Scrupp's dad and Phoebe present, feeding expressed breastmilk to Victoria who is eight weeks old*).

Similarly, one of the most striking things about the two interviews with Ash and her family is the complete absence of men in their lives. Apart from her young aunty

talking about the abusive relationship with her baby's alcoholic father, and a few asides about how rubbish men are, there is virtually no mention of either Ash's dad or the father of Ash's baby in relation to future plans or childcare. Further, her grandmother never talks about a husband or similar. There is a lack of expectation that men will play any part in the feeding of infants or raising of children. There is only one instance in which Ash mentions that Christopher's father has contributed anything or been part of his life and he seems to be mentioned only in the collective sense, as *one* of the people that did not like her idea for a name. *"I picked Christopher as soon as I found out I was pregnant. I picked Tia for a girl, and Christopher Armani at first for a boy. Then I spoke with my ex, baby's dad and changed it from Armani, cos nobody liked it."* (Neonatal interview, Ash, Christopher, her mum, grandma, young aunty, younger sister and Phoebe present, breastfeeding Christopher who is two weeks old).

The exceptions to this are Jessie and Peter and Marley and Tom. Tom was living with Marley and her parents and was a very 'hands on' dad. Here he expresses his relief that he can help and the feeding is going well. *"I didn't find it (breastfeeding) too bad, but when it come to the bottle I found it a lot easier, because then I could take over and help out a bit more!"* (Postnatal interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is 10 weeks old).

Marley discusses that one of her reasons for starting formula was so 'others could feed' and how it has given Paige and Tom some time together, despite his shift work. *"I want to breastfeed and then as it goes on, like, express, so that Tom can feed as well... But now she gets to have, because of his shifts she doesn't get to see him much, he's always either at work or asleep. So that way, it gives them a bit more time together. It's quarter to 6pm till half 3am, and he gets home at 4am, then comes to bed and wakes up at 12. So. So with the bottle, that way they get to spend some quality time."* (Weaning interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is 16 weeks old).

In this way, the babies' fathers are notably absent from the everyday lives of the young mothers. Few expect any practical help from them and of the few references

to them, most are quite critical. This is discussed in the Discussion chapter as it departs somewhat from earlier literature, which found that fathers had an impact on breastfeeding. In this study they were neither supportive nor discouraging of breastfeeding, they were simply not there.

4.5 Delight in motherhood

I met all of the young mothers in their third trimester, so any possible uncertainty about the pregnancy going to term was largely over and had been replaced by excitement. After the babies were born their conspicuous delight in their new babies and love for them was prominent in all of their narratives, though they all also spoke of the difficulties and exhaustion of being a new mother. It is hard to be analytical of the finding that the mothers had sometimes nearly overwhelming joy in their babies. I include it not because it is of particular value to building theoretical or practical conclusions from my research, but because it is important in its own right. They want to be seen as loving mothers and demonstrably are loving mothers - that should be part of this presentation of their experiences.

Jessie discusses the radical change in her life that having a baby has caused, with obvious joy and delight in motherhood but also expressing that it is sometimes a struggle, a worry and that other things, such as her relationship with her partner become side-lined. *"It's such a, such a big difference between being pregnant and having the baby. Like, when you be pregnant, you don't have that much worries things. You're like, 'he's just going to come out and he'll be here. But it's not that much like depressing and things. But when he's here, everything changes, like, you don't have much sleep, you don't get with each other Peter and me, we don't go out. So it's definitely a big, big change. It's like this motherhood is such as, such a different thing. Like, you don't want to leave him, like you're just like every night 'is he sleeping still, is everything fine'?"* (Neonatal interview, Jessie, Lee, Jessie's mum, and sister and Phoebe present, breastfeeding Lee who is two weeks old).

Here is the beginning of Scrupp's repeated description of the strong bond between her and Victoria. She later says that she hardly ever puts her down (and indeed,

never does whilst I am there) and finds even having a shower to be a wrench. *"She'll start making noises, if I've just put her down, and she hates it – she has to be in my arms, and that's about it... I just like holding her, I don't ever want to put her down!"* (Neonatal Interview, Scrump, Victoria, Scrump's dad and Phoebe present, feeding expressed breastmilk to Victoria who is two weeks old).

Scrump describes her delight at the emerging personality of her little baby. *"If she's awake she loves looking at colours. I typed it in on my phone about a week ago, babies cartoons, so I put them on my phone and she were awake so I put it in front of her and she was watching it, and I were like, 'she likes TV! Bless her! I've got her into something!"* (Neonatal Interview, Scrump, Victoria, Scrump's dad and Phoebe present, feeding expressed breastmilk to Victoria who is two weeks old).

Here she describes again how much Victoria needs to be cuddled and also how much she likes it. The whole family all seem to accept and cherish the fact that she needs to be held all the time. *"Scrump: She loves cuddles. I always make sure I'm there with her. I mean, I'll come down for a few minutes to put the steriliser on and that, but otherwise I'm always upstairs with her. I never leave her, do I?... She's got gorgeous eyes, can't help but look at them when she's awake."* (Neonatal Interview, Scrump, Victoria, Scrump's dad and Phoebe present, feeding expressed breastmilk to Victoria who is two weeks old).

In these ways, the young mothers took great pleasure in their developing children. There was also a strong sense of pride in the babies love of them and of their own roles as mothers.

4.6 Physicality of breastfeeding

Breastfeeding as a physical act, rather than in relation to infant nutrition, was not often discussed by the young mothers. As above in 4.1, discussions about the physicality of breastfeeding by the family were mostly tales of pain and difficulty. There is some discussion in the data of practical bodily difficulties ('latching on' for instance) but not much about how it made them feel. I got the sense that this was

because they did not really have the words to describe something so intimate. Several of them said that they found the experience 'weird', but other than that it was not often directly mentioned. Several of them did discuss the physicality and embodiment of pregnancy and referred to breastfeeding as a continuation of the feeling of connection that they felt when the babies were inside them.

Deedee touches on this continuum of embodiment from pregnancy to breastfeeding, saying that as her body has nurtured the baby in utero, so her breast milk and physical presence will sustain him when he is here. *"Well, I think the reason I want to do it [breastfeeding] is because like, it'll, it's like you know because he's inside me at the moment, it's like we'll still have like bonding time kind of thing (p: yep) that no one can take away from us. And then like, I just think that, I don't know, just the thought of keeping him alive and stuff like that."* (Antenatal interview, Deedee and Phoebe present). and then when he is four months old, she says again, *"Like, you can proper tell when you're their mum though can't you, the connection you've got."* (Weaning interview, Deedee, Nyah, Deedee's mum and Phoebe present, formula feeding Nyah who is 16 weeks old).

Ash also discusses the relationship of breastfeeding between herself and Christopher in a positive way. She is also one of the few who talk about feeding cues. *"I'm starting to know when he wants feeding and everything now. Cos when you kiss him he thinks you're a boob and tries eating you. (laughs). He starts like, rooting on your arm. And recently my boobs hurt when he wants to feed as well."* (Neonatal interview, Ash, Christopher, her mum, grandma, young aunty, younger sister and Phoebe present, breastfeeding Christopher who is two weeks old).

Marley, in common with others, found the physical experience of breastfeeding odd. She continues and elaborates the feeling of 'weirdness'. *"Whereas I know like some people, some friends that have got babies, they like having their baby on them. I liked having her close to me and everything. (to Tom, baby is complaining) wanna get a dummy? Shhhh. But it was just weird feeling."* (Weaning interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is 16 weeks old). But when I asked her to elaborate about the weird feeling, she could not put it into words

and ended up talking about the practicalities. When discussing this her posture changed; Marley normally lay comfortably on the couch but during this conversation she sat up and crossed her arms in a much more defensive position. The conversation obviously made her feel physically uncomfortable or awkward.

Kiara also says' *"it (breastfeeding) were right weird"*, especially the feeling of the midwife touching her breasts *"They were just saying they didn't recommend bottle feeding, if he would attach, because like, she would grab my boob and me help put it the position, and show me different positions to help him try and latch on. Like (does 'rugby hold' gesture) and like (dangles boob) hang it over him (P and K laugh). It was just right weird. But he weren't having none of it. He'd get it, then just pull himself away. So I put him on bottles."* (Postnatal interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is five weeks old).

The young mothers here are ambivalent about the physicality of breastfeeding, the reality of feeding a baby. Some see the fact that the baby is still physically dependent on them as a good thing, whilst others find the experience emotionally uncomfortable. Most were formula feeding before the baby was a month old, which was never described as an intimate act though most said that they enjoyed it. Scrump turned to exclusive expressing, in part to maintain her privacy and to avoid the uncomfortable sensations she experienced when breastfeeding.

Summary of theme 1, the immediate context.

In this chapter we see the dynamic relationships within the family circle, starting with the local community and the support of the family. The data relating to the more disruptive side of family relationships which have a significant impact on the young mothers' breastfeeding are then presented. The lived context in which young mothers interact with their family shapes their self-narratives as breastfeeding mothers, sometimes in harmony with their family's view of them and sometimes in opposition. As many of them moved to formula feeding, further narrative work about

how they made this decision and how that fits in with their ideals of being a good mother, one who is a responsible and competent family member, is apparent. The baby's relationship with the family is also problematised by these findings as seen in 4.3 (Mother/daughter roles and family babies), as is his relationship with his mother in 4.6 (physicality of breastfeeding). The baby is not a passive actor in the breastfeeding journey and this is explored further in chapters 6 and 7.

Chapter 5: Results theme 2, the external context

Chapter introduction

Chapter 5 is a description of the participants' narratives that related to the wider community, to the 'public' aspects of breastfeeding and to their relationships with health care professionals and other external support agencies. The young mothers' relationships with health care professionals had a profound effect on the young mothers' infant feeding experiences. Sometimes these relationships were supportive of breastfeeding but sometimes they diminished their confidence in breastfeeding. Most of the participants experienced some tension with the difference in both information and values held by professionals as opposed to their families and peers. The young mothers' needed to create a narrative of "*doing my best*" (Postnatal interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is five weeks old). that fitted in with both value systems, at least at the point of contact with professionals. It is likely that I fell into the health care professional category to the participants. This meant that the data on creating the narrative of being a good mum in the value system of the health care professionals may be more visible in the results, because this was perhaps what they thought I wanted to hear.

This chapter then discusses the narrative work the young mothers felt that they had to do, to demonstrate their mothering abilities to the outside world, in which feeding is a key element. This work also took on a performative aspect, as they used physical symbols to show that they were prepared (mainly bottles and prams) and organised new mothers. The chapter concludes with the organising theme of feeding in public and discovers that, for these mothers, their homes were also a public space.

5.1 Interactions with health care professionals and formal support for breastfeeding

Interactions with midwives, health visitors and general practitioners all played a part in the lived experience of infant feeding for these mothers, sometimes their input and feedback was helpful, sometimes it was experienced as disruptive of breastfeeding. This section analyses the data relating to health care and hospitals, to draw out the key elements of these interactions that in part shaped the young mothers' experiences.

Health care that is experienced as helpful and supportive

Jessie was the only participant to mention having a conversation with her community (antenatal) midwife specifically about breastfeeding. The discussion about breastfeeding is a standard part of antenatal care, so it is likely that most of them were given some information from their midwives. So the question is, why is this not a significant source of information for most of them?

More of them referred to the support and advice given in the short time they were in-patients. Jessie discusses the support she gets in hospital in positive terms, though she found the knitted breasts, absolutely hilarious. Two other participants also have the same reaction to them, finding them rather silly.

"Jessie: "There was also the, umm, what do you call them, the breast things, there's a midwife for the breast – she's probably like from University... Yeah, she was there to helping me, she brought me this booklet that showed me how to put it in his mouth (laughs) things like that. So she told me to get all the breast and nipple in. And she kind of like had this (laughs), you know it was weird (laughs), she had this like a small ball that had this nipple on, like a fake boob (laughs)!"

Phoebe: What was it made of?

Jessie: Wool? Something like that? Yeah, it was like a fake boob (pulls a face, we both laugh) And she had this doll, so she was showing me and things like that

(laughs). So yeah, that was a bit weird! (both laugh). So after that, we (her family) all started laughing! So she was helping me with that, but then after she had gone then everything was fine." (Neonatal interview, Jessie, Lee, Jessie's mum, and sister and Phoebe present, breastfeeding Lee who is two weeks old).

Newmum spoke highly of the support the midwives gave her after the baby was born. *"The lady she had like this, um, sponge, and she showed me how to do it with that. She went, just do this (mimes squeezing action) with your breast, and then it came out and I was surprised! And I was like, 'oh, I actually do have milk!' (excited). I didn't know that I had any!" (Neonatal interview, Newmum, Ahmed, Newmum's step mum and two small siblings and Phoebe present, breastfeeding Ahmed who is four weeks old).* She also values the physical demonstration of milk production and she again later refers to the excitement of seeing milk come out. She mentions that the staff were very quick to offer her a bottle, but when she asked for help she was given appropriate support. *"Yeah, cos she was like, she was going to give me a bottle milk, and I was like, I don't know how to breastfeed him that's why. So she went, oh, I'll teach you, so she got that cotton boob and went, you have to turn it like this. So I copied her and it came out and I was surprised!" (Neonatal interview, Newmum, Ahmed, Newmum's step mum and two small siblings and Phoebe present, breastfeeding Ahmed who is four weeks old).*

However, she does comment that she feels the midwives did not give her realistic expectations and that her stepmother's knowledge was more accurate. *"Cos when midwives talk about breastfeeding, it looks easy, but when I saw my step-mum I thought, it's actually hard. Like when you see them in pain, she said that it hurts a lot, when she told me how it feels. So I'm thinking, so it's not just that one day milk starts flowing out!" (Antenatal interview, Newmum, Newmum's step mum and two small siblings and Phoebe present).*

Health care that is experienced as disruptive of breastfeeding

Some of the participants reported that health care professionals actively encouraged them to use formula milk, though this might have been retrospective justification by

the participants. However, all of the mothers whose babies were given a bottle in the early days, even if the mother then resumed breastfeeding, said that this was done by, or on the advice of, a health care professional.

Kiara found the lack of availability of midwives was a barrier to her seeking their advice. However, although she says she felt much more supported by the community midwives with breastfeeding after her second birth, she actually breastfed Cory for a much shorter period than Skylar. A shortage of professional help to breastfeed was a big concern for Kiara with her first baby, though not with Cory, and Marley also found a deficiency of help after she got home.

"Nanna: In hospital, they don't sit with them for a little bit, 'yeah you're breastfeeding blah blah', show em basically a little bit what to do and then disappear! (p: yeah). So she (Kiara) was getting a little bit upset because..."

Kiara: It were right hard!... (they) just looked at how I was doing it and went and then that's when it started hurting, after a bit, after like five minutes.

Nana: And then they'd just come, and 'oh here, have some cream, that will soothe it' then went. And then Kiara were getting a bit stressed weren't you?..."

Kiara: They were nice, they showed me what to do with her with other things and that, they were just (Nana and Kiara in unison:) Busy! (both laugh, emphasis in the original)." (Antenatal interview, Kiara, Skylar, Kiara's mum and Phoebe present).

The routine neonatal weighing by midwives, and in once case the routine weighing by a health visitor, caused all of the mothers to have some doubts about breastfeeding and seemed to reinforce their worry that the baby was 'not getting enough'.

With Cory, Kiara's new baby, she felt that her breastfeeding was undermined by the weighing schedule. Kiara's great concern, as below, that Cory might be taken back into hospital, is perhaps demonstrative of her desire to express competence and retain control of Cory's care, as well as of motherly concern for his wellbeing. Here

she explains that her concern for further or potential weight loss was a major factor in ceasing to breastfeed.

"I think everyone did help a lot, because if I wouldn't have had the support what I did from the midwives the day after, I think I would have just gave up that first day I had him, because, she (Skylar) were having it too much and it were hurting, but with him he didn't want it, so I thought well I might as well give up. But I at least stuck with it for like 3 or 4 days, until I actually did give up, because I had quite a lot of support and stuff... I were going to breastfeed him, and I breastfed him and he were latching on and taking it, but then the day after he wasn't feeding, he wouldn't have it, so I had to put him on bottles. Because they said that if he would have lost 10% of his body weight then he would have had to be admitted.

P: Had he lost 10%?

K: No, he only lost 3%, (pause) but he just didn't seem to want it. But then as soon as I gave him a bottle, it were like, he demolished it! It (3%) doesn't sound a lot does it, but I were like, well I can't risk him going into hospital if he's not feeding, so I just better put him on bottles." (Postnatal interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is five weeks old).

At our final meeting she reflects on the journey and the issue of a possible readmission is again mentioned. To put this into perspective, any weight loss below 10% with an otherwise healthy baby who is voiding adequately is considered normal. *"The only bad thing is that I couldn't breastfeed him, because he just wouldn't take it, but in a way I'm glad because he didn't have to go into the hospital because he wasn't feeding. I think the good thing is as well is that he's putting a lot of weight on and he's healthy and stuff." (Weaning interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is 15 weeks old).*

Marley also reported the baby's weighing to be a trigger to change to formula. Marley refers to this a lot in the second interview. *"She (Paige) lost a little bit, but when she wasn't putting as much as they liked on after she lost that first bit. So I was like, ok,*

I'll put her on bottle milk and she went really high (mimes 'fat') and now she's putting on loads of weight.... She put on, I think, 11oz in four days..... Little chunk! (laughs)! Marley also felt that she did not get adequate help to breastfeed when she returned home from hospital. "The midwives didn't really help much afterwards, they was like, 'are you breastfeeding' and I was like yeah, and then they went. But my mum tried to help... But, if I had a bit more help on trying to, somehow giving her more or something, or then if I knew that I would produce some more after I stopped then I probably would have carried on." (Neonatal interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is four weeks old).

Scrupp, with her normal eloquence, describes the journey to her eventual regime of pumping and exclusive feeding by bottle through her interactions with health care professionals. Note here the attribution of the first decision to give a bottle to a health care professional. *"I ended up breastfeeding for the first day, and I started getting really sore. And one of the times she were latched on, she were latched on for two hours, two and a half hours. I were that sore I just turned round to one of the midwives, I were like, 'I can't do it, it's too painful'. And, she were like, we'll top her up with a bit of cow and gate, like that's fine, so they gave her that and she were like, do you want to try a breast pump? So I tried an electric breast pump, and that's what I've used since, well I've gone onto a manual one now, so I'm still using breast milk but in a bottle." (Neonatal Interview, Scrupp, Victoria, Scrupp's dad and Phoebe present, feeding expressed breastmilk to Victoria who is two weeks old).*

At our last meeting, much of the interview was dominated by Scrupp being fed up after the health visitor has come round and tried to get her to change her feeding pattern with Victoria. Scrupp feels that it is not a big concern, as Victoria is her normal happy self, but she is still unsettled by the health visitor's advice. *"They came and they weighed her, and her last weighing what were a few weeks ago with the health visitor were 8lb4, ur, yeah, and then she's gone up to 8lb9, what I thought were quite a good, to say it were like 2, 3 weeks ago, but she turned round and she says oh, she's not put on enough weight, so just feed her every three hours and that, so I've got to wake her up in the middle of the night. She were like, just try waking*

her up a few times, I were like, right (very sarcastic)" (Postnatal Interview, Scrump, Victoria, Scrump's dad and Phoebe present, feeding expressed breastmilk to Victoria who is eight weeks old).

Scrump tells me she is annoyed not because Victoria has not put on much weight but because she feels that the advice she has been given does not fit in with her life or her methods of caring for her baby. *"She didn't really tell me anything I didn't know, she were just asking questions like, is she feeding, what you feeding her, are you expressing, this that and the other. She were just asking like general questions but she never said, oh do you know that this might help or that might help, it were a bit like, no I don't really need you here... I didn't think I'd have to feed her every three hours, but I don't really want to be waking her up half way through the night to feed her, my mum was like, just let her sleep through, she'll be fine." (Postnatal Interview, Scrump, Victoria, Scrump's dad and Phoebe present, feeding expressed breastmilk to Victoria who is eight weeks old).*

The hospital stay experienced as disruptive of breastfeeding

Many of the participants felt that the stay in hospital was disruptive of their first attempts at breastfeeding, because of the demands placed on them by needing other care or treatment. Some of them also found it a lonely and frightening experience, especially those who had extended stays for medical reasons. Jessie discusses that being in hospital with the baby was an isolating experience that separated her from the people she counted on to help, which relates back to the importance of the family to these mothers. Many of the participants also said that the hospital stay was directly disruptive to their breastfeeding attempts.

"Phoebe: And how was it coming home with him?"

Jessie: It was such, such, such a good. Because it was more helpful you know, because at night-time I was there (in hospital) always by my own. Day and night time it was just me, and me and me, so it wasn't really helping me. I was really tired so I wasn't giving him that much breastfeeding, I was trying to give him the bottle, that

didn't help. But when we came home that was a lot better, because Thomas (partner) was helping me with him, yeah so, he was getting like more breastfeeding, he was getting every two hours, so he was sleeping for two hours, exactly." (Neonatal interview, Jessie, Lee, Jessie's mum, and sister and Phoebe present, breastfeeding Lee who is two weeks old).

Ash, like several of the participants, experienced the in-patient setting as a public space, which has implications for a group that struggles to breastfeed in public, as discussed in section 5.5 below. She also found the postnatal ward to be disruptive of both sleep and feeding Christopher and found it isolating. Ash talked about having a cannula sited and how this made it 'impossible for her to breastfeed Christopher. "Like, the woman were like, aww let me put some more antibiotics in you and I were like, I don't want any more, I can't do it, I want this thing taking out, and she were like, I've got to do it, I can't not, and I was like, yeah but I can't, how am I meant to feed my baby, I couldn't even change him, I can't even pick him up, I can't bend my fingers without it hurting, but she weren't listening to me, so well like, I'll have to carry on. So I got my mum to come in that next morning. So yeah.... I put him in with me and put that side bit up and put blankets down the side and we slept for an hour and a half and then the midwives come in and woke us up! They always wanted to come in and poke us with things!" (Neonatal interview, Ash, Christopher, her mum, grandma, young aunty, younger sister and Phoebe present, breastfeeding Christopher who is two weeks old).

When she is released from hospital, Ash tells how she has been "*mithered*" (local slang for harassed) by the health care professionals about breastfeeding. This feeling of being harassed was not expressed by all the participants but those who experienced it felt it keenly.

"Phoebe: Have you had the support at home that you were expecting from the peer supporters?

Ash: I've had about 100 phone calls from them! Every single children's centre in Sheffield has probably rang me." (Neonatal interview, Ash, Christopher, her mum,

grandma, young aunty, younger sister and Phoebe present, breastfeeding Christopher who is two weeks old).

Deedee also discusses how disruptive to breastfeeding and motherhood, being on the postnatal ward was. Deedee discusses feeling supported by a member of staff (it isn't clear what cadre she is) who offered to bottle feed the baby, so she could have a rest. She contrasts this woman's behaviour to the rest of the ward environment, which she saw as very disruptive of feeding and sleeping. *"Then the first morning, everyone comes to see you, like the breastfeeding people, the Bounty Pack people, every time I tried to eat or have a nap, someone else would come in. Just people there all the time."* (Weaning interview, Deedee, Nyah, Deedee's mum and Phoebe present, formula feeding Nyah who is 16 weeks old).

The participants did not attend mother and baby groups

The initial research protocol included a plan to do participant observations at any postnatal groups the mothers attended, but this came to nothing as none of them attended any classes or groups. Only Scrump had plans to do this, but ended up deciding against it as she preferred to stay at home. She also refused social engagements as she enjoyed being at home with the baby.

Jessie explains why, for her, groups would not be appropriate as she sees it as intrusion on her family's own knowledge and control. *"J: uh uh, I don't need it (postnatal groups), I'm fine definitely, I don't need any other things when I've got my mum here and all the support from the family around (P: yeah) and they've already had, like five kids and all that, so that's ok, I don't need no more people to tell me, 'don't do this, do this' (p: (laughs) So I'm fine with my family!"* (Neonatal interview, Jessie, Lee, Jessie's mum, and sister and Phoebe present, breastfeeding Lee who is two weeks old).

Scrump discusses why she would like to attend classes when I met her whilst she was pregnant, though like Jessie above, she changes her mind once Victoria arrives. *"Hopefully going to that mum and toddler group thing should be alright... That will be*

a good day out... She (friend) says she met lots of her new friends through that and all of them have got little kids, and she's able to take her little one and someone else's little one for a day while they go and do something else and then they swap, she says it's nice right." (Antenatal Interview, Scrump, Scrump's dad and Phoebe present).

The data concerning the interactions with health services show how the young mothers can experience breastfeeding support from health care professionals as positive and welcome. Other facets of the care pathway, such as weighing and inpatient stays in hospital were experienced as disruptive of breastfeeding, as we see in Scrump's disgruntlement with the health visitor. This data also reinforces the claim that external (e.g. midwives) sources of information and support are diminished in favour of the knowledge of the family for the young mothers, as described in the previous chapter 4.

Public health information on the benefits of breastfeeding

All of the participants said all had received some kind of feeding advice from a midwife or nurse. Jessie states that breastfeeding is for the benefit of the baby only, at a cost to herself, and that she is doing it primarily for health reasons. *"J: Umm, probably for him I'm doing it, everything is for him. I'd rather that I wouldn't be breastfeeding, you know, your boobs just fall down and get really weird (laughs)." (Neonatal interview, Jessie, Lee, Jessie's mum, and sister and Phoebe present, breastfeeding Lee who is two weeks old).*

Jessie is also one of the few participants to voluntarily mention the health benefits of breastfeeding in the antenatal interview – and she explicitly says that she is doing this because the midwife has told her it is better. *"yeah yeah yeah, she (midwife) said that it's a lot better than the bottle, because you've got more um, more like 100% everything inside that's more healthful than the bottle. Because, um, the bottles only got like, all them not really healthful things, like all the products and things." (Antenatal interview, Jessie and Phoebe present, Jessie's mum often*

coming in to offer food). She also implicitly equates breastfeeding with 'natural' which is a theme mentioned by several other participants.

However, despite her earlier commitment to breastfeeding as '*healthful*' she categorically refuses to try again: Jessie breastfed exclusively for several months but she very adamantly declares that she would not breastfeed her subsequent children: *"J: Mmmmm. When I have another one, I want him to go straight onto the bottle. Because, you have problems with your boobs, because of the milk and then they get really swollen up and the nipples and they're so painful."* (Weaning interview, Jessie, Lee and Phoebe present, Jessie's mother often coming in to offer food, formula feeding Lee who is 18 weeks old).

Scrup seems to have more focus on the specific health benefits of breastfeeding than the other participants, this may be because she has studied health care, so she perhaps has more insight into public health messages than the others. *"I'd rather not put her on formula. It's alright for some people, and I know some people choose that at first, even if they can express, but I didn't want to, I'd rather keep here where I know she's getting as much nutrients as possible, rather than formula. And she seems to like it. She didn't seem to like cow and gate did she?"* (Neonatal Interview, Scrup, Victoria, Scrup's dad and Phoebe present, feeding expressed breastmilk to Victoria who is two weeks old).

Therefore, most of the young mothers are not overly interested in the potential health benefits of breastfeeding and the advice that they have found useful and remembered is sometimes misunderstood. Scrup is the only one who talks about health benefits at any length or with particular feeling and she exclusively expressed for over five months; Victoria was exclusively fed on breastmilk and was the baby who received breast milk by far the longest. She was also the last weaned onto solid food.

5.2 Having stuff for the baby

Having things for the baby was very important to most of the young mothers and was much discussed. All of them had bottles ready before they gave birth, though obviously, as per the inclusion criteria for my study, all of them had expressed a desire to breastfeed. Some said the bottles were just in case they needed them, whilst others saw them as just something you have to have when you have a baby. The cost of baby equipment and clothes was also often discussed and it seemed that expensive things were a source of pride, though most had a very limited amount of money to spend on themselves and the baby.

Having things all ready before the baby's arrival was very important to all of the participants. Jessie expresses this when she talks about her excitement and mentions the things she has bought as being part of that excitement. *"But everything is alright, and I'm looking forward to it and getting excited. We've got everything for the baby, we've got a pram and cot and everything so, it's going to be a really really good experience (emphasis in the original)." (Antenatal interview, Jessie and Phoebe present, Jessie's mum often coming in to offer food).*

There also seemed to be an element of telling me that they were ready, to demonstrate that they were doing well and were well prepared. As Alfie's nan says, when Alfie is about 30 weeks pregnant: *"She's bought everything, she's got everything for the baby, she's not got to get nothing! We've already done that, ant we." (Antenatal interview, Alfie, Nannan and Phoebe present).*

After the birth of the baby, there is still much discussion about the baby's things and clothes. Marley focuses on the stuff she has bought for Paige, both before she is born and in subsequent interviews. By the time of my third visit the house is crowded with baby toys and equipment. *"We had our anniversary a couple of weeks ago, went into town, and I was like, we're not buying owt for Paige, we're not going to talk about Paige. And then we ended up spending about fifty quid on her!" (Postnatal interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is 10 weeks old).*

The type of pram was particularly important; all participants had very expensive prams. Jessie tells me about her new pram, and how much it cost. *"Yeah, definitely, it was, I was about 8 months pregnant, my mum got it, yeah she's got it for £500! I was like, 'nice present! For £500!' (laughs)." (Neonatal interview, Jessie, Lee, Jessie's mum, and sister and Phoebe present, breastfeeding Lee who is two weeks old).* This is notable because all of the young mothers reported struggling with money at various points during their pregnancies and when the baby arrived.

Most of the participants had breast pumps before the baby was born. Marley says that they were just part of her organisation for breastfeeding *"I had the bottles, but that was just, they just came with the breastfeeding packs (She here indicates the breast pump pack she has bought) and everything. And we bought them mainly for when she starts drinking water and stuff."* She also says in our last interview that bottles were a real symbol of her lovely tiny baby for her, which she valued because they represented her dependence on her. *"Now that I'm giving her food, and I do like it, because I like seeing her eat, but I don't like it because I'm thinking 'oh she's growing up' and I miss her being really small and like having a little bottle and stuff." (Weaning interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is 16 weeks old).*

The young mothers were all interested in having things for the baby and for most of them having the best, expensive things was a priority, perhaps because it demonstrated how invested they were in their babies. They were all also keen to show me the things and make it clear how much they had done to prepare at the first interview.

5.3 Young mothers and stigma

The young mothers in this study found the attitudes of the wider world, sometimes including health care professionals, to be threatening and sometimes, in the case of Newnum, directly unhelpful. They all also told me stories of other young mothers they knew, who weren't coping so well, and said that they were not like these other 'teenage mothers'. Their stories were told with the awareness of the normal

criticisms of young mothers such as immaturity and lack of preparation. They all very clearly stated that they were the exception to this stereotype.

Deedee condemns other young mothers, who could breastfeed their own babies, but 'choose not to', because she wanted to but was unable. Here Deedee positions herself as unable to do otherwise than bottle feed Nyah because of the limited resources the family has. *"But because obviously we don't have much money and we don't have a fridge because the fridge broke, so we ended up having, I didn't eat enough to be able to feed him myself....It's just like it weren't doing nothing for him, so it kind of really upset me that I couldn't look after my child and all these other people (reference to a friend, discussed earlier) could and they don't choose to. It really annoyed me."* (Weaning interview, Deedee, Nyah, Deedee's mum and Phoebe present, formula feeding Nyah who is 16 weeks old). Here Deedee at once demonstrates that she had no choice and that she needs to be excused for not continuing to breastfeed. This is especially interesting, as she does not come from a family that expects breastfeeding.

Deedee then goes on to say how worried she is about a friend, who she doesn't consider ready for motherhood. *"My friends about to have a baby and she's really scared and everything, cos she's like, she's one of those people who loves to be immature and everything. And she's not really independent and stuff...I really worry for her because she's going to find it really hard."* (Weaning interview, Deedee, Nyah, Deedee's mum and Phoebe present, formula feeding Nyah who is 16 weeks old).

Scrupp also tells me a story about a concealed pregnancy of one of her friends at college and wonders how she would cope without the intense preparation that she herself has done for the new baby. *"I was thinking like, how did she cope wi it? She'd got nothing, she'd got no cot, no pram, nothing! What she going to do about feeding him, she going to breastfeed him? Obviously she's got to, she's got no formula. And I were like, how did she cope? I was set up for her (Victoria) when I were like 5 months gone."* (Postnatal Interview, Scrupp, Victoria, Scrupp's dad and Phoebe present, feeding expressed breastmilk to Victoria who is eight weeks old).

Newmum is the only participant who openly discusses the stigma of being a young mother in reference to herself, many of the other participants allude to it, but she is very explicit about how it makes her feel: *"Yesterday we went to the hospital. So it was like, getting on a bus and everything, it was like. It was easier than I thought because I don't like people like looking and thinking 'she's that young and she's got a baby', but I got used to it. I think it's just that, I keep thinking that."* (Neonatal interview, Newmum, Ahmed, Newmum's step mum and two small siblings and Phoebe present, breastfeeding Ahmed who is four weeks old). She also relates this perceived stigma to problems asking for help with learning to be a mother: *"Yeah, I think. I don't mind asking people but I don't really know what to say, like I don't know how to say 'I don't know how to breastfeed'. They'd think, oh she doesn't know what to do."* (Antenatal interview, Newmum, Newmum's step mum and two small siblings and Phoebe present).

On the other hand, there is also an increase in status in becoming a mother, which many of the participants obliquely discuss. Scrump says the following, partly in jest, but it does demonstrate an important point. Although 'teenage pregnancy' has negative connotations in general, within their own communities it can also makes the participants seem more grown up, more important. *"Yeah, I love being a mum, but like all my friends that were getting pregnant, it's like why, I wanted to be only one wi a kid!"* (Postnatal Interview, Scrump, Victoria, Scrump's dad and Phoebe present, feeding expressed breastmilk to Victoria who is eight weeks old).

This theme shows the resistance the young mothers have to the perception of them as being unable to be good mothers because they are young. None of them however, directly challenged this stereotype but instead recognised and perpetuated the stigma but asserted that it did not apply to them. They also all felt that they had to demonstrate this to me so that I would also know that they were good mothers. This finding resonates with the theme of 'having stuff for the baby' as above (5.3) and also fits into the discussions of producing a 'good' baby, which is discussed extensively in chapters 6 and 7.

The theme of young mothers and stigma also clearly demonstrates the narrative work that the participants have done, to create their mothering identities. For example, Deedee (above) tells herself and me a story of how she was unable to breastfeed, not that she was ever unwilling. Scrump tells the tale of the young friend at college, who did not embrace her pregnancy and as a result was unprepared. This narrative work is discussed further in chapter 7.

5.4 Breastfeeding in public and private as public

It was not possible or even thinkable for most of the young mothers to breastfeed in public. Jessie did once when she was 'caught out' at a large shopping centre but she is very clear that she would not do so again. None of the others ever breastfed in public, under any circumstances. Further, only Ash ever breastfed in front of me, with her female family members present.

In the antenatal interviews, most of them stated that they would either express or give formula in order to be able to bottle feed when in public. As Alfie says, *"I'll do bottles then, I don't think I'll do it outside. Only bottles when I go out."* (Antenatal interview, Alfie, Nannan and Phoebe present). Marley elaborates on this feeling, almost a fear, of feeding in public *"I don't think I'll be comfortable feeding her outside, I don't, cos, there's a lot of people who are judgmental about it!"* (Antenatal interview, Marley, Tom and Phoebe present).

Jessie, who lives in a family in which breastfeeding is considered fairly normal, expressed some uncertainty about how she would manage feeding in public: *"Probably yeah (I would feed in public), definitely if he would be like hungry, of course, I'll just put a blanket over me, just go ahead, definitely. Or I would probably buy the sucking thing (pump) and give him a bottle. It depends. I don't know. We don't go out now, anyway!"* (Neonatal interview, Jessie, Lee, Jessie's mum, and sister and Phoebe present, breastfeeding Lee who is two weeks old).

Here Jessie discusses the one time that she fed Lee out of the house (in a big shopping centre), that she was embarrassed, but the support of her partner helped her to feed him. She felt covering up was mandatory.

"Jessie: Yeah, not bad, I put a cover over me and I tried!"

Phoebe: Where were you?

Jessie: In (big local shopping centre), we were eating there.

Phoebe: How did it feel?

Jessie: It was alright, I was embarrassed, but then like Peter (partner) told me, 'oh don't be stupid' and things like that, you're not going to let him be hungry! So we did try!" (Postnatal interview, Jessie, Lee, Jessie's mum, grandma, aunty and Phoebe present, formula feeding Lee who is nine weeks old).

Kiara also talks about her plans for the future with Cory and her previous experience when little Skylar was breastfeeding.

"Kiara: I think that's when I'll express, if I'm in the house and stuff, then I'll put him on the breast, it's just when I'm out, it's just, I don't know, right embarrassing!"

Phoebe: With Kiara did you ever try to feed her out of the house?

Kiara: No, (pause) I were too shy to breastfeed outside!

Phoebe: Yeah, I understand.

Kiara: Like she'd always want it in a public, right public place, so I were like 'no!' I can't do that! (laughs). It were too embarrassing. Because I felt like people were staring if ever I were doing it outside... It's embarrassing, isn't it!" She later discusses how worried she is about feeding Cory. *"I go out every day....It's a bit difficult, because there's nowhere to warm his bottles up and stuff, but I do prefer it in a way, but it's like easier, and I don't [then have to] feel ashamed to get my boob out in*

public... what about if he wanted it in ASDA or something!" (Postnatal interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is five weeks old). The practical difficulties of bottle-feeding here are nothing compared to the barriers to breastfeeding in public for Kiara.

Other members of the family also find the idea of openly feeding in public to be problematic. Here Pinky's partner discusses feeding in public " *She wouldn't do it (feed in public) anyway, regardless! Whether I'm embarrassed or not, she won't do it! It's easy enough, innit, if you've got a breast pump? It's not hard.*" (Antenatal interview, Pinky, Pinky's mum and Pinky's partner and Phoebe present).

Some of the participants told me stories, either related to them by friends or things they had observed about feeding in public. Jessie is discussing seeing a woman breastfeeding at the GP's surgery and it also reminds her about how exposed she felt the one time she fed Lee in public. "*Yeah, some people were like looking weird at her, like 'what's she doing taking her boob out at the doctors.'* You know, if the baby wants you have to feed around people. What can you do? That's what happened to me in (big local shopping centre)!" (Weaning interview, Jessie, Lee and Phoebe present, Jessie's mother often coming in to offer food, formula feeding Lee who is 18 weeks old).

Towards the end of our final interview, Marley tells me this funny story about a friend of hers. It is a good example of how exposed she and the other young mothers feel, but it also reiterates how mothers tell each other negative stories about breastfeeding, which is partly why feeding in public becomes such an anathema.

"Marley: One of my friends she was breastfeeding, and it was like when it was really sunny and she covered the baby up so she didn't want people to see, and then like this old woman came up to her and ripped off the cloth and said, 'it's too hot for the baby to be under there!' and then she started breastfeeding in public since then. Yeah.

Phoebe: Some granny just walked up to her?!

Marley: Yeah! I don't think I'd go out and do it. I have trouble enough getting out with a bottle, I'd be like, 'I'm making sure I'm getting home before I feed!'" (Weaning interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is 16 weeks old).

A lot of the mothers also discussed the media portrayal of breastfeeding, which they thought was mostly negative.

"Ash: Yeah, you see in the newspaper that people don't like people, you know, people breastfeeding their kids." (Antenatal interview, Ash, her mum, grandma, young aunty, younger sister and Phoebe present).

Several participants and their families thought that breastfeeding in public was against the law, as Alfie's Nannan says here:

Nannan: Or do like the rest, just pull your titty out and feed him on the bus. That's against the law now, isn't it!" (Antenatal interview, Alfie, Nannan and Phoebe present).

For all of the young mothers, living with their families, the home itself is a public space, in which they can neither regulate guests nor find privacy anywhere other than their own bedrooms. Deedee discusses that even at her mum's she had to cover up *"I like fed him here (at her mum's house) when my little brother was here and everything, and I've had to do the blanket thing and stuff like that." (Weaning interview, Deedee, Nyah, Deedee's mum and Phoebe present, formula feeding Nyah who is 16 weeks old).* Kiara reiterates this *"It were like, you know, a bit harder, because I've got a big family, and everyone were here, it was like, embarrassing! (laughs). My brother, and my brother's friends were here. I still stuck it out for, I think it were about four weeks." (Antenatal interview, Kiara, Skylar, Kiara's mum and Phoebe present).*

For all the participants, feeding in public is an issue and their homes are public spaces, with siblings, friends and other male family members wandering in and out. In this context 'feeding in public' really means 'feeding in front of men'. In all these

narratives, what makes a place 'public' such as home, the shopping centre or the GP surgery, is primarily the presence of men. Marley again reiterates this finding: *"I'd feel really uncomfortable breastfeeding in front of my dad. I'd have to go upstairs. I'm going to have to juggle that when I get there."* (Antenatal interview, Marley, Tom and Phoebe present).

There was some resistance to the constraints of feeling like they are unable to feed in public from several of the participants in the antenatal interviews, particularly from Ash and Scrump. In addition, Scrump's Dad had different views from most of the other older generations of the participants, being very at home and open to breastfeeding. Scrump's faith in her own convictions is also evident here. However, despite this, Scrump never does feed in public and later states that one of the reasons she is using expression and bottle-feeding is that she can get out of the house.

"Scrump's Dad: It's pretty much accepted now isn't it? I don't see why it ever wasn't accepted. My generation it wasn't accepted, and I'm thinking why? It's just a natural thing."

Phoebe: Now there is consequences if anyone gets bullied about it in public, which is good.

Scrump: I'd go straight to the papers! (all laugh)" (Antenatal Interview, Scrump, Scrump's dad and Phoebe present).

Ash and her family also discuss feeding in front of men and in the first interview Ash says that she doesn't care. Subsequently however, she would not feed out of the house, nor in front of her ten-year-old brother. This tension is evident in the following exchange between her mum and herself:

"Ash's Mum: I did it for 12 weeks with Momo an all, but it started hurting after a while. It were annoying. Plus, I had a houseful as well and people kept walking in while I were breastfeeding, it were like, nah!"

A: I don't mind that, I'll just whack me boobs out. I don't care! Yeah! (laughs)... If I wanna feed my baby, I'm gonna feed my baby, that's how I see it. (Pause)... Yet there's still some places in (seaside town) that like, they'll kick you out if you're breastfeeding, because some men don't like it, an there's like complaints and everything." (Antenatal interview, Ash, her mum, grandma, young aunty, younger sister and Phoebe present).

Therefore, all of the participants struggle greatly with the practical and emotional issues of feeding in public. Further, for all of the participants feeding in front of men means feeding in public, regardless of the closeness of the relationship. None of them ever discuss whether they would let their partner see them breastfeeding, except for Jessie (as above). Perhaps this is less of an issue to them or maybe this reflects the general invisibility of the baby's father in their lives (discussed in the previous chapter 4). There is some antenatal defiance of the perceived taboo against public feeding, but none of them, barring Jessie's one brave venture, actually breastfed in public when the baby arrived.

In this way the spaces available to the young women for breastfeeding are severely limited. It is really only possible for them to breastfeed in a way which is acceptable to them in their own bedrooms if any men are present, which greatly curtails their family and social life. Part of the reason for this is the discussed fear of public disapproval, but there is also the sense that it is immodest, even sexually risky, to feed in front of men. Not being able to feed in public means that they could not continue with their normal lives, going shopping and occasionally seeing their friends. Using a bottle, even a bottle of expressed breast milk as Scrupp does, was a liberating decision for many of them. They were also critical of other mothers who may breastfeed in public (though few had seen this happen) or at least expected that they would attract criticism from other members of the public.

Summary of theme 2, the external context

Health professionals were sometimes helpful contributors to the young mothers' breastfeeding journeys although many encounters with the midwives and the

hospital were experienced as disruptive of breastfeeding. The results also begin to illuminate how important it was to my participants that they were able to demonstrate that they were good mothers. This appears in several ways, both through the emotional work of resisting the perception that they will be incapable mothers and through performing good motherhood by preparing the baby's things, including bottles. Lastly, the public display of breastfeeding was anathema to all of the participants, and as we see, public also includes their own front rooms. Fear of being disapproved of and of losing modesty in front of men meant that there were very few places they could breastfeed their babies, which in turn constrained their lives. They negotiated this constraint by using bottles, either expressing milk as Scrump did, or breastfeeding in their bedrooms and using bottles in public, with breastfeeding ceasing early in the neonatal period.

Chapter 6: Results theme 3, the babies and the milk

Introduction

This final global theme is that of the babies and the milk. Much of this global theme is centred around the importance of having a 'good' baby, one who sleeps and puts on weight at a fast rate. There is also a discussion of the young women's understanding of the process of lactation and their lack of confidence in their bodies to produce a sufficiency of milk for the babies.

The chapter begins with a discussion of sleep and breastfeeding, as most of the mothers found breastfeeding to be very tiring as it necessitated more night waking. The agency of the baby is then considered explicitly in addition to the discussion on the baby's role in the family (already discussed in chapter 4). The organising theme of Bonny Babies is prominent in this chapter, as the need for a fat ('bonny' in the local vernacular) and quiet baby is the young mothers' motivation behind much of the other activities they undertake to care for their child, expressing breast milk and early weaning in particular. The chapter then closes with a conclusion to the entire results section and leads on to the Discussion in chapter 7, which draws practical and theoretical conclusions from the research findings.

6.1 Sleep and the good baby

Most of the participants described their babies as 'good' and for some, such as Scrump and Marley, this was an often repeated theme, seemingly central to their narratives of their motherhood. The participants told me that a 'good' baby is one who sleeps well, usually through the night, eats plenty and is otherwise quiet. As lacking sleep was described as the hardest part of being a mother for most of the participants, the babies' sleep routines became very important. All of the mothers

who discussed having a 'good' baby, except for Scrump, found that breastfeeding did not make the baby 'good' and that formula feeding did.

Jessie describes to me how bottle feeding had led to Lee sleeping for much longer periods. *"Ummm, (bottle feeding was) a bit easier, because when I was breastfeeding him, he was still sleeping one hour, half an hour, because you know how the babies they always want to be on the boob. They're always there to sleep and everything, so I thought this was better because he sleeps for 3 or 4 hours, so I'm a bit relaxing for that, so it's better. Definitely. I'm getting used to it, at the night time he's a lot better now, he only wakes up like two times, so that's all right. When we was breastfeeding, oh my god, it was horrible, like so knackered and everything, it was horrible, like every one hour waking up and feeding!" (Postnatal interview, Jessie, Lee, Jessie's mum, grandma, aunty and Phoebe present, formula feeding Lee who is nine weeks old).*

Marley also discusses how sleep was the major issue for her when she was breastfeeding Paige. *"She was on me from the moment she was born until the next day, I had no sleep! I was like 'noooo!'. She was just really hungry. And then we got home, and I tried to carry on doing it for, I think it was about a week maybe, maybe just a little bit less. And then I was getting like, really tired, cos she was, I don't think I was producing enough, cos she was on me 24/7, and when I was expressing hardly anything was coming out. So then I was like, oh fuck, try her on bottles, and as soon as she went on bottles, it was the same with me when I was a baby, she gulped it all down and started putting on weight again. And then, so yeah, we tried that. And then once, when she was say about a week after being on the bottle, I was like leaking like crazy. I was like oh, you're kidding!" (Neonatal interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is four weeks old).*

Deedee discusses how hard missing sleep was at first and goes on to say that because she introduced formula so he would sleep, she then noticed a decline in her milk supply. *"Like, the first time (he had a bottle) he did, because he was starting to wake up more often and everything, and then I gave him, I thought he's probably waking up because I'm not eating enough to like feed him where he's satisfied, so I*

tried him with the bottle and he did, he slept for the full four hours for the first time. And then I just thought, oh, I can just give him the odd bottle when I think he might need it, and then I just kind of didn't have much milk, and obviously because I was using bottles I wasn't giving milk as much where it would come a lot, so I just put him on bottles." (Weaning interview, Deedee, Nyah, Deedee's mum and Phoebe present, formula feeding Nyah who is 16 weeks old).

After she decided to formula feed, Marley perceived a real change in Paige's behaviour and felt happy with her decision, because it had made her a 'good' baby, one who sleeps and is quiet. *"You couldn't ask for a better baby!. I forget that I have her sometimes, because before, when I was pregnant, I used to just tidy up and come and sit back down and watch TV. I do that now and I keep forgetting that she's here, and I feel like it's just normal, like it was when I was pregnant. And then I'm like 'oh yes!' It's time to feed! Because she just sleeps throughout the whole day... (and) sleeps through (the night)." (Postnatal interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is 10 weeks old).*

The participants dealt with this perceived difficulty in getting the babies to sleep through the night in different ways. Scrup used expressed breast milk in Victoria's bottles, whilst all of the others used formula. Issues of sleep deprivation were commonly cited as being the main struggle of having a baby (as discussed in chapter 7) and underlying this were worries that the baby was not happy and was not being adequately fed, as discussed in 6.3 below.

6.2 Agency of the baby

All of the participants discuss the baby's agency, in terms of likes, temperament and behaviour - in 'choosing' one mode of feeding or the other. Most say that the baby likes formula more, but Scrup says that Victoria *prefers* breast milk and Jessie says that Lee did not like formula; though she did formula feed him after a few months. This appearance of 'liking' is perhaps because the mothers observe that

some babies breastfeed easily and some do not. The mothers all describe the initial difficulties with attachment to the breast as the baby refusing to latch; they used the words 'will not' rather than 'cannot'.

Preferring formula

Kiara here describes Cory as disliking breast milk, a conclusion she has come to because of his behaviour *"A little bit, um, I just hand expressed after that, because they tried to give it him with a little beaker as well, but he'd just spit it back out. But then soon as I gave him the bottle, he just demolished it, but when I tried with the nipple covers, what are like bottle teats, He wouldn't take it, it were like he knew, it were right weird."* (Postnatal interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is five weeks old). Similarly, Deedee describes how Nyah prefers bottle milk when he is *"crying for a bottle,"* (Weaning interview, Deedee, Nyah, Deedee's mum and Phoebe present, formula feeding Nyah who is 16 weeks old). rather than just crying.

Jessie, however, told me that Lee did not like formula. A running theme with Jessie is Lee's gastro-intestinal problems, which she worries a lot about, and the root of those worries is what he is eating. Jessie has more 'belief' in breastfeeding as her mum breastfed all of her children well into their toddler years and is knowledgeable about breastfeeding.

As well as preferring the substance of formula milk to breast milk, some of the young mothers reported that their baby did not 'want' to attach to the breast, Ash says *"I told you he were going to be lazy though!"* (Neonatal interview, Ash, Christopher, her mum, grandma, young aunty, younger sister and Phoebe present, breastfeeding Christopher who is two weeks old). Similarly, after Kiara told me that Cory just 'did not like' the breast, I asked her to explain what exactly made her feel like he did not want it. She explains: *"He was just like, moving his head about, then he'd grab it and pull hiself off, then he'd have another go and pull hiself off. He just, weren't right bothered."* (Postnatal interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is five weeks old).

This theme demonstrates how the agency of the baby is shown both in the baby's behaviour at their breasts and in the motivations which the mothers impute to their children. This agency becomes part of the mothers' narratives about feeding their baby and formula feeding is in part their response to what they perceive their babies' want and need.

6.3 Bonny babies, hungry babies and missing milk

All of the mothers worried that breastfeeding would not definitely meet the baby's need, though some, such as Newmum, felt that this could be overcome if she ate enough. Other organising themes such as sleep and the good baby (6.1), early weaning (6.6) and interactions with health care professionals are partly rooted in this concern of the young mothers; that breast milk does not adequately supply the baby with what s/he needs to be bonny and contented. In this section the importance the young mothers place on a bonny, quiet and 'good' baby is demonstrated alongside their perceptions that their milk is not sufficient to achieve this aim.

Bonny babies

At our second interview, Marley was talking about how pleased she was that Paige was getting chubby, so I asked her to elaborate on why this was important. *"It's just about, when they are chunky, it's like better. It shows that they're healthy and they're eating. There's more of them to love! (laughs). (p: yes). We're just used to having chunky babies in the family... But when she's like this I know she's eating and everything. She's getting what she needs. (Neonatal interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is four weeks old).*

Marley often refers to her cousin who is something of a mothering role model to her. Marley goes on to explain that having a chubby baby is an important thing to the whole family and is considered normal for her family. *"But, her (cousins) kids as well, they're big like Paige's getting, as soon as you put them on the bottle. That's (indicating photo on mantel piece) how big they are! And the smallest one's only 4 months there, and he eats so much! So for our family, it's better like to put them on*

the bottle and get them really fat. That's how I was, and that's what Paige's starting to do!" (Neonatal interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is four weeks old). This quote also illustrates how the family influences Marley's understandings and values; key parts of her lived experience. Marley's developing narrative of motherhood includes the wider family's expectations and her need for Paige to be a 'family baby' as discussed in chapter 5.

Similarly, Scrump often reiterates how contented Victoria is and here she makes the connection between being happy, calm and putting on weight. *"She eats so much and she's so chubby, it's unbelievable! (P: brilliant). She's such a good baby, you couldn't ask for anything better... She's putting on weight, I'm happy with it, I'm happy she's putting on lots of weight."* (Neonatal Interview, Scrump, Victoria, Scrump's dad and Phoebe present, feeding expressed breastmilk to Victoria who is two weeks old).

Many of the mums said that their babies were 'hungry' babies, meaning that they wanted to be fed frequently. This was often said with some pride, as it also seemed like a sign that they were developing well and growing. Kiara describes both Skylar, and later Cory as 'hungry babies'. Here she talks about Skylar when she was small *"It were like, with her I didn't really want to bottle feed her, but it was too hard. She were like having half an hour feeds every hour, it were horrible!"* (Antenatal interview, Kiara, Skylar, Kiara's mum and Phoebe present). But then after she began to formula feed she noticed the change in Skylar's behaviour: *"She's really easy! She's such a good baby. She were so hungry, she were on 6oz hungry baby milk (laughs)."* (Postnatal interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is five weeks old). After she has stopped breastfeeding she also describes how Cory has taken to formula milk and is very hungry, although at the breast he was 'lazy'. *"He just, he's a gannet on it. He has four ounces every two and a half hours."* (Postnatal interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is five weeks old). I noted that several of the mothers used formula milks marketed as 'hungry baby' milks. The fact that this product exists could reflect a more general concern that babies are settled between feeds in order to reassure mothers of satiety.

Missing and volatile milk

As with most of the young mothers, Marley has a preoccupation with the exact amount of milk that Paige is taking and here complains that the breast milk was not satisfying her. *"I know that the first part of the breast milk is like the most important part, so I tried to keep it going for a week. But I thought, I don't want to starve her!"* (Neonatal interview, Marley, Paige, Tom and Phoebe present, formula feeding Paige who is four weeks old).

Pinky and her mother also discuss the way in which breast milk cannot be trusted to fill the baby up. She has mentioned that if she 'can't' breastfeed then she will use formula, so I asked her:

"Phoebe: What things might make you think he needs a bottle?"

Pinky: If he just weren't settling and crying a lot. Um, that's about it. If he were unsettled.

Pinky's Mum: I think with a bottle, you can say, oh he's had 3 ounces, or he's had so many ounces, but when you're breastfeeding... you could do with a little gauge, couldn't you!" (my emphasis) (Antenatal interview, Pinky, Pinky's mum and Pinky's partner and Phoebe present).

Similarly, Ash and her family told me that often people do not produce enough and that too frequent feeding is unacceptable, a sign of insufficiency.

"Ash: [Young Aunty] breastfed with him (indicates baby on cushion) for the first few weeks I think, and then he were feeding every two hours, for like 45 minutes every two hours, so I said maybe breast milk just weren't enough, so she put him on bottles to see how he takes them and then as soon as he went onto bottles he were only feeding every four hours. So I think maybe breast milk weren't enough or he were just really really hungry at the time!"

Ash's Mum: Some people just don't produce that much milk. That's one of the reasons I stopped with the twins, because I just weren't producing that much." (Antenatal interview, Ash, her mum, grandma, young aunty, younger sister and Phoebe present).

For Ash and her family, breast milk is seen as an uncertain and uncontrolled substance, which can occasionally be unhealthy for baby, not just through insufficient volume but also by the nature of the substance itself. Here is Mum and Nan discussing with Ash that breastfeeding can actually be bad for babies.

"Ash's Mum: Plus you don't know if he's going to have a reaction to your milk as well.

Ash: Yeah, if he's becoming ill from my milk, if he's lactose intolerant or whatever it is. Like my aunty Karen were. (Antenatal interview, Ash, her mum, grandma, young aunty, younger sister and Phoebe present).

For Jessie also, her milk became something that was bad for Lee. *"Because after that my milk turned into water, one of my boobs had turned into water and the other one was normal milk, so I was trying to give him that because I thought the water is probably going and the milk will be coming but it didn't come, so it was just watery, so he was vomiting from that so if that didn't make him well." (Neonatal interview, Jessie, Lee, Jessie's mum, and sister and Phoebe present, breastfeeding Lee who is two weeks old).*

Maternal diet was seen as central to a mother's ability to adequately breastfeed her baby. This comes up for most of the participants in one way or another. For Deedee, she ceased breastfeeding because she wasn't eating enough herself, and says that her sister stopped for the same reason. She also discusses this relationship between maternal diet and (in)sufficient breast milk in her sister's case. It was common for all of the participants to refer to vicarious experience, usually that of a sibling, especially in the antenatal interview.

Pinky and her mum also speculate that she will not be able to eat enough to successfully breastfeed: *"And it's like, for Pinky, is a bit funny with your eating aren't*

you? And what she eats. And I'm thinking, is she going to be able to produce enough milk.... You've got to eat proper and be able to produce enough milk, and feed your baby." (Antenatal interview, Pinky, Pinky's mum and Pinky's partner and Phoebe present).

For Newmum her diet is an issue but here constructed in a positive way, that by eating enough herself she will be able to feed Ahmed and is supported by her grandmother in this. *"My grandma's fab. She's like, 'don't bottle feed'. She wants me to breastfeed. She's also like, 'eat! Because if you don't eat well then you won't breastfeed'. Then she's always like giving me food and coming to me, 'eat this! Eat this!'. (both laugh). She's like, 'you won't be able to breastfeed if you don't eat or drink'. But yeah. She's always making me big breakfasts and I'm eating like, half of it and everything, and she's like 'you haven't eaten!' and I'm like, 'it was massive!' (both laugh)." (Neonatal interview, Newmum, Ahmed, Newmum's step mum and two small siblings and Phoebe present, breastfeeding Ahmed who is four weeks old).*

6.4 Fatalism in breastfeeding

Fatalism in breastfeeding was a recurrent theme at all stages of the infant feeding journey. This means that the young mothers assumed that breastfeeding would be difficult if not impossible or that pain and unhappiness were inevitable. They often framed this with comments to the effect that they would try to breastfeed, despite the futility of the endeavour.

All of the mothers worried that they would be unable to breastfeed, mainly because of issues with milk supply. Scrupp overcame these worries by beginning to express whilst she was still pregnant, whilst others such as Newmum thought that there might be challenges but that it was possible. At the other end of the spectrum, some mothers such as Alfie and Marley thought it was unlikely that they would physically produce enough milk, but said that they wanted to try nonetheless. This uncertainty was expressed by the young mothers' as anticipating future physical difficulty with breastfeeding.

Whilst she was pregnant Alfie described her expectations of breastfeeding. *"I don't know if there'll be any problems, if I can't then I can't can I? (p: yes). But if I can, then I'll try. It's down to experience."* And later, *"Might not be able to get no milk. I think that's it."* (Antenatal interview, Alfie, Nannan and Phoebe present).

When I met Jessie before the baby was born she discussed the fact that she might not have enough milk, and that he might not like it, but she also explained her commitment to breastfeeding and her hopes that Lee would enjoy it. *"He's gonna take, and he would like it, and I would like it, and everything will go on really good, then maybe for six, seven months. So if he's going to have food and milk, and breastfeed him as well, then that will be more better for him, more healthful. Hopefully!"* (Antenatal interview, Jessie and Phoebe present, Jessie's mum often coming in to offer food).

Scrump is very pragmatic about infant feeding, she is very determined and like a lot of things she does, she is very prepared and has been expressing antenatally. However, there is still very much a sense of, if it works, great, if it does not, never mind. *"I mean, I will try, if baby takes to it then it's obviously one of the positives, but if she doesn't then I'll have to think about another way to do it."* (Antenatal Interview, Scrump, Scrump's dad and Phoebe present).

Fatalism about the given ability to breastfeed pervades all the narratives, though some like Scrump and Newmum are more hopeful and positive than others whilst they are pregnant. Postnatally, narratives of inability to breastfeed become woven into the retrospective justifications of the decisions they have made. In this way, breastfeeding is sometimes seen as a project that, for whatever reason, they are physically unable to accomplish. This links back to the data on not being part of a breastfeeding community, in that their lived experience reflects the stories that they have been told about breastfeeding; that it is uncertain and difficult.

6.5 Expressing breast milk

Expressing breast milk to feed the baby was spontaneously discussed by all of the participants, and all except Newmum had a breast pump before the baby was born. This was a surprising finding as it indicates a high level of interest in using expressed breast milk from the early days. Expressing breast milk was attractive to most of them as it is a way of feeding the baby breast milk without the difficulty and exposure of breastfeeding. However, few of them had much knowledge about the practicalities of expressing milk, which can be a tricky and time consuming business. Scrump was the only participant who successfully pumped enough to feed her baby in the longer term. Expressing milk was also seen as a reassurance that they are lactating if they are able to get milk and as confirmation that they are not able to produce enough if pumping is not immediately productive. Lastly, the ability for other people to feed expressed breast milk (see 4.3) was an added reason to try to express.

Milk expression does not figure largely in Deedee's narrative. She bought a pump before Nyah was born, and did use it with some result, but did not either find it necessary or work it into any kind of 'routine'. She does mention that it is because of her success in expression that she felt that she was well supplied with milk in the early days, which resonates with other mothers in the study. *"I used to get loads out, about 5oz in 20 minutes or something, it just used to come out!" (Weaning interview, Deedee, Nyah, Deedee's mum and Phoebe present, formula feeding Nyah who is 16 weeks old).*

Conversely, Kiara planed to express but found it even more difficult than breastfeeding. Here she discusses pain, which put her off the plan to express and feed. *"It didn't really work, because like I were trying, I had a hand one, it just didn't seem to be bringing owt out, and it were painful expressing as well... just when I were expressing, it just didn't feel right." (Postnatal interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is five weeks old).*

The majority of the data on expressing is from Scrump who, as mentioned above, managed to exclusively express and feed Victoria breast milk until she began to wean onto solids, apart from a few bottles of formula in the immediate period after birth. She suffered from mastitis when Victoria was about four weeks old, but overcame this difficulty and continued her pumping regime.

When we start to discuss why she prefers expression to breastfeeding, which she says is hard work, she discusses the benefits of pumping for her. This is not just 'freedom' from the baby, such as leaving the house but also freedom from the tyranny of doing nothing but feeding. *"At the minute, it's like with expressing, you sort of like can go out for a few hours and then think, oh, I've got to go back to express, and then you think, I can express wherever I want. But at the same time I like doing it sitting down in my bedroom, sort of doing it privately, watching TV. It gives me a relaxing time. And she's alright down here with them for a bit, I mean I only express for 20mins and I manage to get enough. It just gives you a bit of time to yourself, being able to express, I mean. I would have carried on breastfeeding, but it were too much. I mean my cousin's girlfriend does it and she can be sat there for an hour trying to get her little one to latch on, and sat there for another two hours feeding him. I said to her, why don't you just start pumping, it's so much easier and they're getting all the nutrients. She says, 'but I want to do it myself!'. But then she wants to go back to work as soon as possible as well. I don't know, I prefer pumping because when I feed her it's still a connection, but other people can feed her as well and it gives me a break. So I'm not sat here all the time like, 'urrgh, I've got to do this.'" (Neonatal Interview, Scrump, Victoria, Scrump's dad and Phoebe present, feeding expressed breastmilk to Victoria who is two weeks old).*

Expression figures in all of the young mothers' narratives, but is not a common practice among them; most find it prohibitively difficult, painful or unproductive. Scrump is exceptional among the participants for her dedication to feeding Victoria breast milk and she has found the routine and method that suits her and her family life best.

6.6 Weaning onto solid food

Many of the themes from breastfeeding also continue into the weaning period. The desire for a bonny and good baby, wanting independence but also help from family, and worries that the baby was eating enough, all figure in the narratives around weaning. In addition, the babies 'wanting' to wean was felt by some of them to be a sign of maturity, of which they were proud. Professional advice as to timing of weaning and choice of food was generally not adhered to. Of the eight participants who contributed data about weaning, the earliest weaned at 8 weeks and the latest at 18 weeks. The mean age was 15 weeks. Currently, standard public health guidance in the UK is to wean at around 26 weeks.

When I visited Kiara for the last time, she discussed how hungry Cory was. She also here connects being 'hungry' with being ready to wean. *"I had to put him on hungry baby milk, because it just weren't doing anything for him, he was wanting like, 6oz bottles every half an hour. So, I put him on the hungrier baby milk because my health visitor told me to, and he seems a lot better but he's still having 6oz hungry baby milk as well! He's right greedy! Cheeky chops, yes! Greedy guts! But last night, he was screaming for some barbeque sauce off me, from a Chinese, so I were giving him that. He enjoyed it, he were wanting more. She were the same, she were like, eating proper Sunday dinners at three months old, she were as greedy as him."* (Weaning interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is 15 weeks old).

Here Jessie explains that the reasons to wean were the same as those that promoted her to start feeding Lee formula. *"He sleeps a lot more, he sleeps better through the night now, I've noticed, because last time he were like, getting up every hour for a feed, but now he like sleeps and gets up once for a feed in the night. And he seems a lot happier... now he's on solids and stuff like that."* (Weaning interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is 15 weeks old).

Kiara discusses weaning practices quite extensively in the last two meetings. She has weaned Cory just a little before three months, and she tells me of her feeding routine. *"(It's going) really well, he has some baby rice in the morning for his breakfast then he has like jars through the day, he has about four jars in the day, and then he has his last jar about four o'clock in the afternoon, and then bottles through the night."* (Weaning interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is 15 weeks old).

Scrump discusses weaning and her perception that Victoria is ready to wean. Agency is attributed to Victoria in the decision to wean (she is showing Scrump that she is ready) and she is proud of how grown-up Victoria is becoming. *"Every time we cook food she's a nightmare. Cos I try and sit down and she's like, looking at me food, like 'can I have bit?.. I think she'd probably take it now if she could, she's obsessed like, at tea time when we're all sat here eating she's like looking round as if like, who can I take it off?... But, I know she'll start food as soon as she can. We're giving her that gripe water as well at minute, because we think she's got a bit of colic and I put a bit on a sterile spoon to give her and she were like taking it like it were food, trying to eat the spoon!"* (Postnatal Interview, Scrump, Victoria, Scrump's dad and Phoebe present, feeding expressed breastmilk to Victoria who is eight weeks old).

Narratives of weaning are an extension of the narratives around breastfeeding and formula feeding. Having a thriving, bonny and happy baby, as indicated by a lot of weight gain and sleeping for long periods, was still paramount to the young mothers in later infancy (see 6.3).

Summary of theme 3, the babies and the milk

In these examples of the narratives about the milk itself and its effect on the babies, we see how the young mothers conceptualise the milk. The importance of a baby who is quiet and fat as being the only way in which mothers are assured, or perhaps reassured, is also demonstrated. Thus, many of the young mothers also told me that bigger is better when it comes to a baby's weight. Marley was particularly concerned

that Paige ate a lot and therefore became very chubby. Many of the mothers referred proudly to how 'hungry' their babies are and several of them chose to use fortified milks to satisfy this hunger. At the root of the use of formula to create a bonny baby or to satisfy a hungry one, is the mistrust of breastmilk to provide the quantity that a baby needs. The young mothers talked of their babies not being satisfied by breastfeeding and also of their inability to supply a sufficient quantity and quality for various reasons. These reasons included their own diet, exhaustion and simply just a lack of supply.

Further, they told me that a 'good baby' is one who is happy to go to and be left with other family members (this is related to the family theme too, as above). As we saw in 4.3, one of the young mothers' worries in breastfeeding, was that it would lead to being 'too bonded' to the mother alone. From a more practical view, a 'good baby' who will go to others, allows the young mums to get on with their lives.

Most of the young mothers therefore, prioritised feeding a large amount of either formula or food and most describe their babies as being particularly 'hungry'. Through this understanding of what the milk means to them and what they want for their babies it becomes easier to see why breastmilk is often not a trusted food for their babies.

Overall, the findings above portray the participants' narratives that relate to how they want the babies to be. The babies' behaviour affects the mothers' valuation of their own mothering practices and how other people may judge their mothering. The mothers' construction of the baby's agency, their likes and dislikes, become part of the narrative of the developing relationship between the dyad and a part of the mothers' emerging mothering identity. Much of their discourse on their infants was around ideas of a good and bonny baby. All of them told me how 'good' their babies were, but at the same time offered much evidence of stress, difficulty in sleeping and exhausting feeding demands, especially in relation to breastfeeding rather than bottle feeding.

6.7 Summary of results chapters 3-6

These four chapters take us through the lived experience of the ten mothers. Starting with their home lives and themselves we see how their intimate familial relationships give breastfeeding meanings other than just nutrition. We then see the negotiations that are necessary to breastfeed in the external context of health care professionals and the wider community. The importance of demonstrating good mothering is central to the global theme of the external context as the young mothers feel, and to a certain extent are, more closely observed and judged than other mothers. This feeling of being judged is perhaps less acute within the family; other family members were keen to contribute and expected the young mother to need help and support.

Finally, the construction of the meanings of milk and the agency of the baby are examined. The young mothers' mistrust of breastmilk and breastfeeding to satisfy and nourish a baby can be understood when the appropriate behaviour of a 'good' (quiet) and 'bonny' (fat) baby is the stated aim of feeding. These in turn reflect both a concern to be a good mother and to have a healthy baby but also the need for respite. These three chapters create a holistic picture of the young mothers' lived experiences. The meanings of these narrative themes and the theories that can be built from them are discussed in the next chapter (chapter 7).

Chapter 7 discussion and conclusion

Chapter introduction

This study set out to capture and describe the whole journey of infant feeding from pregnancy to weaning onto solid food, to help to understand the dynamic nature of young mothers' infant feeding experiences. This study investigates not just what factors create a culture of formula feeding but also how they interact. This new understanding is now used to inform the discussion of young mothers and breastfeeding, in reference to the lived experience and wider socio-economic influences that play a part in the infant feeding journey. This chapter also develops theoretical models of young women's experiences of motherhood.

The first section (7.1) is a development of the analytic framework, discussing in detail how the Ricœurdean theory of the self can be used to make sense of the narrative work the young mothers did in becoming 'good' mothers. This includes the novel concept that infant feeding/health behaviours are situated in the interrelation between the young mothers themselves as individuals, and their lived experience as new mothers. This space between individual and others is both captured and created by the narrative of their own motherhood, what good motherhood is and how each aspect of motherhood affects the whole. Within this, the meanings of infant feeding are created and we can see that breastfeeding is often at odds with the young mothers' narrative selves.

The following section (7.2) presents a detailed discussion of the data in relation to the global themes presented in chapters 4-6. This includes suggested models to describe the experience of infant feeding, which aid the understanding of why formula feeding is so prevalent in this group. The product is a reframing of the situation by offering both practical and theoretical concepts of the meaning of infant feeding to young mothers and the dynamic interplay of factors which produces the current status quo; the cultural prevalence of formula feeding.

The following section (7.3) is an interpretation of the data in terms of crosscutting themes in the study. These discuss the possible implications of the data to the wider understanding of the lived experience of infant feeding to young mothers in the UK.

Section (7.4) discusses the strengths and weaknesses of the research design and the limitations and value of the findings. Finally, the conclusions to the thesis (7.5-7.7) suggest further research and implications for midwifery and other professional practice in supporting young mothers to breastfeed. The chapter ends with a consideration of the findings that are most relevant to practice and suggestions for further research into this topic.

7.1 The analytical framework revisited

I introduced Ricœurdean (1992) theories of the self in chapter 2, and this section elaborates on how these theories can be a useful analytical framework to understand the experiences of young mothers and infant feeding. I also relate this framework to the existing theoretical understanding of influences of breastfeeding in prior literature.

The narrative work of the self as the mediator between *idem* (sameness) and *ipse* (selfhood) (Ricœur 1992) identities is potentially more challenging when the person is experiencing life change and, particularly, *role* change. The time of great flux that is both being an adolescent, positioned between adult and child, mother and daughter, makes the work of the narrative continuity of self more prominent and more difficult. This may be particularly so if the pregnancy is unplanned, as was the case for all but one of the participants (Marley). In order to understand why young mothers do not, in general, breastfeed we need to first understand what breastfeeding means to their relationships and their nascent mothering identities, as well as considering the practical and pragmatic obstacles to continued breastfeeding as discussed above.

It is possible to see breastfeeding as more disruptive of identity, requiring more mediation between the *idem* and *ipse* to provide an internal (and in the case of

performative motherhood as above, also external) unity to the narrative work of the self. To explain this process in terms of the grounded data, the young mothers believe that they are fundamentally 'good' and that they want to be 'good mothers'. As Spidsberg and Sorlie (2012) point out in their study of midwives' care of lesbian couples, Ricoeurian narratives are never morally neutral.

Breastfeeding challenges this 'goodness' on several levels. Firstly, it does not produce the 'good' baby, a model created by all their own and family's experiences of how a good or content baby will behave. This is discussed in greater detail below in section 7.2-7.3. Secondly, it infringes on their model of the good, non-sexualised mother and daughter – both in the intimacy of feeding (feeling *weird*) and the exposure necessary to sustain breastfeeding, especially when they command so few truly private spaces. Thirdly, it threatens to undermine the status of the baby as a bonded family member, important for practical as well as emotional reasons, they need to ensure the baby is part of the family. All the participants said that letting someone else feed the baby (commensality) was central to the baby bonding with others.

Elaborating the concept of narrative identity means delving deeper into what the concept of self really means. As we can see throughout the results in this study, the influence of the family is key to both the decisions that the young mother makes and how she thinks about herself as a mother. The production of her self is in part a co-production with others. She may be the main protagonist of her story, but she is not the only author. This is the philosophical basis for the very practical conclusion below, that in promoting or supporting breastfeeding, one must strive to include the family, partner or other significant people. As in McInnes et al (2013) and Dykes et al. (2003) we gain a deeper understanding of the challenges mothers face when trying to breastfeed, if we also include relational aspects of their lived experience; i.e. the role of other people.

This is not to say that the young mothers are not making rational choices about infant feeding. Rationality is when we take stock of the evidence before us and align our actions with our reasons for action. What some of the prior literature on

breastfeeding has failed to take into account (for example Smith et al. 2012, Nelson and Sethi 2005) is that the *reasons* for the mothers' actions may not be the abstracted goal of reducing the risk of illness but instead the achievement of the narrative continuity of good motherhood. The factors that create and impact upon the ideal of good mothering are discussed in detail below in the discussion grounded in the results (7.2) and further elaborated in the cross-cutting theories in section 7.3.

This study's contribution to the theoretical understandings of breastfeeding behaviours is perhaps a beginning of the unification of the moral frameworks with the practical barriers. We see from prior literature that breastfeeding is a moral act (for example Dyson et al. 2010, Condon et al. 2013). We also know that practical difficulties, such as a perception of insufficient milk supply, or sleep deprivation (for example, Noble-Carr and Bell 2012, Ineichen et al. 1997) play a big part in mothers changing to formula milk. This thesis brings both understandings back to a common root – the narrative work of the self.

The narrative of good mothering depends on maintaining morality, for example not exposing your breasts in public and a lack of selfishness with 'sharing' the baby's feeding. It also depends on being a nurturing mother – ensuring that the baby is well fed and settled. Hunter and Magill-Cuerden (2014) touch on this, but conclude that breastfeeding is held up as an element of good mothering by the young mothers in their study, because it is better for the baby. In the discussion below, we can see that it is sometimes more complicated than this and different symbols of good mothering interact and are woven into the mothers' narrative of her self. More often than not this may steer the mother towards formula feeding as it more closely aligns with the production of the symbols that mean good mothering to her.

This is the philosophical basis for the analysis of the findings below and both the practical and theoretical conclusions set out in sections 7.5 and 7.6. The creation of the narrative self is woven through the analysis, with thought being given to the implications of this concept for each finding.

7.2 Discussion of key findings and their relationship to previous literature

This primary research was a qualitative study using ethnographic methods, to answer the research question "how do young mothers experience infant feeding?" By capturing and analysing the whole journey, it was possible to understand the lived experience of the young mothers and find out not just what factors create a culture of formula feeding, but also how they interact in the space of the narrative self.

The product of this research is therefore a reframing of the understandings of young motherhood in relation to infant feeding; offering both practical and theoretical concepts of the meaning of infant feeding to young mothers and the dynamic interplay of factors which produces the current status quo – the prevalence of formula feeding.

Each organising theme within the global themes presented in chapters 4-6 is analysed in turn. Both the relationship to previous research and the original contribution that this research makes are considered. This informs a discussion of the implications for both further research and midwifery practice.

Global theme 1: the immediate context

The results of this primary research (presented in chapter 4) concur with previous work (Noble-Carr and Bell 2012) that young mothers are less likely to seek health care professional advice about infant feeding than older mothers. Further, in this study and in the work of others we can see that these mothers are mostly situated in normative formula feeding cultures. Therefore, what exactly is it about the family/community knowledge that takes primacy for these young women? In the following section I show how new insights, generated from this research, address the research questions and also suggest novel interpretations of questions posed by previous research.

Family support is a key organising theme in this study but there was a cost to this in the work the participants had to do to maintain both their relationships and

simultaneously develop their own mothering role. The immediate context both created and directed the infant feeding practices of the young mothers and also informed their narratives about these practices. Through their relationships with their existing family and with their new babies, the young mothers underwent a very acute transition to a new identity. They negotiated both a new external status of 'teenage mother' and at the same time reconciled themselves to the difficult process of becoming a mother - that of displacing their own needs for that of their baby's as they gave mothering love.

The first organising theme analysed was 'not being part of a breastfeeding community (4.1). This was originally titled without the 'not', as this theme was first discussed as such by Brown et al. (2011). However, with the exception of Newmum, as above, none of the young mothers had much substantial experience of breastfed babies, so the negative seemed to be a more appropriate title. Wambach and Cohen (2009), Brown et al. (2011) and others discuss peer support as a way to create a kind of breastfeeding community. Peer support has had some success, though not in all areas (Hoddinott et al. 2009). However, as noted in chapter 5, none of the mothers attended any post-natal groups or classes, though such things were available. So for this particular group of mothers, it is debatable whether such a service would be of any use and careful thought to how it would be made accessible would be needed.

This lack of exposure has two main consequences. Firstly, as Condon et al. (2013) and Ineichen et al. (1997) found, this positions breastfeeding as something that is not normal. Secondly, as discussed in detail in the following section on the babies and the milk, the young mothers did not know how a breastfed baby would feed. That is to say, the pattern of behaviour typical of a breastfed newborn - cluster feeding and waking frequently for feeds - was interpreted as a sign of unhappiness in their babies.

Whilst family members did agree that 'breast was best', the experiences they narrated were uniformly uninspiring if not downright terrifying. These were tales of pain, blood, and ejection from communal spaces and of cloistered loneliness. A lack

of ability to breastfeed was also suggested to be inheritable. The maternal grandmothers recalled that there was not enough milk for their babies and told their daughters that they might be the same.

Given this environment, the lack of confidence in breastfeeding, reinforced by their own early experiences of frequently suckling newborns, is understandable. This section contributes to answering the research question “what and who influences the decisions young mothers make about infant feeding?” by illuminating the family's impact on the mothers' decisions through encounters with their discourses of breastfeeding.

Family practical support and information was very important to the young mothers (see section 5.2) Practically, the tension between needing help, wanting to be a good and also independent mum and needing the baby to be a member of the family too leads to milk expression and/or bottle feeding. This is because bottle feeding is a mode open to all (whereas breastfeeding can only be done by the mother) and because feeding the baby is a form of commensality. It is seen as the primary method of other family members to bond with the baby, which is desired at times by all of the participants. For these young mothers their own mothers' and fathers' (grandparents) relationships with the baby are equally, if not more, important than that of the baby's father.

In Section 4.2, the research question, '*what practical difficulties do young mothers encounter when breastfeeding?*' is explored. However, the results in this section highlight the converse – the huge amount of support that most of the young mothers got from their families. Practical support to 'have a little break' was discussed by all the participants, and looking after the baby for a while was seen as a good thing by the grandparents too. For example, Scrump described her mother and father playfully 'fighting' over who got to look after Victoria when she was in the shower.

Relying on family to provide information and guidance on childcare in general was also common to all the participants. This was also found by Smith et al. (2012), Noble-Carr and Bell (2012) and Dykes et al. (2003). This study concurs with the

previous literature on sources of information and elaborates this finding to demonstrate how, as family knowledge is seen as the most important source of information, a lack of breastfeeding experience in the family reinforces the need for formula feeding. Further, family confirmation that they were doing a good job was given in relation to how a formula fed baby behaves. The implication of this is that you cannot be a good mother if you are '*starving him*' (*Postnatal interview, Kiara, Cory, Skylar, Kiara's older sister and Phoebe present, formula feeding Cory who is five weeks old*). as Kiara worried she was, when she was breastfeeding Cory.

The mother-daughter roles and family babies (4.3) is a key facet of how the lived experience of young mothers may diverge from that of older mothers who are otherwise in a similar in socio-economic position. All of the young mothers moved back into the family home to better utilize the emotional and practical support that their families offered. However, this reliance was not without complications; all of the young mothers wanted, to a greater or lesser degree, to assert their status as mothers and by implication as adults.

Further, unlike a lot of mothers over 20, all of the participants were living, or moved back in, with their own mothers. They are still children/daughters but must also become mothers and present good (Hunter and Magill-Cuerden 2014), or at least adequate, motherhood to the world and fight for that identity change within their own families. In the family home they are still situated as children/daughters but they also desire to and are expected to find a mothering identity. Thus, there is tension between these two conflicting identities and this requires much narrative work to produce a mothering identity.

This was sometimes difficult, sometimes led to conflict when they were (back) in the family home and positioned as daughters. Some, like Scrump and Jessie, enjoyed being looked after; Scrump's father was sometimes portrayed as a father to both Scrump and her baby Victoria. Although Scrump did often discuss wanting independence, her own place, at some soon future point. Deedee and Ash were more explicit in describing the internal conflict and sometimes outward struggle with their own parents in making decisions about their babies and being seen to be

adults. Infant feeding was sometimes understood through this struggle and also was used to exemplify a more general discourse on maintaining both a daughter and a mother role at once.

From the perspective of the respondents' parents the pregnancy and arrival of the baby also brought change, though all I spoke to expressed pleasure at becoming grandparents. Scrump's dad exclaims, without rancor, that the house was 'like Mothercare' because of all the baby's stuff. Marley's mum and dad moved house to accommodate the baby and Marley's partner.

Unlike much of the previous research (Nesbitt et al. 2012, Noble-Carr and Bell 2012, Ingram et al. 2008, Dykes et al. 2003), male partners (see Section 4.4) did not figure much in the young mothers' discussions of infant feeding and of child care more generally. For most of the mothers they were notable by their absence both from the room and from the young mothers' discussions.

Two fathers were still living with the mothers of the babies; Jessie and Peter, Marley and Tom. Tom was always present at the interviews and seemed to have a very 'hands on' role and although I never met Peter, Jessie did often discuss how helpful he was. Other than that, the only comments from the other mothers were few and critical. This may have been because I did not purposively sample for fathers or this may have also been just a facet of the young mothers who contributed to the study, although they were all in diverse situations, areas and of different ethnicities.

In this way, the babies' fathers are notably absent from the everyday lives of the young mothers. This departs somewhat from earlier literature, which found that fathers had an impact on breastfeeding. In this study they were neither supportive nor discouraging of breastfeeding, they were simply not there. Either way, when we discuss including others in breastfeeding promotion, we should be aware that for this group of mothers, fathers may not be the second care givers and a more 'open' invitation to family could be considered. It is also of great importance that we do not judge those young mothers who appear to be without a male partner.

All of the mothers mentioned the physical discomfort or pain of breastfeeding (see section 4.6) and most also said that it felt 'weird' – usually with body language of encountering something that made them feel a little squeamish. For some this was simply ploughed through, such as Newmum, but for some it was part of what ended breastfeeding. Scrump, for example, exclusively expressed, in part to avoid the 'weird' feeling.

It is difficult to extrapolate meaning from a finding that was more displayed in the faces and bodies of the young mothers as explicitly discussed. As seen in the results section 4.6, the mothers did discuss pain quite openly, but the 'weirdness' was mentioned but never elaborated on. There were definite boundaries given to the 'appropriate' ways to breastfeed, several were amused and aghast at the idea that anyone would breastfeed after, say, the baby was walking. As discussed above, breastfeeding is an inherently physical and intimate act (Schmeid and Lupton 2001), and perhaps the young mothers, still coming to terms with their own adolescent sexuality, found breastfeeding to be a bit too intimate and full of strange sensations.

Global theme 2: the external context

The previous literature pertaining to interactions with health care professionals and formal support for breastfeeding present a very mixed picture of what young women find helpful and what the challenges of such support might be. For example, Ingram et al. (2008) found that young mothers wanted classes and services specifically for them so that they would not feel judged by older mothers. In contrast, Noble-Carr and Bell (2012) found that their participants did not want to be labelled as young mothers and therefore approached teen pregnancy services with caution. Similarly, with weighing there are some divergent findings in the previous literature. Radius and Joffe (1998) find that more regular weighing may be encouraging to young breastfeeding mothers, whereas Noble-Carr and Bell (2012) found that the weighing regime and postnatal care in general produced 'mixed messages' that the mothers experienced from the health care professionals.

In this study, some participants found health care professionals useful at times but also felt 'mithered' (harassed) or let down at others. Of course, in any long-term contact with a health service there will be elements of frustration and also of gratitude, but there do seem to be some inconsistencies across the young mother's narratives (see section 5.1) that bear closer scrutiny. For instance, several of the mothers such as Marley and Scrump felt abandoned by their health care professionals when they return home and need breastfeeding support, whereas Ash and Deedee feel harassed by their midwives and breastfeeding workers. This may of course just reflect individual variations in care but there are also echoes of this dichotomy in the wider body of research (for example MacVicar 2015 and Sipsma et al. 2015). As several literature reviews find (Renfrew et al. 2012 and Hoddinott et al. 2011), face to face support which is offered rather than sought is more effective in prolonging the duration of breastfeeding, but the nuances of how to do this without intruding on the young mother's feelings of privacy and autonomy are not clear from the extant evidence. Therefore, further research into what kind of approach is perceived as helpful and what is not may be of much use for this group of mothers.

This primary research has provided a rich description of young mothers encounters with professional breastfeeding support, which may provide some explanation of these divergent findings. Firstly, many of them felt the lack of support most acutely when they were inpatients. This was experienced as deeply frustrating because they believed that all midwives would be 'pro-breastfeeding' but weren't getting the crucial support that the early days can require. Young mothers are not alone in this frustration, but perhaps the more abstract understanding of life which comes with adulthood is necessary to see that whilst the public health advice may be given, the complexities of service provision in understaffed and over busy hospital units may mean breastfeeding support is not prioritised.

Secondly, there was tension between the young mothers and the midwives that is particular to this age group. They all had social services referrals made at booking (local protocol for any mother 18 or under) and felt their motherhood to be under scrutiny (Hunter 2008). Whilst there were very supportive care encounters, there was

often an element of mistrust. For example, Newmum felt that if she asked for breastfeeding advice, thus demonstrating that she 'didn't know how to do it', she may appear not to be a very able mother. One possible solution may be the use of specialist young mothers' lay breastfeeding supporters, who may be more approachable.

The data showed that the newborn weighing regimes were experienced as disruptive of breastfeeding by the majority of the young mothers. Indeed, all of the young mothers who ceased breastfeeding within the neonatal period said that the decision had been made (or at least finalised) after they found the babies had lost some weight. Local protocol states that newborn weight loss under 10%, in the absence of any clinical symptoms of illness, is normal and no action should be taken. Nonetheless, the midwives encouragements to feed frequently to prevent further weight loss (which is part of the routine postnatal advice given), made the young mothers distrust breastfeeding as an adequate way to feed their babies.

In these ways, the behaviour of the health care professionals may channel women, especially these mothers, towards formula feeding. There is disruption of feeding in hospital and negative feedback from the neonatal weighing regime. Further, the divergence in the voices of authoritative knowledge (Jordan 1997) in the young mothers' lives may also create narrative dissonance; they must be a 'good' mother to two different sets of judgments on what 'good' is. That they usually abide by their own family's values is understandable, as midwives are only a brief presence in their lives.

All of the young mothers discussed the stuff they had bought for the baby (see section 5.3) both in pregnancy and in our meetings afterwards. Bottles, as discussed above, are the visual symbol of preparation and of nurturing motherhood, especially in, but not confined to, a normative bottle-feeding community. There was also a focus on 'status' baby items, especially very expensive prams. It is interesting that even the mothers who were adamant that they wanted to breastfeed still bought bottles. My initial thoughts on this were that the performance of motherhood (in which 'stuff' is particularly visible) may be more important to these young women

than, perhaps, older ones, because of the high level of 'observation' and the prejudice that they will not be adequate mothers, because of their age. Going deeper into this finding, it also seemed there was a symbolic aspect to the bottles too. Bottles are also a symbol of contented and caring mothering. Go to any playgroup and you will see a small child bottle-feeding a toy baby. The implications of performative motherhood, of which bottles are a part, are discussed below.

The young mothers all discussed stigma (5.3) in one way or another. But instead of rejecting the 'teenage mother' stereotype, they instead concurred with these views whilst at the same time insisting that that they do not apply to them. They are not 'one of those teenage mothers'. As discussed above (7.1) being a good mother was very important to them but also appearing to be a good mother mattered as Hunter and Magill-Cuerden (2014) also find of their participants.

This struggle to appear 'good' against a perception that they will not be, necessitates a more exacting display of the 'correct' mothering behaviour to the health care providers. It is vital that the babies are not seen to be lacking adequate feeding. As breastmilk is not a 'reliable' source of food to these mothers, bottle-feeding becomes necessary. This also leads to early weaning to continue to ensure a bonny baby.

Much of the previous literature on young mothers and breastfeeding has discussed issues around feeding in public. The young mothers in Hunter and Magill-Cuerden's (2014) study found feeding in public to be a real barrier, as did earlier works by Nesbitt et al. (2012), Smith et al. (2012), Condon et al. (2013), Dyson et al. (2010), and much of the work preceding this as discussed in the meta-synthesis in section 1.4. In summary, fears of public exposure of breasts and of being stared at, shamed or ejected from public spaces made feeding in public a very difficult prospect for young mothers. Similarly, this study found that the young mothers felt very strongly that breastfeeding openly in public was unacceptable. This was sometimes because of the need for sexual modesty, which Ash in particular talked about, and sometimes because they feared the opinions of other people.

A finding from this primary research is the importance of understanding that for many young mothers, who have moved back (temporarily or permanently) into the family home, most of the house is a public space. Brothers, family friends, their own fathers are frequently in the house and so the only space the young mother can use to breastfeed is her bedroom. As Hunter and Magill-Cuerden (2014) also find, this can be a lonely and isolating experience. This study also suggests the novel finding that public space is about being visible to strangers but that this but also gendered – when *men* are around the home is a public space, even if this is the mothers own father or brother.

Previous authors discuss the issues young mothers have with the sexuality of the breast in conflict with the mothering act of breastfeeding. Hunter and Magill-Cuerden (2014) and Dyson et al. (2010) in particular found that the sexual 'exposure' associated with breastfeeding was a barrier for the young mothers to feeding in public. From the findings in this study it is possible to speculate that in addition to the issues of exposure, there may be some conflict between nascent sexuality and mothering roles.

Global theme 3: the babies and the milk

There is a notable absence of any discussion of agency of the baby in much previous work on breastfeeding and young mothers, though McInnes et al. (2013) discuss the baby's agency in a study of women of all ages and also find it to be an important part of why women change feeding modality. For the young mothers in this study, their baby's behaviour, their understanding of the babies' feelings and their own construction of the baby's desires play a huge part in decisions they make about infant feeding.

All of the mothers talk of 'good' babies, and most think that their own baby falls into this category. Part of this is that a 'good' baby means a 'good' mother, but there is also the overlay of a generation of Gina Fordesque (1999) expectations that a baby will sleep consistently, feed reliably and be 'routinisable' early on. In my professional and personal experience, and also in a lot of the newer literature on the subject (Ball

2003), this is rarely the case. The NHS guidance now is to 'demand' feed (i.e. be alert to feeding cues and allow a baby to stop feeding when he is full) when feeding with formula. Indeed, one of the benefits of breastfeeding is thought to be the conditioning of the satiety response, which is put forward as a theoretical mechanism for the lowering of the risk of obesity in later life (Beyerlein and Von Kries 2011, Gale et al. 2012).

However, as discussed in chapter 6, the work of Ball et al. (2003) finds that formula fed babies do sleep for longer periods, at least in the early days. This work also addresses the issue of bed sharing as a way to ameliorate some of the sleep deprivation. Ball's work in her sleep lab at Durham University finds that when breastfeeding both mother and baby sleep for longer and have less disturbed nights if they are bed-sharing. This then raises other issues, as advice given to parents in the UK is that there is an association between co-sleeping and sudden infant death (NICE 2014). These risks are increased substantially if the mother or immediate family smoke, which was true for all of the participants except for Newmum. This is a persistent dilemma, but further research on strategies to help young mothers cope with frequent night waking may be an important facet of wider strategies to increase breastfeeding in this group.

Establishing routines for babies may be a commonly held ideal, for example, "The Contented Little Baby Book" (Ford 1999), has over 25% of the market share of baby care books in the UK. In this book Ford (1999) sets out strict regimes for neonatal care. This includes an expected 8.45 hours of continuous sleep overnight by 12 weeks of age.

None of the participants ever mentioned using baby care books, nor said that they would use books as a source of knowledge, but they all did talk about how important routines were for their babies. Somehow, the belief in regimes for babies has become a part of their understanding of what 'good' baby care should include. Therefore the question becomes, how much of the anxiety about 'sleeping through' is due to the normative expectation that the babies will, and how much is quite reasonable tiredness and wanting the babies to sleep more for practical reasons? It

has been suggested that teenagers need more sleep than adults (Carskadon 1990) that might perhaps exacerbate the 'normal' feelings of exhaustion caused by having a small baby.

However, the extent to which the mode of feeding is attributed to the baby's intelligent and considered preference is much more centered in the young mothers' ideas about how much control they have in the situation, or perhaps how much they want to take responsibility for choosing to formula feed.

Another factor is that breast milk is seen as unpredictable, it is hard to measure, seems to change its consistency and even colour in the first few days, and neonates will tend to 'snack' by drinking small amounts frequently. This is because of the tiny size of their stomachs, by eating little and often they actually ensure that they process the largest amount possible and usually thrive if allowed to do this (UNICEF 2012). This is time consuming and exhausting for mums though, who sometimes feel like they cannot do anything but breastfeed. If this is what one is expecting, and there is practical and emotional support available then it is possible *not* do anything but breastfeed. However for mothers who lack support, have other children and are under pressure from the family and peer group to be up and doing things – to get 'back to normal', then such a regime is prohibitive.

Thus, a perception that breast milk is insufficient, due to a non-sleeping 'hungry' baby, coupled with coping with the practical and emotional difficulties of breastfeeding, creates a process of diminishing returns for these young mothers. They expect and desire a bonny and good baby and when breastfeeding does not deliver this normative expectation, begin to top up with formula milk. Having a good baby is perhaps a key part of being a good mum. This creates an imbalance between the 'supply and demand' mechanisms of lactation and further reinforces the idea that breast milk is insufficient. This cycle continues until the baby is fully fed on formula.

Figure 8: The bonny baby process of diminishing returns



In conclusion, as the normative expectations of a baby who will sleep for long periods is coupled with an absence of modeling of successful breastfeeding, it is difficult to overcome the belief that many young mother have; that breastfeeding does not work. This belief is reinforced by the positive feedback cycle described in the diagram above (fig. 8). Further research needs to be done as to what will support young mothers to feel confident in the ability of breastfeeding to sustain a thriving baby.

7.3 Cross-cutting theories

This section describes the three cross cutting theories that are the main outputs from the primary research and are the 'take home' results from my work. The theories are developed from the research findings and the more detailed analysis of the results in the previous section (7.2). This section presents the analysis as a coherent whole, highlighting issues of the self and the interrelation self which cut across the themes in which the data is otherwise ordered. These cross cutting theories attempt to reframe the discussion of infant feeding and young mothers, to take account of their own values and beliefs. The participants were striving to be good mothers and their decisions on infant feeding are understandable in the context in which they are made.

Theory 1: Feeding is inherently a family activity for young mothers

Nesbitt et al. (2012), Smith et al. (2012) Dyson et al. (2010) and others find that family influence, either partner or the extended family are key factors in both predicting (Dyson et al. 2010) and sustaining (Smith et al. 2012) breastfeeding duration. This study contributes to the literature by examining the mechanisms by which families influence infant feeding and providing a richer description of how family life is experienced by young mothers.

As seen in chapter 4, the creation of a normative formula feeding culture, the need and desire for family support and acceptance and the narrative conflict of being at once a mother and a daughter in the family home, means that breastfeeding is a more difficult option than bottle feeding for young mothers. This theory is based around the finding that it is important for other family members to feed, as well as for a practical 'little break'. I use the theory of commensality to demonstrate why breastfeeding can be seen as a challenge to the life of the family. This may mean that the emphasis that the recent breastfeeding promotional campaigns have put on breastfeeding as a form of bonding may in fact lead young mothers to introduce some formula or try to use expressed milk. As Ash said, she didn't want her baby to be "*too bonded*" (*Neonatal interview, Ash, Christopher, her mum, grandma, young*

aunty, younger sister and Phoebe present, breastfeeding Christopher who is two weeks old). To her, as he also needed to bond with the rest of the family. The focus on bonding worked against her own understandings and priorities in this case.

Whilst milk expression is possible, and for Scrump was very successful, some mothers struggle to produce large volumes (whether large volumes are necessary in the early days is another matter) of expressed breast milk without expert support (Spear 2006). Therefore, the demands of commensality, at work with the other mechanisms discussed in this chapter, mean that feeding with a bottle is very important to the young mothers. These demands mean that formula feeding may be seen as a *more appropriate* mode of feeding.

In addition, being a 'good' mum entails displaying that your child is getting fed properly. As above, breastfeeding is not trusted as a reliable source of nutrition. This leads to milk expression and/or formula feeding to both demonstrate adequate consumption and to allow others to bond with the babies. This pattern also informs weaning practices with precedence being given to family habits; the 'new' advice to wean at six months is rejected.

For these reasons, and the important reason of needing a "little break" (Deedee), support for expression may be empowering. As discussed in chapter 1, there is a gendered inequality in infant feeding, as there is in much domestic and child centred labour. Supporting young mothers and, perhaps, any mother situated in a normative formula feeding culture, to express may be helpful; more research needs to be done into this as a potential strategy.

In conclusion, the theme of the family is a central point to much of the rest of the findings. The practical, emotional and informational ways in which the mother is embedded in her family create the lived experience in which she does, or does not breastfeed. Further, the breastfeeding itself becomes an act which can mediate or preclude her own and the baby's relationships with the rest of the family. The young mothers are at once both daughters and mothers and their narrative identities as adult mothers must emerge from this tension.

Theory 2: Performative motherhood leads to formula feeding

Upon all mothers is an obligation to demonstrate adequate mothering, both socially and to professionals. This is particularly so of young mothers who, as Newmum tells us, have to face negative views of their ability to mother just because of their age. Other authors (Hunter and Magill-Cuerden 2014, Dyson 2010) have also found that appearing to be a good mother is important for this group in particular. I argue here, that despite breastfeeding being promoted as 'the ideal', formula feeding often more usefully fits the image of a good mother for these young mothers.

Firstly, bottles are the visual symbol of preparation and of nurturing motherhood. I noted in my participant observations that *all* of the mothers, even Newmum who went on to exclusively breastfeed, had bottles prior to the birth of the baby. For some this was, on one level, pragmatic, a 'just in case' strategy. Others also had breast pumps and wanted to express and feed (though only Scrump expressed regularly). But when we talked about the bottles, many of them discussed them as part of the 'stuff' you have when you are preparing for a baby. The participant as above offered the 'stuff', including the bottles, as proof of readiness.

Scrump's tale of the girl at school, who concealed her pregnancy, was told with more concern for the fact that she was 'not set up for him' than for the psycho-social implications of a concealed pregnancy, and immediately after Scrump told me that she had everything by five months, hastening to assure me that she was not like this other mother. The stuff, the expensive prams and full baby kit, are at once a sign of preparedness and organisation as a mother as well as a display of being well resourced enough to be a parent. Therefore, it is possible to see bottles as an important part of performing good motherhood. As Scrump said, referring to the story of her friend who concealed her pregnancy "Obviously she's got to (breastfeed), she's got no formula". Breastfeeding here positioned as something one has to do because you are not ready.

Other authors (Dyson et al. 2010) also find that some mothers thought breastfeeding made them look lazy, for not getting up in the night to prepare bottles. Whilst this last

point was not explicitly stated by the participants in this primary research, it was said that being ready for the baby meant being ready to bottle feed.

Further, similar to the findings of Hunter (2008) their ambivalent relationships and negotiations with midwives over the weighing and early days of the baby's life seemed to create a situation where they felt judged and/or worried if the baby lost any weight at all and that to perform good motherhood, to avoid accusations of neglect, they should be formula feeding, which was (for other reasons as discussed below) seen as more reliable. The tension between 'adequately feeding' and 'breast is best' is dealt with by the moral work well described in the literature (for example Dyson et al. 2010) and also found in this primary research.

In these ways, the increased pressure on young mothers to be seen to be good mothers, as Hunter and Magill-Cuerden (2014) also describe, leads to formula feeding actually being seen as the safer option for performing good motherhood. The young mothers narrative work of creating her self as a good mother is easier and perhaps safer when she feeds her baby with formula.

Theory 3. Creating the good baby precludes breastfeeding

Family norms of how babies should behave, perhaps in part created by the previous generation of childcare advice as discussed above, leads mothers to worry that breastfeeding is not adequate for their babies – it is not making them happy. This was also a cause of early weaning.

All of the mums (except Newmum, who was the only one who had first hand, intimate experience of how a breastfed baby behaves) thought that unless the baby conformed to their expected pattern of a 'good' baby, then the babies were not happy, "weren't getting enough" (Marley) and they were therefore not good mothers. Scrump also thought this, but because she could measure and control the amount of breast milk Victoria was taking, she felt that this could be managed with expressed breast milk. The narrative identity of the 'good mother' is assured by the assurance of a certain quantity of milk, in this case.

Producing 'Bonny babies' was seen as important to these mothers and all apart from Newmum and Scrump, expressed the view that that formula feeding was more likely to produce a fatter baby. This was seen as a visible representation that you are doing a good job. Further, a good baby is not 'too bonded' and is happy to go to others. This also feeds back into the 'family baby' discussion and also, practically, allows the young mums to get their life back on track – there is expectation (including internal ambition) that they will 'do something' with themselves. This is another way of preserving the narrative self, a self who continues to have prospects and goals, despite the unintended pregnancy.

Underlying the 'good baby' construction is that breastmilk is not to be trusted to achieve this and feeding in public is prohibitive which also leads to a very public display of infant distress (the 'not good or unhappy baby'). Therefore, again we see that formula milk is seen as the option more likely to produce the baby (and by reflection the mother) that these mothers valued.

7.4 Trustworthiness, strengths and limitations

In this section, the primary research presented in this thesis will be assessed according to the criteria given by two seminal works on qualitative methodologies in health care. Using a combination of the guides for assessing qualitative work from Mays and Pope (2000) and the earlier Hammersley (1992), I will discuss how my research meets these quality criteria and what the actual and potential weaknesses might be. These 'checklists' for quality are used because they are seen as key texts within health research and are used in combination because, although Mays and Pope (2000) build on Hammersley's (1992) work, his assessment of relevance and credibility still provides a more detailed framework.

These criteria used here are: the clarity and appropriateness of design, data generation and analysis in terms of the research question; credibility; transferability and relevance and reflexivity.

Clarity and appropriateness of methods used

As discussed in chapter 2, in order to investigate the lived experience of participants, a qualitative methodology with elements of ethnographic methods was ideal. The exact methods, of longitudinal interviewing and participant observation generated data to enable the research questions to be answered. The process was overseen by my doctoral supervisors and selections of raw data and the analysis thereof was inspected by the supervision team. I used a well known and substantiated method of analysis for qualitative research in health care (Thematic Network Analysis, Attride-Stirling 2001)

In relation to sampling, participants were chosen using the selection criteria (aged 16-20 and pregnant who expressed some interest in breastfeeding during their routine antenatal care). This gave a group of young mothers who were engaged with the research and had much to contribute. I approached four young mothers whose details were given to me by the midwives who declined to take part in the study. Their reasons for declining were that they did not have time (three young mothers) and were *"too stressed already"* (one young mother). These answers are not amenable to further analysis, as it is doubtful if any young mother would have felt able to discuss how the idea of talking about breastfeeding really made them feel on the phone to a stranger. However, one potential weakness of the research is that the participants who elected to be part of the study may well have been in a more stable environment, than those who did not.

This does not just apply to the four decliners who were identified as potential participants but also to those who did not express an interest in breastfeeding at all to their midwives. It is speculation, but considering breastfeeding was perceived as potentially difficult and risky by the participants, perhaps they felt more able to try as they were all supported by their families. This does not invalidate the results of the study, but it does suggest that those who choose from the outset to formula feed may perhaps have slightly different lived experiences of young motherhood in general and infant feeding in particular.

A second potential problem in sampling was the decision not to recruit anyone under 16 due to the safeguarding issues and the much more lengthy ethical permission process of working with vulnerable minors. As it turned out, none of the potential participants selected by the midwives were under 16 (I did not give them an exclusion criteria, just asked them to approach any mum who wanted to breastfeed), so no-one was excluded from this study because of age. Again, this could relate to the fact that the under 16s were also less likely to express an interest in breastfeeding.

Thirdly, the decision to only recruit participants with a reasonable command of spoken English may have led to the loss of some more data on ethnicity and the intersections with young motherhood. It would not have been possible, given the resource implications of translation, to include them. However, only one participant who did not speak English but who otherwise met the criteria, was being cared for at the time of recruitment by the Teen Link Midwives.

Lastly, as detailed in chapter 3, only five of the ten participants completed the final interview at weaning and only four completed the postnatal interview (though two of these had a subsequent interview). However, data saturation in relation to the core themes was reached by the second of the final/weaning interviews, meaning that when the transcripts were coded, no new themes emerged. However, after this point I completed the interviews already arranged to confirm this, and used the opportunity for informal member checking, and out of politeness. This is a small sample, of a 'hard to reach' group (Arai 2003), but the depth of the interviews and observations and the interactions throughout the journey provide enough richness of data to develop some theories and suggestions for practice as set out below.

Internal and external credibility

The internal credibility (that the study accurately represents the lived experience of the participants) was ensured by a process of member checking once data saturation had been reached. In the two final meetings (from which no further open codes were created) after the interviews I discussed some of the emergent findings

with Scrump and Jessie. Neither participant disagreed with the overall themes (as presented in the results chapters 4-6) although they had quite different backgrounds, though neither made any substantive comments. This may also have been out of politeness! I did some more formal member checking, contacting all of the participants after the study had ended using the PPI feedback sheet in Appendix 9 to elicit their views, but no further comments were made by any of them – they had all moved on. Therefore, I took the results to a local young mums group and gave a brief presentation. I also fed back the results to the Teen Link midwives. Neither group disagreed with any of the findings, though the comments from the midwives were that 'sometimes they don't want to breastfeed, but don't want to say so'. This may be true, but the results generated were sufficiently in depth for this 'not wanting to say so' to be incorporated into theories of both narrative continuity and into ideas of performative motherhood.

The interplay between the participant observations and interviews was used to provide further confidence in the findings and in the coding decisions (see Appendix 10) (Silverman 2010). By using two different data generation methods and then comparing and contrasting the results added both depth and confidence to the findings. In general the two methods were complementary; one finding elaborated upon another. There were a few discordances, such as mothers discussing how they planned to live independently from early in the baby's life, but having all their baby 'stuff' at their mothers' house. These discordances enabled a greater look at how the mothers dealt with internal conflicts and external pressures, and overall the two modes of data generation were complementary.

In the initial research protocol, I had planned to use digital methods (social media contact) to provide further variation in data generation methods and also to access the pivotal moments (Hoddinott et al. 2012) of the young mothers' experiences. However, none of the young mothers were willing to allow me access to their social media worlds until the end of the study. After they had spent six months with me and we were familiar with each other they 'friended' me. This enabled some last contact and a gentle lead out of the study, but there was very little specific content on infant

feeding by this point. The late adoption seemed primarily about trust (in me) but also their social media activity seemed to be about them presenting their young and glamorous selves to the outside world, and was not usually very focused on motherhood, perhaps because most of their peer group were not mothers. This again illustrates tension as they construct a mothering identity whilst preserving the continuity of their narrative selves.

The external credibility to this study is given by the similarities to previous research, but with new themes and theoretical models emerging (such as performative motherhood) and other themes more deeply understood (such as private space as public). I have also presented the findings from this work in one international conference (MAINN 2015) and two UK academic seminars (University of Sheffield, University of Leeds) to researchers in the field of infant feeding, and the feedback has been both positive and interested.

Transferability and relevance

From the outset, as a piece of qualitative health research a (Mays and Pope 2000) position as regards the research truth has been assumed. That is to say, although this is the lived experience of just ten young mothers, some of the findings are useful to enable broader theorising about the experience and positioning of young mothers in the UK as a whole. This study does not attempt to make generalisable claims but to expand and build upon existing work to further the understanding of young mothers and infant feeding. The fact that many of the findings are similar to, and build on, previous research is a confirmation of this. For example, Dyke et al.'s 2003 study found the primacy of family knowledge for many young mothers and this study found the same and elaborated on the tension between two different family identities (the mother and the daughter at once) as a possible explanation for this.

The relevance of this primary research is that it has generated some novel implications for practice and for a broader framing of the issue of young mothers and breastfeeding as a whole. This is discussed in depth later in this chapter. Further, PPI activity at the start and end of the study, asking groups of young mothers to

comment on the research design, aims and final results, implies not just trustworthiness but hopefully a relevance to their own lives and experiences too.

Reflexivity

From the outset I have maintained a reflective diary and made formal reflections on the participant observations and interview transcripts as they were processed and analysed. One of the main points of reflection was my role as a practising midwife and a breastfeeding mother at the time, and how this might impact upon the research. As Kanuha (2000) states, *"For each of the ways that being an insider researcher enhances the depth and breadth of understanding a population that may not be accessible to a non-native scientist, questions about objectivity, reflexivity, and authenticity of a research project are raised because perhaps one knows too much or is too close to the project"* (pg. 444).

The practicalities of being a midwife and a researcher

Being a midwife definitely enabled a greater access to this group of mothers, than is often the case. From the outset I was able to meet and discuss recruitment with the Teen Link Midwives in ways that would be difficult for a non-midwife; they saw me as part of the team. I was very careful not to recruit any young mothers to whom I had previously given maternity care and chose to recruit from clinics that were outside of my community practice at the time. Luckily, the vast majority of the under 20's are cared for by the specialist team and therefore I was unlikely to come across any participants during antenatal care. Only once did my clinical and research paths cross, as one participant was admitted to the labour ward whilst I was working. This was a difficult situation and I chose not to go and say hello, though afterwards this participant (Deedee) asked me why I hadn't (her midwife had mentioned that I was there as Deedee had told her about the project). I said that I had not wanted to intrude, and she seemed to think this was reasonable though said that it would have been nice *"to see a friendly face"*.

Although I always introduced myself as a researcher, the participants seemed to regard me as a midwife. From general conversations they saw the value in the

pragmatic goals of the research, basically that I was finding out what helps mums with breastfeeding, but did not perhaps understand either the research process or the role of academic research in practice development.

Prior to beginning fieldwork, I had discussed what I would do with my supervisors, should I be asked questions about midwifery care or motherhood by the participants. We decided that I should refrain from making any clinical recommendations but to listen and try to signpost the participant to the most relevant service (e.g. midwife or GP). In the end, I was actually asked very few questions about infant feeding. The two direct clinical questions I was asked were about infant care in the extended post-natal period. This was perhaps because they all had intensive support from their midwives in the early days. I suggested for each of these questions (one about the development of the spine, another about an eye infection at four months) that they call their GP as these symptoms were outside my professional remit in any case.

The clinician-researcher dialectic (Kanuha 2000)

Some, if not all, of my analysis and interpretations of data are undoubtedly affected by my professional training and experience. Indeed, as in the introduction to this thesis (pg. 9), the topic itself grew out of observations from my practice and personal experience of breastfeeding mothers. This has positives in that the field was familiar to me, undoubtedly helping me to quickly build rapport with the participants. One concern is that the results may be seen "*through the lens*" (Allen 2004) of midwifery. Through reflection and discussion I tried to separate my 'midwifery' thoughts from that of a health researcher. Perhaps because my initial training was anthropology followed by several years of working in grass-roots research and support, I found this easily possible. My supervisors also helped me to see when I was considering a 'midwifery' truth rather than the perspectives of the participants; for example, when mothers told me that their "*baby will not breastfeed*" I needed to reflect on my initial analysis about the physiology of attachment to the breast and lactation and focus on what *they* thought this meant - that the babies did not want breast milk.

It is also possible that, as a midwife, the young mothers may have been more inclined to tell me what I wanted to hear about breastfeeding. Whilst this may have been true initially, the fact that they were still engaged even after they had ceased to breastfeed, and because of the growing intimacy during the study, I hope this was overcome as the project (and my interviewing skill) progressed.

The research has also changed my midwifery practice, not in terms of any single understanding or encounter, but in reframing for me what women's priorities may be and understanding more thoroughly why women do not necessarily adopt public health advice given by well meaning midwives, all of the time.

Lastly, the conclusions to this primary research are intended for midwives as much as for an academic audience, and I intend to reflect this by publishing the implications for practice in a professional midwifery publication.

7.5 Implication for practice and suggestions for applied health research.

1. Family support and support for milk expression

Firstly, my findings suggest that supporting and including the family around the young mother may be important to designing effective breastfeeding support. What all of the ideas in Sections 7.1-7.3 for understanding young women's experiences of infant feeding have in common, is that they all involve relationships with other people as well as internal narratives. Quite literally "oneself as another" (Ricoeur 1992).

The majority of public health breastfeeding promotion is aimed solely at the mother herself and the baby's benefit. We talk of reductions in future cancer risk, a reduction in atopic risk for the baby, avoidance of weight gain and diabetes for both mother and baby. None of these benefits mention the other actors in the young mothers' lived experience. I here also suggest that the understanding that health behaviours are also situated in the relationships between families, communities and with health care professions (perhaps this last one is much less significant than the others) are key to designing public health interventions that work. This is partially a pragmatic

solution, because we know that family members have a say in how the baby is raised. More theoretically, this is also important because the narrative of the self is constructed by and because of these relationships, in the confirmation and challenge to the narrative continuity of the self (Ricoeur 1992) that the relationship imposes.

One practical solution is to include the family at key points of breastfeeding education (as Smith et al. 2012, Dykes et al. 2003 and Ineichen et al. 1997 also suggest, with more emphasis on the partner than the wider family in the latter two) though this may be difficult as we lose more continuity of midwifery and are more centralised in our working practices (i.e. less one to one care at home). Another suggestion is, given the importance of "*having a little break*", commensality with the baby and privacy/modesty, is to work on milk expression techniques and education in a more focused way with the young mothers and to be more 'compromising' about mixed feeding – working out individualised plans to support lactation whilst still including bottle feeding (with either EBM or formula). Certainly more research needs to be done to see if this is both practical and effective in sustaining breastfeeding for longer.

2.Understanding infant behaviour

Secondly, as discussed in 7.2, the normative behaviour of the baby is at odds with breastfeeding. Changing the expectations of a generation of women raised in a normative bottle-feeding culture is not easy, but more information and personalised education for the whole family on the normal behaviour of a breastfed baby may help to reassure mothers who want to breastfeed, that they are doing 'a good job'. More research on this as a proposed intervention would be very useful.

The new BFI guidelines published in 2015 (www.unicef.org.uk/BabyFriendly) have put more emphasis on the mother and infant bond and communication of feeding cues, which is important for all mothers, but perhaps especially so for young mothers. A common theme in much of the research was a young mother's worry that because their babies wanted to breastfeed frequently, that meant that they were

hungry and that they were not 'doing a good job' (Hunter and Magill-Cuerden 2014, Spear 2006).

3. Feeding in public

The stigma of breastfeeding in public is still a problem for many mothers, and especially young mothers, despite recent legislative changes. Hunter and Magill-Cuerden (2014), Dyson et al. (2010), Condon et al. (2013) all find that the fear of public breastfeeding was an issue for the young mothers in their studies. In my own breastfeeding experiences, I have been asked to leave a theatre, a family pub and once a doctor's waiting room if I wanted to continue breastfeeding. I made the appropriate complaints, although it did make me feel awful at the time.

For young mothers, who are not always so convinced about the inherent 'goodness' or acceptability of breastfeeding, such encounters can be the 'pivotal point' (Hoddinott et al. 2012) at which they assess it as too difficult or 'not for them'. As this research makes clear, the family home is also often a public space and therefore the young mothers' choices of places to feed are severely limited. Deedee discusses the problems with feeding in her family home, which is a 'public space' as she cannot control who visits and when. *"I like fed him here (at her mum's house) when my little brother was here and everything, and I've had to do the blanket thing and stuff like that.* Kiara, 18, reiterates this *"It were like, you know, a bit harder, because I've got a big family, and everyone were here, it was like, embarrassing! (Laughs). My brother, and my brother's friends were here!"* Offering support to negotiate breastfeeding space in the family home may be a useful option for some young mothers.

Social marketing campaigns, like the Be A Star campaign mentioned in chapter 1, have tried to make breastfeeding in public more socially acceptable and 'normal' for young mothers. From a practice point of view, producing regularly updated lists of local 'safe' places to feed (such as mother and baby rooms in stores) may help young mothers to feel more confident in going out and still being able to breastfeed.

Further, because of these well documented issues with feeding in public (this work, Hunter and Magill-Cuerden, 2014 Nesbitt et al., 2012, Smith et al., 2012, Condon et

al., 2013, Dyson et al. 2010) support for milk expression may be important. By expressing the mothers could feed their babies breast milk but also preserve their physical intactness, to use a concept from Davis-Floyd (1998) they mediate their feeding relationship with technology. By expressing, they can measure and control the amount of milk as well as making feeding a less physical act. However, although all of the mothers discussed milk expression, and all but Newmum had breast pumps, only Scrump managed to successfully feed expressed milk to six months. This may reflect physical difficulties with pumping, such as pain and 'not getting much off', or perhaps there are other psychosocial reasons. This is a key area for further research.

7.6 Contribution to the literature and further recommendations for research

This primary research presents novel findings on why young mothers do not often breastfeed beyond the neonatal period. In summary, through a rich description of the lived experience of young mothers in relation to infant feeding I have produced theories of the mechanisms by which formula feeding becomes the dominant feeding option. I have also made suggestions as to how to reframe the experiences of young mothers; in a relational context as well as how the work of the self may be more challenged by breastfeeding than formula feeding.

Therefore, I would like to do further research on how the work of the self is challenged by breastfeeding in a wider group. These developing theories are complementary to theories of behaviour change and may be of particular use when interventions, such as the last decade of intensive breastfeeding promotion and support, do not seem to have an effect on a particular group of mothers. Understanding health behaviours as part of the narrative work of the self produced new insights into why this group doesn't breastfeed and what might be done to support them.

7.7 Conclusions

Neither the qualitative nor quantitative literature in the UK can explicate all of the factors involved in young mothers' low rates of initiation and attrition of breastfeeding. However, we do have a good descriptive picture of the last 10 years of the rates of feeding and the experiences of young mothers. There is a good starting point of understanding of the various influences on infant feeding practices and some research conclusions on the cultural meaning of breastfeeding for young mothers. This research has been designed to investigate the dynamic interplay of these existing findings and to generate new theories of young mothers' experiences. With this more holistic understanding, research into new or more targeted interventions will be informed to provide more successful support to young mothers who wish to breastfeed. Further, theoretical understandings of young mothers' health and parenting practices have been suggested.

In conclusion, to return to the earlier metaphor of the ship of Theseus (chapter 2), breastfeeding occurs at a time of other great changes. This includes new status as a mother, outside potential criticism, personal physical and psychological changes. Breastfeeding therefore, which does not fit well into the values and expectations of the women and their families, may mean changing a few planks too many on the ship of the self. Breastfeeding creates a greater disruption to narrative identity than formula feeding does for these mothers. In order to support more young mothers to breastfeed, we need to research interventions that understand and support the mothers' own sense of good mothering.

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Appendix 1: Interventions and initiatives to support young or disadvantaged mothers in Sheffield (2012-2015)

Sheffield Doulas

Inclusion/support Criteria:

- Mental health issues
- Substance misuse
- History of domestic abuse
- Care leavers
- Learning disabilities
- Already receiving multiagency support and social isolation

The Doulas support the women in the antenatal, intrapartum and postnatal period with the emotional and physical support that they may require. Breastfeeding is a very key part of the support the doulas provide and they are given extensive training in promoting and supporting breastfeeding.

The Doula project works with the Midwifery services in Sheffield along with the voluntary and community organisations in order to promote healthier and more positive birth outcomes. The aims are to support women from disadvantaged and isolated backgrounds and make a difference. The project has been developed and replicated with support of the Goodwin Project which has successfully been running for over five years and has helped bring the caesarean section and intervention rates down and increased breastfeeding rates in the Hull area along with reducing smoking in pregnancy.

NSPCC Minding The Baby

Two year program, young vulnerable mums 14-25 years, to promote attachment, communication and babies' security, using a program of alternative visits every week between the social worker/ therapist and health professional (midwife, nurse or HV).

Inclusion/support Criteria:

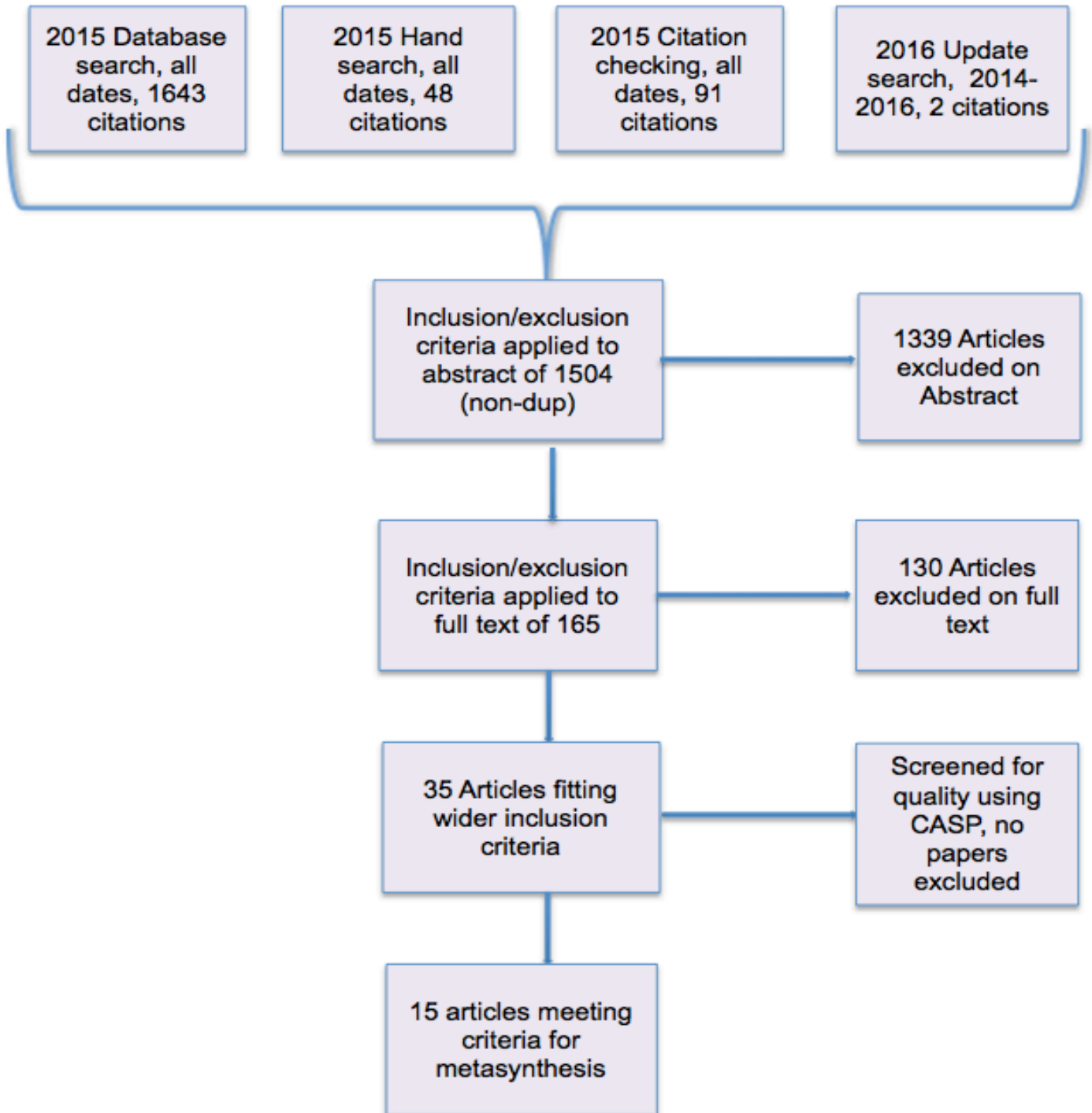
- Homelessness
- Teenage parent
- Asylum seeker (English speaking only)
- Learning difficulties
- Domestic abuse
- Alcohol abuse
- Mental health problems (depression)
- Care Leavers or Hx abuse

Family Nurse Partnership (FNP) Project

The FNP is a national program designed to support all first time young mothers aged 19 or under. All young mothers can opt into the project and will then get regular visits by a specially trained family nurse until the child is two. The family nurse supports the young mothers in all aspects of childcare, including infant feeding. More information can be found at <http://fnp.nhs.uk/about-us>.

Appendix 2: Literature search

PRISMA Chart of systematic and comprehensive literature search.



Databases systematically searched:

1. Assia
2. Anthropological Index Online
3. CINAHL
4. Cochrane Library
5. Embase
6. IBSS
7. Intermid
8. Medline

Journal hand searches

1. British Journal of Midwifery
2. International Breastfeeding Journal
3. Journal of Human Lactation
4. Midwifery

Table 6: Search term synonym table

OR↓

←AND→

Teenage*	Breastfeed*
Adolescen*	Lactation (see below)
Young mother*	Infant Feed*
Young parent*	Bottle Feed*
Young woman*	Artificial Feed*
Young women*	Formula Feed*

Table 7: Inclusion/Exclusion Criteria for meta-synthesis (from Mcdermott et al. 2004).

Parameters	Inclusion Criteria	Exclusion Criteria
Location	Global	
Language	Studies written in English	Studies not written or translated into English
Time Frame	All	
Population	<p>Studies which focus on or include women under 20-24 or a mixed population but with a focus on or relevance to young mothers and infant feeding.</p> <p>Studies on women who are pregnant or caring for one child or more.</p>	<p>Studies only with women who are 20 and over, or with no focus on young mothers/parents infant feeding.</p> <p>Women who are not pregnant or caring for any children.</p> <p>Premature or Low Birth Weight or unwell babies. Mothers with serious pathologies.</p>
Study Type	Primary research including meta-analysis or meta-synthesis.	Book reviews, opinion pieces, literature reviews, policy documents
Quality	Meets the relevant CASP criteria for the type of study.	Does not meet the relevant CASP criteria for the type of study.
Outcome	Studies concerned with teenage mothers and mothers-to-be own accounts and experiences of their breastfeeding and infant feeding practices.	Studies that focus on the assessment of an intervention to promote breastfeeding in young mothers.

Appendix 3: Research protocol inclusion and exclusion criteria

Inclusion Criteria

1. Pregnant
2. Aged 16-20 years old
3. Expresses an interest in breastfeeding and/or is willing to share opinions about infant feeding in general.
4. Reasonable command of spoken English (the study does not have the resources to provide interpreters)

Exclusion Criteria

1. Serious pathology of pregnancy or serious underlying medical problems (defined as any acute illness requiring intensive care or life limiting condition). This will be assessed and discussed with each potential participant's midwife and the researcher's supervisory team on a case-by-case basis.
2. Serious pathology or death of the infant at any point during the study. This includes birth before 34 weeks gestation, neonatal admission to the special care baby unit (SCBU) of over one week and pre-existing or pregnancy related maternal morbidities that require intensive care. Admission to the special care baby unit for a non-life limiting condition for a period of less than a week will not constitute criteria for exclusion.
3. Removal of this infant, or previous children, from the mother's care by social services.

Appendix 4: Participant observation guide and sample field notes

Sheet number:

Date:

Time:

Location:

Physical Environment

- Description and map of room:
- Context of Gathering (e.g. class, interview, informal meeting)
- Equipment present
- Public or Private?
- Relevant structures of access (e.g. staff only area or appointment only etc.)

Participants

- Count:
- Descriptions of dress and other accouterments
- Length of time each individual present
- Roles and signifiers of participants

Activities and Interactions related to infant feeding

- Frequency and duration of specific activities
- Symbols and Symbolic Language and Objects
- Non-verbal communications
- Language and interpersonal reactions

P3 PO

Arrived at the house - MV here. Grandma, Great-grandmother
+ sister all here, grandma doing laundry, sister cooking + go
sleep on the sofa > Elena in bed with the baby +
feeling well. House is tidy, warm + smell of cooking -
16 is bones our place, I saw her at her house the
first time. - Sister made me tea and cake!

Elena has a Venetian piano - with matching accessories in
the old style (the furniture are new) which
he will use like in with 6 months or so - new +
looks very fancy. Sister tidies up house for her

Wants drinks for MV to finish

Elena shows the flat with her boyfriend, but 2 up/2 down
place with a garden (is a semi detached, central or
ex council place in a poor but nice coming in
Shelton

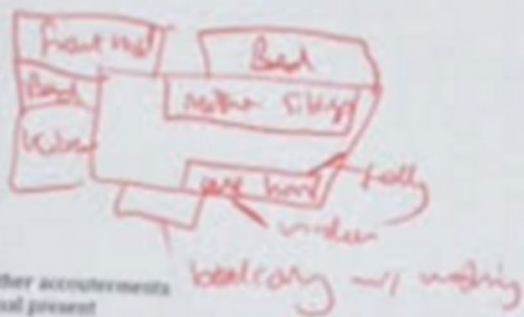
Saw Elena in her kitchen, really nicely done + nice
Baby had an orange cat (strong Lewis) with love +
Joys - a present from her mum.
Elena cuddled TL the whole time + he was very
engaged w, his mum

Physical Environment

Description and map of room
Context of Gathering (e.g. class, interview, informal meeting)
Equipment present
Public or Private?
Relevant structures of access (e.g. staff only area or appointment only etc.)

Location:

Small + crowded gr flat, living with parents (mother in law) 2 younger 1/2 siblings, older sisters in 2 bed council flat. Room was clean + tidy, sofa's entire side was over.



Participants

Count: 4
Descriptions of dress and other accoutrements
Length of time each individual present
Roles and numbers of participants

Mum in law, 2 kids + Mommah,

Appendix 5: Participant information flyer

Young Mothers and Infant Feeding In South Yorkshire A PhD Study



Hello, I'm Phoebe Pallotti and I'm a post-graduate research student at the University of Sheffield, in the Department of Public Health.

You are invited to be part of my PhD study about the infant feeding experiences of new mothers, who are under the age of 20.

My research is about young mothers experiences of infant feeding, in and around Sheffield. The aim of the study is to understand the things that influence how a mother chooses to feed her baby, and what help and support a mother finds most useful when they are making decisions about feeding their baby.

I am inviting some young mothers in Sheffield to get involved with the research, which will involve interviews and informal meetings at clinics and children's centers, and at home. If you have any questions, please call me on the number below, or email, Tweet or Facebook me any time. Further information can be found at: ***Infantfeedingsheffield.wordpress.com***

Phoebe Pallotti RM (Postgraduate Research Student)

School of Health and Related Research,
University of Sheffield,
Regent Court,
30 Regent Street,
Sheffield. S1 4DA.

Email: p.pallotti@sheffield.ac.uk

Tel: 0114 222 0700 (9am-5pm)



Phoebe Pallotti



@phoebepallotti

Appendix 6: Participant consent form

An Ethnography of Young Mothers' Infant Feeding Experiences in South Yorkshire

Phoebe Pallotti, ScHARR, University of Sheffield. p.pallotti@sheffield.ac.uk, 0114 222 0700.

Participant ID Name:

GENERAL CONSENT TO PARTICIPATION

Please **initial** the boxes

1. I confirm that I have read (or had read to me) and understand the information sheet dated 25th October 2013, version 3, for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. In addition, should I not wish to answer any particular question or to have a particular event recorded, I am free to decline.
3. I agree to my interview responses being digitally recorded, when permission is given at the time.
4. I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.
6. I agree to take part in the above study.

Phoebe Pallotti

Name of researcher

Date

Signature

Name of participant

Date

Signature

Copies:

A signed and dated copy of this consent form will be given to you at the beginning of the interview for you to keep.

Appendix 7: Participant information sheet

Project title:	An Ethnography of Young Mothers' Infant Feeding Experiences in Yorkshire
Chief investigator	Phoebe Pallotti
Research Supervisor	Dr Sarah Salway
Telephone number	0114 222 0700
Project Sponsor:	University of Sheffield
Sheet Reference	25 th October 2013, version 3

You are being invited to take part in our project. This information sheet is designed to give you information about that project so that you can decide whether or not you would like to be involved. Please take time to read and consider the information. Talk to others if you wish and feel free to ask for more information or clarification from us if you need it. Thank you.

Introduction:

Every mother has to decide how to feed her baby and many things may influence her choice. We know that many young mothers often choose to bottle feed their babies or, if they start to breastfeed, many stop after just a short time. We don't yet know enough about the things that influence young mother's decisions and whether they may need, or want, more support around infant feeding.

What is the purpose of the project?

By gathering information on what young mothers think and do about infant feeding we will better understand the things that influence infant feeding decisions. Findings will be used to develop better approaches to supporting young mothers with infant feeding, and to contribute to future research. This study is research undertaken by a Ph.D. candidate at the University of Sheffield

Why have I been chosen?

You have been invited because you are having a baby and you are 16-20 years old and live in South Yorkshire. Your midwife has given us your name because, after discussing the study with you. She feels that you may be interested in discussing infant feeding as part of this research.

Do I have to take part?

No. It is up to you to decide. We will describe the study and go through this information sheet, which we will then give to you. If you do want to take part, we will ask you to sign a consent form to show that you have agreed.

It is important to remember that you are free to withdraw at any time and without giving any reason. A decision to withdraw at any time, or a decision not to take part, will not affect your care from the midwives or other services in any way, and no one will question you further about the study.

If you want to take part, but there are things that you say or experience that you do not want the researcher to write down or use, then you can say so and the researcher will always do what you want.

What will happen to me if I agree to take part?

- Together we will plan a schedule of interviews, informal chats and observations of your journey through the last two months of pregnancy and when your baby arrives, until you begin to wean your baby onto food.
- The timings and locations of the interviews and observations will be to suit you, and will usually not require you to go anywhere that you would not normally be (baby clinics, at home etc.).
- We will collect some basic information from you (name, address, year of birth and some information about your family). This information will not be shared with anyone outside of the research team (Sarah and I), except in the unlikely case of serious child protection concerns.
- You will be asked to choose a name for yourself in the study, which will be what we use when writing anything about you down. At the end of the project, we may quote your words in final publications (such as academic journals), but always without identifying you by name or context.
- We will also ask you if you would like to follow me on Twitter, and to link your Facebook account to your Twitter account so that we can communicate using both websites. You do not have to do this, and you can still take part in the study without using social networking websites if you wish.
- At the end of the study, we will show you what information we have collected and ask you what you think of it. You will be given the opportunity to remove anything from the data record that you do not want to be included.

What will I get out of participating?

It is possible that there will be no direct benefit to you or your family. As a result of this study, we may be able to improve the support for young mothers in infant feeding in your area and inform future research about what support young women need for infant feeding.

We will offer you a small 'thank you' gift at the end of the study to acknowledge your important contribution.

Infant feeding can be a very emotional subject for some mothers, and it is possible that by telling us about your experiences as part of the study you may become upset. Support is available, as you request and you will always be treated with kindness and respect by the research team. **Your midwife can be contacted by calling 0114 2268301 (community office) or the mobile number she has given you.** You can also contact the breastfeeding peer support team by calling your local children's centre. The number for your local centre can be found at: <https://www.sheffield.gov.uk/education/information-for-parentscarers/care-support/childcare/childrens-centres.html> or by calling Sheffield City Council on 0114 2734567.

Will my taking part in this project be kept confidential? Who will know about the things I tell you in the interviews?

Everything that you tell us will be treated with strictest confidentiality. Nobody other than the project team will be told about the information you have provided. We would like to record some of the discussions using a tablet PC, so that we do not have to write everything down and to make sure that nothing you say is missed. We will always ask you before turning on voice recording.

After the interview, the recordings will only be listened to by researchers involved in the project and nobody else will have access to the recordings. We will make a written version of what is said during the interview. Neither your name nor any identifying information will appear on the written interview document or any written documents produced by the researchers. These materials will be kept in a locked cupboard and on an encrypted laptop and the recordings will be destroyed after the written document has been made.

Any reports or summaries that are made will not include any reference that could lead to identification of you or your family.

What will happen to the results of the Project?

At the end of the project a report of the findings will be presented to the University of Sheffield as part of the chief investigator's Ph.D. project. Findings of the study may also be published in academic and scientific journals. The results will also be presented to the midwives and other health professionals who provide care to young mothers in Sheffield.

Who is organising and funding the study?

The study is being organised and managed by a team of researchers from the University of Sheffield. The research is being funded by the CLAHRC SY as part of their Addressing Inequalities in Health Theme. More information can be found about CLAHRC at <http://clahrc-sy.nihr.ac.uk/>

Who has reviewed the study?

The research has been reviewed by independent peer review by senior researchers at the University of Sheffield and Sheffield Hallam University. All research within the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and granted a favourable opinion by South Central Berkshire B Research Ethics Committee.

What if I wish to complain about the way in which this study has been conducted?

If you have any cause to complain about any aspect of the way in which you have been approached or treated during the course of this study, you should contact the research supervisor in the first instance (Dr Sarah Salway, as below). You can also complain via the Sheffield Teaching Hospitals website at www.sth.nhs.uk at any time.

What if I have a problem or question about the study?

If you have any problems or questions arising in relation to the study you can contact Phoebe Pallotti on the number or email address below. She can call you back or arrange a time to come and see you and discuss your questions if you prefer.

Phoebe Pallotti, Postgraduate Research Student, School of Health and Related Research, University of Sheffield, Regent Court, 30 Regent Street, Sheffield S1 4DA. Telephone – 0114 222 0700. Email – p.pallotti@sheffield.ac.uk

Dr Sarah Salway, Senior Research Fellow, School of Health and Related Research, University of Sheffield, Regent Court, 30 Regent Street, Sheffield S1 4DA. Telephone – 0114 222 4296. Fax - 0114 272 4095. Email - s.salway@sheffield.ac.uk

Where can I find out more about the study?

The study website can be found at www.infantfeedingsheffield.wordpress.com

Thank you very much for reading this information sheet. A copy of this sheet is available for you to keep.

Appendix 8: Favourable ethical review



NRES Committee South Central - Berkshire B

Bristol REC Centre
Whitefriars
Level 3, Block B
Lewins Mead
Bristol
BS1 2NT

Telephone: 01173421331
Facsimile: 01173420445

24 October 2013

Ms Phoebe Pallotti
School of Health and Related Research (SchARR)
Regent Court
30 Regent Street
S1 4DA

Dear Ms Pallotti

Study title: **An Ethnography of Young Mothers' Infant Feeding Experiences in South Yorkshire with Digital Methods.**
REC reference: **13/SC/0567**
IRAS project ID: **136435**

The Proportionate Review Sub-committee of the NRES Committee South Central - Berkshire B reviewed the above application on 28 October 2013.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Miss Stephanie Macpherson, nrescommittee.southcentral-berkshireb@nhs.net.

Ethical opinion

- The Committee noted that this study will only concentrating on 5 - 8 participants over 6 - 8 months which would limit the data collected but agreed that the supervisors seem well qualified and were happy with the proposal.
- The Committee stated a statement to indicate that this study has received a favourable ethics opinion from the South Central- Berkshire B REC should be added to the PIS.
- The Committee stated that there should be an additional statement on the PIS to provide

the support contact details.

- The Committee noted that there may be some sensitive issues discussed but these are covered in sections A6-2 and A23 of the IRAS form and the Protocol.
- The Committee stated that there should be an additional statement in the PIS to indicate that some of the questions / interviews / discussion groups may cause the potential for distress.

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of

the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

1. Changes to the Participant Information Sheet (PIS):
 - a) Add a statement to indicate that this study has received a favourable ethics opinion from the South Central- Berkshire B REC.
 - b) Add a statement to provide the support contact details.
 - c) Add a statement in the PIS to indicate that some of the questions / interviews / discussion groups may cause the potential for distress.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The documents reviewed and approved were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Investigator CV	Sarah Salway	
Investigator CV	Phoebe Pallotti	
Investigator CV	Elizabeth Goyder	
Other: Project Registration		02 August 2013
Other: Participant Observation Guide		
Other: Independent Review		12 September 2013
Participant Consent Form: Consent Form	2	20 September 2013
Participant Information Sheet: Participant Information Sheet	2	20 September 2013
Protocol	3	19 September 2013
REC application		

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

There were no declarations of interest.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website. Information is available at National Research Ethics Service website > After Review

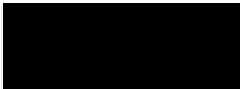
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Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



**Pp Dr John Sheridan
Chair**

Appendix 9: PPI feedback results sheet

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We talked to mums under 20 who *wanted to breastfeed* during their pregnancies and after the baby was born, including up until when they started solids. These mums said:

- They wanted more information on breastfeeding and valued their family's advice but found that they didn't know very many people who had breastfed.
- They wanted to breastfeed but also wanted other people to have the chance to feed the baby.
- Sometimes breastfeeding felt weird.
- Sometimes midwives and nurses were useful but sometimes they made things harder with feeding.
- All of the mums found it very embarrassing to try and feed out of the house, and sometimes at home there were too many people around to feel comfortable enough to breastfeed.
- The mums wanted their babies to sleep and found that they didn't sleep as well when they were breastfeeding.
- Babies were hungry and the mums worried that this meant they weren't getting enough from breastfeeding.
- Lots of the mums worried that they would not produce enough milk for their babies.

Appendix 10: Sample of the preliminary coding

Code	Page	Text
Work	8	
accommodation	12	
comments on other peoples feeding practices	4	
criticism of (other?) teenage parents	7	
FAMILY	11	..Formal Childcare
others 'having the chance' to feed	16	
asserting nascent mothering identity	18	..Delight in motherhood
'Genetics'	4	
sense of 'togetherness' in the family	86	
family ambiguity towards pregnancy/baby	8	
Importance of Family knowlege	70	
family babies	20	
Practical Contribution of family	60	
Importance of friends peer group	22	..Agency of Baby: being good/bad/greedy and prefer
involvement of other siblings or young c...	13	
Striving for independence from family	14	
Vicarious/Previous Experience of feedin...	40	..Delight in motherhood
Grandfathers (of baby)	23	..Cost and Resources 16
Grandmothers (of baby) 5	38	..Agency of Baby: being good/bad/greedy and pr
grandmothers feeding practices whe...	14	..Delight in motherhood
grandmothers 'taking over' the mater...	20	..mothers communication with baby
Dads involvement 6	32	
dads being pushed out by feeding	4	
comments about mens behaviour	13	..comments about mens behaviour
HCP 20	32	
Products and leaflets for Breastfeeding	5	
Knitted Breasts	4	
trust in midwives and other hcp	14	
First bottle by/because of hcp	8	
bounty packs	1	..Advice for fixed timings of bf
Refusing treatment or advice	6	..Missing Milk
hcps as a homogenous group	7	DEVELOPMENT OF BABY (incl. weight)
negative experiences with hcps	27	..negative experiences with hcps
Seeking GP advice	10	..missing milk Baby 'getting enough' 11
disturbance of feeding in hospital	5	..babies sleep patterns
Advice for fixed timings of bf	9	..Mothers sleep and exhaustion (or lack there)
Post-natal hospital support for bf	6	..Routine 1
LABOUR	22	..Seeking GP advice
birth impact on feeding	2	..Uncertainty about wellbeing and feeding
pain relief	4	EBM 19
Cost/status of baby equipment/performativ...	19	..need to measure the amount baby is getting
Isolation	1	
Isolation in hospital	10	
	2	Discussion about nurseries prior to recording:
	3	S: I think everyone, wi the nursery she goes in, will just be picking her up all the time, just like aww. Because they're all obsessed with little ones, aint they? And she's going in at three months, so she'll be the youngest one there.
	4	P: They'll all love her.
	5	S: I just put her on the mat all the time, we just put her on the floor, she's so cute lying there.
	6	Telling S about my work
	7	S: I'm still getting used to doing everything one handed (signing for receipt of voucher) with baby in her arms. Everytime I put her down, she gets really figity, so I pick her straight back up again. Usually, she'll be bang out, and I'll put her down and she'll be asleep for about two minutes and then she'll wake up again and start whining.
	8	P: Have you tried a sling?
	9	S: See, I were gonna get one, but she's too nosey, she likes looking round! I don't know which one to get. I might as well wait.
	10	P: There are sling libraries in Sheffield, I found the one I bought Lyra didn't like, but we had an old handmedown one that she loved.
	11	S: I'm finding that the things I'm buying whats quite expensive, she hates, but everything what I'm getting off friends she loves. I might as well just wait! My mums gone out and bought all these crackley toys, all sorts, she'd rather sit there looking at clouds. It's like, oh, but she's so good! She's obsessed with her dummy though. If she aint got a dummy in her mouth, that's it. She gets a right face on. Only time it ever falls out of her mouth is when she's in her cot, well in her moses basket asleep. Then she don't bother with it. Are you gonna get up and show her your eyes? (to baby). She's got gorgeous eyes, can't help but look at them when she's awake.
	12	P: They were really dark blue when I was last here?
	13	S: They've gone lighter, they're light blue in the middle then still right dark on the outside.
	14	P: Your's are blue, aren't they?
	15	S: Like a bluish-green, her dads are like a really crystal blue though. She's not really took after him much, thank god.
	16	P: She's the spit of you. So what was the HV's worry (referring to a previous conversation on the phone)?
	17	S: They came and they weighed her, and her last weighing what were a few weeks ago with the health visitor were 8lb4, ur, yeah, and then she's gone up to 8lb9, what I thought were quite a good, to say it were like 2, 3 weeks ago, but she turned round and she says oh, she's not put on enough weight, so just feed her every three hours and that, so I've got to wake her up in the middle of the night. She were like, just try waking her up a few times, I were like, right.
	18	P: Is she sleeping through.
	19	S: She's like, if she goes down about 7, she'll wake up about 12 and then usually about 5 and usually she's asleep till about 9. So it's like every 5 hours she wakes up through the night, but it's not bad, it just means I'm not getting up as much (laughs). So I'm always asleep, but I'm getting at least about 8, 9 hours a night. She's only, she's had one bad night in six weeks. That's it. And, she was sort of like, she was constipated for about six days, so I panicked and I were like, that's when we went to the doctors. And they said everythings fine, and that's when she had her bad night. But she's been alright since. So.
	20	P: Are you still expressing everythign for her?
	21	S: Yeah, I'm managing to express 4 or 5 ounces a time (P: brilliant). It's not bad, I managed to freeze like 7 bags and there's like 4 bottles in the fridge and I'm like, my dads like, why don't you just start selling it off to people you've got that much (laughs).
	22	P: People pay a fortune for it in America! There's no market for it here (both laugh).

Appendix 11: Glossary of abbreviations

BFI	Baby Friendly Initiative, UNICEF
CVD	Cardio Vascular Disease
HCP	Health Care Professional
IMD	Index of Multiple Deprivation
IQ	Intelligence Quotient
NICE	National Institute for Clinical Excellence
RCT	Randomised Controlled Trial
TNA	Thematic Network Analysis
UNICEF	United Nations Children's Emergency Fund
WHO	World Health Organisation