“It’s a relief to talk…”: Mothers’ experiences of breastfeeding recorded in video diaries

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Abstract: "It's a relief to talk…": Mothers' experiences of breastfeeding recorded in video diaries

Background: Despite breastfeeding providing maximum health benefits to mother and baby, many women in the UK do not breastfeed, or do so briefly. Using tenets of ethnography, this study aimed to explore the everyday experiences of first time breastfeeding mothers in the early weeks following birth.

Methods: Using a camcorder, five mothers captured their real-time experiences in a video diary, until they perceived their infant feeding was established. A multi-dimensional approach involving thematic analysis was developed to ensure that both the audio and visual elements of the data were analysed.

Findings: Three themes, significant to mothers were identified. First, how the camcorder empowered mothers to record their experiences '24/7', providing audiovisual insights into the socio-cultural context and embodied nature of breastfeeding. Embodying the camcorder enabled mothers to offload their thoughts, feelings and experiences in real-time, revealing an emotional rollercoaster. The second theme showed how the video diary provided a platform for mothers to work out how to survive their 'state of flux' with their breastfeeding baby. Deep personal reflection involved identity work and plans to get back to 'normal'. The third theme highlighted the complex nature of support including what mothers experienced when they felt under medicalised surveillance by the healthcare team, nurtured, influenced or undermined by family and friends, and when they sought information for themselves.

Conclusions: For the first time, this thesis reports on the 'unique presence of being there' to observe mothers' real-time everyday experiences of breastfeeding as recorded in their video diaries. It reveals the unique therapeutic role of the camcorder, the evolving nature of mothers' identities in the first few weeks after birth, the impact of commercialisation on breastfeeding and the negative impact of medicalised surveillance when healthcare workers scrutinised rather than supported breastfeeding mothers. Recommendations are made for practice, education, policy and further research.

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1 Introduction

1.1 Introduction

My interest in undertaking this study arose from a yearning to enhance my knowledge and understanding of what it is like to breastfeed, from mothers' perspectives. Having worked as a practising midwife and been a keen advocate of breastfeeding for many years, I have supported many mothers who have struggled with breastfeeding, some who gave up with huge personal regret. During this period, I worked with and trained breastfeeding peer supporters, enabling my local health service to offer a peer support group. I have also breastfed three children but experienced few challenges. My Master's degree used women's narratives of their lived experiences of breastfeeding to explore the impact of education on midwives' attitudes to breastfeeding (Taylor and Hutchings 2012). This provided enhanced insights into how listening and learning to the audio-visual elements of women's video interviews on 'the Healthtalk' website (Ryan and Alexander 2007), embraced both cognitive and affective learning, which was at the core of the attitudinal change amongst midwives. Along with an appreciation of the poor breastfeeding rates in the UK, I was keen to find out more from mothers' experiences of breastfeeding.

1.2 Organisation of the thesis

The chapters are divided into numbered sections. For easy cross referencing, the number in brackets will appear next to the text, e.g. (4.3). Although images have been used and therefore participants are not anonymous, pseudonyms have been used throughout this thesis.

Chapter 2 is the background and context to the study. I begin by exploring the evidence that underpins breastfeeding as a public health issue (2.2), then the infant feeding culture in the UK in relation to rates of breastfeeding (2.3), the political landscape that underpins initiatives and strategies to promote and

support breastfeeding (2.4), current evidence for early breastfeeding cessation (2.5), and finally my reasons for undertaking this study (2.6).

In Chapter 3, I provide a review of the literature using a meta-synthesis approach focusing on qualitative studies exploring women's experiences of breastfeeding published between 1999 and 2009 (3.1). I discuss how the literature search was conducted (3.2), the studies appraised (3.3) and then the findings (3.4) are arranged in four themes (3.5): 'emotional turmoil', 'producing a happy healthy baby', 'negotiating a new identity' and 'fitting in or falling outside of cultural norms'. I highlight gaps in research (3.6) before presenting my research question (3.7).

Chapter 4 is an in-depth discussion of the methodology, methods and an outline of the study design (4.2), my philosophical perspective (4.3) and theoretical framework underpinning the use of the video diaries (4.4). Discussing the methods (4.5) I provide details of the pilot study (4.5.1), recruitment onto the main study and participant profiles (4.5.2), ethical considerations (4.5.3), data collection (4.5.4) and analysis (4.5.5).

In Chapter 5, I present the first theme, 'But what I really wanted to tell you… mothers using the camcorder', which is split into two subthemes. In the first 'any time, any place' (5.2), I explore mothers' perspectives of using the camera to capture 'breastfeeding and filming 24/7' (5.2.1), 'the context of breastfeeding' in relation to the socio-cultural environment (5.2.2) and video footage which provides unique insights into the 'embodied nature of breastfeeding' (5.2.3). Discussing the second subtheme, 'embodying the camcorder', I demonstrate how mothers represented themselves in their own 'self- portrayal' (5.3.1), how mothers 'personified the camcorder' in order to talk to someone they had in mind (5.3.2), and how they embodied the camcorder in order to 'offload' their experiences 'in a rollercoaster of emotions' (5.3.3)

In Chapter 6, I discuss the theme 'Working it out'. In the first subtheme, I discuss how the mothers used the recording time to work out how to 'survive'

breastfeeding in the early days (6.2).This included working out a whole array of issues, including why their baby was always breastfeeding, how to survive night feeding, whether to try to establish a routine in their daily life, how to get a balance between work, rest and play, how to deal with problems and what breastfeeding paraphernalia they purchased. Surviving involved determination and resilience. In the second subtheme I explore how mothers sought to 'get back to normal' from 'their state of flux' (6.3). This involved identity work as they tried to work out who they were as breastfeeding mothers as well as the logistics of getting out and getting back to work.

The final theme, 'The Support Conundrum' in Chapter 7 analyses the daily challenges mothers faced in relation to breastfeeding support. In the first subtheme I explore how mothers perceived and dealt with being **'**under surveillance' (7.2)**.** This included when mothers felt supported and were 'on the right track' (7.2.1), when they felt 'scrutinised, judged and sabotaged' (7.2.2) and 'abandoned and alone' (7.2.3). In the second subtheme I discuss how mothers went about 'managing support from family and friends' (7.3) when they felt 'nurtured' (8.3.1), when well-meaning support compromised breastfeeding with the intention of assisting 'a new equilibrium' (7.3.2) and when they received support that they perceived as 'interfering opinion' (7.3.3). In the final subtheme 'the gap and filling it' (7.4), I demonstrate how mothers needed to answer questions and challenges by 'looking it up' (7.4.1) and 'reading more' (7.4.2).

In Chapter 8, I discuss five important areas alongside relevant up-to-date published international research literature that draws on the main themes. These five key areas included exploring the effect of 'Offloading: therapeutic use of the camcorder' (8.2), discussing the identify work mothers did in their 'state of flux and getting back to normal' (8.3), the effect of 'breastfeeding consumerism': 'essential paraphernalia' on mothers' breastfeeding experiences (8.4), the impact of 'the biomedical approach' on mothers (8.5) and the limitations of the video diary method.

Chapter 9 presents my conclusions (9.2), and key recommendations for clinical practice (9.3.1)., education (9.3.2) and research (9.3.3).

2 Background and Context

2.1 Introduction

My aim, to explore mothers' daily experiences of breastfeeding, was due to concerns about the poor breastfeeding rates in the UK and my passion to understand more about the experiences and challenges breastfeeding mothers face in the early weeks following birth. Here I will outline the context of this study including factors that inspired its design.

2.2 Breastfeeding as a public health issue

Research has consistently described human breastmilk as a dynamic living fluid because it not only contains species specific nutrients required for growth but thousands of bio-active molecules necessary for optimum transition from intra-uterine to extra-uterine life and healthy growth (Ballard and Morrow 2013; Hoddinott et al. 2008). It includes immunological, anti-inflammatory and antimicrobial factors which compensate for the baby's immature systems (Do Nascimento and Issler 2003; Labbok et al. 2004). Despite scientific developments in manufacturing formula milk, no nutritional substitute has replicated human milk.

There has been a plethora of research examining the benefits to mothers and babies of breastfeeding and/or risks to mothers and babies of formula milk feeding. Indeed a systematic review and meta-analysis commissioned by World Health Organisation (WHO) identified 60 new studies examining the long-term health benefits of breastfeeding in the six year time period between 2007 and 2013 (Horta and Victora 2013). Since most studies have been observational, (it would be unethical to assign some babies to formula and some to breastfeeding), critics have highlighted the methodological weaknesses particularly in relation to publication bias and confounding variables in high-income countries (Fewtrell 2011; Horta and Victora 2013; Ip et al. 2007). Despite these limitations the evidence is compelling, and demonstrates that breastfeeding is the optimal

choice for most mothers and babies (Hoddinott et al. 2008). Indeed, Entwistle (2013, p.19) goes as far as to say that “no other health behaviour has such a broad-spectrum and long-lasting impact on public health”.

Focusing on studies conducted in the UK or systematic reviews of the evidence, research has demonstrated that babies who are exclusively breastfed have a reduced risk of gastroenteritis (Fisk et al. 2011; Kramer and Kakuma 2012; Quigley et al. 2006, 2007), respiratory infections (Fisk et al. 2011; Howie et al. 1990; Ip et al. 2007; Quigley et al. 2007), ear infections (otitis media) (Abrahams and Labbok 2011; Fisk et al. 2011; Ip et al. 2007), eczema (Ip et al. 2007) and Sudden Infant Death Syndrome (SIDS) (Hauck et al. 2007; Ip et al. 2007). Generally the longer the baby exclusively breastfeeds, the greater the benefit (Kramer and Kakuma 2012). Additionally, short-term risk factors of formula feeding children under one year in England, have been highlighted in a government report examining the correlation between higher prevalence of breastfeeding with fewer hospital admissions for lower respiratory tract infections, infant feeding difficulties, wheezing, gastroenteritis, non-infective gastroenteritis, eczema, otitis media, infant feed intolerance, lactose intolerance and asthma (Department of Health (DOH) 2013a).

Systematic reviews and meta-analyses have also confirmed long-term benefits of breastfeeding associated with lower risk of high blood pressure, type 2 diabetes and obesity later in life (Horta and Victora 2013; Ip et al. 2007). Research has also demonstrated that breastfeeding increases cognitive development (Iacovou and Sevilla-Sanz 2010; Quigley et al. 2012) and IQ (intelligence quotient) in childhood and adolescence (Horta and Victora 2013).

Evidence that breastfeeding benefits the mother includes a reduced risk of ovarian and breast cancer (Ip et al. 2007). The World Cancer Fund (2007) recommended breastfeeding as one of the ten public health goals to reduce the risk of cancer. Breastfeeding helps to lower the risk of developing postnatal

depression (Dennis and McQueen 2009) and has a protective effect against stress, enhancing physical and mental wellbeing (Mezzacappa 2004).

Exclusive breastfeeding for the first six months, with breastfeeding continuing until at least 24 months alongside appropriate weaning foods, is recommended (Kramer et al. 2012; Department of Health 2003; World Health Organization 2003). The public health message appears to be reaching parents, as according to the national infant feeding survey:

> "Over four in five mothers said they were aware of the health benefits of breastfeeding (83%) and three-quarters (75%) were able to name a benefit spontaneously." (McAndrew et al. 2012, p. 68)

Nevertheless, breastfeeding comes under regular attack in the media. Fewtrell (2011, p.721) ,who received "research funding and performs[ing] consultancy work for companies manufacturing infant formula", disputes the evidence suggesting that methodological weaknesses do not provide convincing evidence for current recommendations in the UK. A number of papers published in the same vein including one in the *British Medical Journal* (Fewtrell et al. 2011) resulted in an attack on breastfeeding (BBC 2011; Hope 2011; Smith 2011). Mixed messages making headline news only serve to confuse parents who are living in a culture where formula milk feeding, is already more common (Renfrew 2011). In the next subsection I will describe briefly the introduction of commercially made formula milk and explore the cultural norm for infant feeding in the UK by examining both national and local statistics.

2.3 Cultural norms for infant feeding in the UK

After the introduction of National Dried Milk in the UK in 1941 as part of the Government's Welfare Food Service, the development, production and marketing of infant formula during the 1950s seriously challenged breastfeeding as the normal method of infant feeding (Crawley and Westland 2015). By the 1960s formula feeding was prevalent, and with aggressive marketing by commercial manufacturers of formula milk and free samples provided in hospitals, most

babies in the UK were fed formula milk in the 1970s.Thus for generations now it has been the cultural norm to use formula milk in a bottle to either exclusively or partially feed babies (Entwistle et al. 2011) and statistics continue to demonstrate this.

The most recent UK National Infant Feeding Survey revealed that many mothers either did not breastfeed, or did so for only a short time (McAndrew et al. 2012). Although initiation rates increased from 76% in 2005 (Bolling et al. 2007) to 81% in 2010, a substantial proportion of mothers (31%) had given their baby something other than breastmilk on the first day after birth, and less than half of all mothers (48%) were exclusively breastfeeding one week later (McAndrew et al. 2012). The numbers continued to drop with just over a quarter (27%) exclusively breastfeeding by six weeks, and a negligible number (1%) at six months (McAndrew et al. 2012), revealing poor compliance with the Government's recommendations to exclusively breastfeed for the first six months (Department of Health 2003). Despite these figures, longer-term trends are showing some improvements in the prevalence of breastfeeding in the UK so that at six weeks following birth, 42% of mothers were breastfeeding either exclusively or partially in 2000, 48% in 2005 and 55% in 2010 (Bolling et al. 2007; Hamlyn et al. 2002; McAndrew et al. 2012).

In the year quarter and the geographical area where most of the data were collected for this thesis, statistics indicated a 76% breastfeeding initiation rate, with 50.3 % of babies being totally or partially breastfed and 49.7% not breastfed at all at six to eight weeks (Department of Health 2013b). This means that more than half the babies were given formula.

The findings from both national and local surveys, particularly at six to eight weeks are similar, although there could have been inherent differences between one region and a whole nation. There are also limitations due to methodological differences (Callen and Pinelli 2004), because participants self-reported data to the National Infant Feeding Survey unlike the DOH integrated performance

return, which collated breastfeeding rates as reported by health professionals at the six to eight week health assessment (NHS England 2014).

Whichever report is considered, partial breastfeeding is in fact part of the UK's formula feeding culture. Hoddinott and colleagues (2010b) found that women were more likely to breastfeed if they had recently had a positive encounter with someone breastfeeding. Scott and Mostyn (2003, p. 270) highlighted the difficulties mothers faced when they were attempting to breastfeed within a "bottle-feeding" culture, because they were isolated, had no role models, were unprepared for the realities of breastfeeding, were embarrassed to feed in public and were pressurised to give a bottle by friends and family. UK surveys supported this latter point (McAndrew et al. 2012). Entwistle (2013) agreed that the prevailing UK formula feeding culture presents many challenges for breastfeeding mothers. This culture pervades society including the health service. In the next section I will explore the political landscape and how it has influenced breastfeeding promotion and support nationally, regionally and locally.

2.4 Political landscape, national, regional and local initiatives

In 1992, the Baby Friendly Hospital Initiation (BFHI) was launched globally by WHO and UNICEF with the aim to protect, promote and support breastfeeding (WHO 2009). It was introduced to the UK in 1994 at a time when entrenched healthcare practices supported a bottle feeding culture, and UK breastfeeding rates were one of the lowest globally (Renfrew et al. 2012b). Applying the 'Ten steps to Successful Breastfeeding' (WHO 1998) and the 'International Code of Marketing of Breastmilk Substitutes' (International Code) (WHO 1981), Baby Friendly Initiative (BFI) UK endeavoured to bring health services up to a minimum standard of evidence-based care to support breastfeeding, starting in hospitals from 1994 and then expanding to community services from 1998 and universities in 2005 (UNICEF UK BFI 2008). Services and institutions can select to undergo a staged assessment process and once they have met the required standards are fully accredited as 'Baby Friendly'. BFI standards in the UK were updated in 2012

(UNICEF UK BFI 2012b), but because this occurred after my data collection, the newer standards were not being applied at that time.

Positive evaluations of the impact of BFI on staff attitudes, knowledge and supportive practices for breastfeeding mothers (Cattaneo and Buzzetti 2001; Ingram et al. 2011), breastfeeding initiation (Bartington et al. 2006) and duration of breastfeeding (Broadfoot et al. 2005; Del Bono and Rabe 2012; Ingram et al. 2011) have been widely published. While causal effect cannot be determined, breastfeeding initiation rates have increased from 62 % in 1995, just after the start of BFI, to 81% in 2010 (McAndrew et al. 2012). Thus, although the National Institute for Health and Care Excellence (NICE) advised an economic analysis of BFI to compare it with different programmes or standards of care, the 'Postnatal Care' Guideline in 2006 and again in 2015, recommended that:

> "All health care providers (hospitals and community) should implement an externally evaluated structured programme that encourages breastfeeding, using the Baby Friendly Initiative [BFI] as a minimum standard." (NICE 2015, p. 7)

NICE has consistently recommended the need to encourage breastfeeding (NICE 2007, 2010a, 2010b, 2011, 2014b) and to use BFI as a minimum standard to support the mother-infant dyad in a wide range of guidelines (NICE 2008a, 2008b, 2014a, 2014c).

An economic cost analysis as suggested by NICE (2006, 2015) has not yet compared BFI with another programme. This might be because there is not another externally validated programme to compare it to. However, recognising the lack of breastfeeding as a significant public health issue, UNICEF UK commissioned an economic analysis to identify whether increasing the prevalence would create cost savings for the National Health Service (NHS) (Renfrew et al. 2012b). Using a robust approach, a large multi-professional team with diverse expertise, systematically reviewed, categorised research and calculated the potential costs of treating mothers and babies with health issues related to formula feeding. As a result it was found that a moderate increase in exclusive breastfeeding could save the NHS £40 million each year to treat five

illnesses associated with formula feeding (Renfrew et al. 2012b). The authors argued for greater investment in services that would increase prevalence of exclusive breastfeeding which would subsequently significantly reduce health inequalities and ensuing health costs (Renfrew et al. 2012b).

Despite recommendations by NICE (2006, 2015) it remains the decision of commissioners of health services to determine whether they invest in time and resources to meet the five-staged assessment process necessary for full accreditation. This means that it is still a 'postcode lottery' whether or not services meet UNICEF BFI standards. In this study, the two maternity units where mothers gave birth and the community services where mothers lived were all working towards BFI accreditation and had achieved stage 1, the third of the five-staged assessment. For this stage, all documentation, including policies, guidelines and a curriculum for training to achieve BFI accreditation had been assessed and approved. These services would have started staff training using the approved curriculum, but it is unknown how many staff had been trained at the time.

Over the last decade, successive governments have incorporated breastfeeding in national, regional and local strategies. Indeed DOH England, recognising that breastfeeding was one of the ten priority health outcomes most frequently cited by PCTs (Primary Care Trusts) in their strategic plans (DOH/ Department for Children, Schools and Families 2009), invested £7million between 2008 and 2010 in local services to support and promote breastfeeding including implementing BFI standards in hospitals, the community and within educational programmes for midwives and health visitors in universities (Entwistle 2013). Collaboration between maternity services and children's centres to provide peer support programmes, family support networks, and breastfeeding workshops were encouraged (HM Government 2010). During the period when this study was conducted, breastfeeding support services were available. Peer support groups were established in some children's centres and local clinics throughout the area. During pregnancy, breastfeeding workshops were available at the main hospital. Only mothers living in the main town (2/5 in my study), had access to a

breastfeeding support service that worked closely with the midwifery and health visiting service (Appendix 1).

Public health policy continues to underpin many of the breastfeeding support services available with some of the most recent strategies emerging from the 'health improvement' outcome named in 'A Public Health Outcomes Framework for England' (DOH 2012). Despite these strategies, both at national and local levels, mothers continued to face many challenges to breastfeeding in the early weeks and gave up breastfeeding and/or introduced formula before they felt they were ready (McAndrew et al. 2012; Renfrew et al. 2012a). In the next subsection, I will explore what the evidence suggests about early cessation of breastfeeding in the UK.

2.5 Early Breastfeeding Cessation

The UK national surveys suggest biophysical reasons why women are unable to sustain breastfeeding in the first two weeks of life including breast refusal, insufficient milk supply and painful breasts or nipples (McAndrew et al. 2012; Bolling et al. 2007; Hamlyn et al. 2002). Bates (1996) suggested that the reasons given by women to national surveys for discontinuing breastfeeding might have been a substitute for the real cause, because they were unable or unwilling to articulate the actual reasons, not wanting to look like a failure once a decision had been made. However, over 80% of these mothers wished to breastfeed for longer and some cited inadequate support from health professionals and family (McAndrew et al. 2012). Renfrew and colleagues (2012a) concurred, stating that many mothers would not need to give up breastfeeding if they had received better care and support when they had problems. Latham (2011, p.294), discussing human rights, argued that the main barriers to breastfeeding related to the *'*medicalisation of infant feeding' and inadequate support from health professionals. Battersby (2006) agreed that the medicalisation of infant feeding has triggered an innate belief in society that the female body cannot feed and sustain an infant without medical or technological solutions and that somehow

these solutions are scientifically better than breastmilk. This is substantiated with links, identified in the national infant feeding survey, between giving a supplement of formula feed in the early days and giving up breastfeeding altogether (McAndrew et al. 2012).

Research suggested that health professionals' support for breastfeeding can impact on whether mothers initiate and continue breastfeeding (Renfrew et al. 2012a; Swanson and Power 2005; Tarkka et al. 1998). McFadden and Toole (2006) proposed that women's experiences of breastfeeding can be improved by just one midwife offering support. However, health professionals' attitudes and opinions can hamper women's breastfeeding experiences leading to early cessation because they have been ambiguous, inconsistent, inaccurate, neutral or negative (Baxter 2006; DiGirolamo et al. 2003; McFadden and Toole 2006; Redshaw and Henderson 2012).

In a recent survey, The Royal College of Midwives (RCM 2014) stated that mothers continually cited inadequate support from health professionals as the reason for giving up breastfeeding before they had intended to. A survey of midwives, maternity support workers and student midwives, however, levelled the blame at commissioners and providers of maternity care for running an under-resourced "Cinderella service" (RCM 2014, p.9).

Examining different demographic variables, the National Infant Feeding Surveys have consistently highlighted lower socioeconomic group, deprivation, maternal age under 25 years, completing full-time education before 17 years and white ethnicity as factors associated with the lower initiation, prevalence and duration of breastfeeding or receiving breastmilk (McAndrew et al. 2012; Bolling et al. 2007; Hamlyn et al. 2002). These surveys, however, are only able to provide statistical links between the factors that impact on mothers' breastfeeding experiences without details of what these factors actually mean. Thulier and Mercer (2009), conducting a literature review on variables associated with breastfeeding duration in America, detailed a number of demographic, physiological, social and psychological issues. They emphasised the need for further research to focus on

the challenges that cause breastfeeding cessation before six months and to explore interventions that could support mothers to breastfeed longer. Latham (2011), suggested that other barriers to breastfeeding relate to the marketing of breastmilk substitutes and poor support for breastfeeding at work. Statistics in the UK in 2010, however, refuted the latter, suggesting that going back to work was less of a barrier to breastfeeding than it had been previously (McAndrew et al. 2012; Bolling et al. 2007), perhaps as a result of increased maternity leave and maternity payments (Smith 2010).

Other research has examined women's attitudes to breastfeeding using a quantitative approach, investigating biomedical or socio-demographic aspects (Greene et al. 2003; Ineichen et al. 1997; Scott et al. 2004). These studies, however, do not provide a detailed exploration of the multifaceted influences that affect women's infant feeding choices and experiences and the longer-term emotional consequences. This biomedical preoccupation has led to a rather restricted focus on breastfeeding outcomes, which Ryan and Grace (2001, p.495) suggested produces a "mechanistic, cause and effect approach", where a biomedical understanding appears to dominate discourse rather than women's embodied knowledge and experience. Indeed, there is a lack of evidence, about how breastfeeding fits into the daily lives of mothers and how the culture around them challenges breastfeeding on a daily basis. As Britton (2003) argued, breastfeeding is not a solitary incident that can be rationalised by scientific explanations and statistics alone but is socially constructed within the woman's social environment and set in a wider context. To date, research had not tapped into this socio-cultural environment to witness visually mothers' daily experiences of breastfeeding their first baby in the early weeks following birth.

2.6 Enhancing new understanding

Having an appreciation of the public health benefits of breastfeeding, the culture of bottle feeding in the UK, the political landscape and investment in strategies to support breastfeeding and the available evidence suggesting why mothers do not

continue breastfeeding fuelled my thirst for new knowledge and understanding. My literature review (Chapter 3) clearly indicated a gap, suggesting I needed to witness visually the multi-faceted nature of breastfeeding on a daily basis within mothers' own social environment to gain insights into the socio-cultural context of breastfeeding. These new insights would (a) provide an enhanced understanding of how lay supporters and healthcare workers can support postnatal mothers better and (b) enable commissioners and service providers to develop policy with mothers' real-time breastfeeding experiences at its core. This was the impetus for the research design using video diaries.

3 Literature Review

3.1 Introduction

This research is exploratory in nature, therefore a review of the literature using a meta-synthesis approach for qualitative research (Walsh and Downe 2005) was undertaken to inform the design and analysis of the study. The systematic search strategy helped identify relevant qualitative research. This was followed by an approach to synthesis that sought to juxtapose and combine descriptions and explanations from research findings, and use interpretation and re-analysis to create broader understandings (Jenson and Allen 1996; Pope et al. 2007) of women's experiences of breastfeeding within the UK. Meta-synthesis has been under scrutiny by some researchers, who warn that each qualitative study should be viewed as distinctive in all its fullness rather than summarised and interpreted together with other studies (Sandelowski et al. 1997). However, it was necessary to use this approach in my thesis to gain a holistic interpretation of mothers' experiences to identify gaps in knowledge and understanding.

3.2 Search strategy

To ensure the search strategy was systematic, initial inclusion and exclusion criteria were set (Table 1), and a tool for electronic database indexing was used.

3.2.1 Inclusion criteria and exclusion criteria

The principal focus of this review was research conducted in the UK and it needed to be written in English language. This initial literature review was undertaken in 2009, covering the previous 10 years to ensure that it was relevant in the context of rapid change in healthcare policy and provision in relation to support for breastfeeding women (Demott et al. 2006). International literature published since 2009 is discussed along with my findings in the Discussion (Chapter 8).

Inclusion criteria	Exclusion criteria
Breastfeeding (as the core concept)	Exclusive formula feeding – no breastfeeding
Mothers'/women's experiences	Not mothers' experiences of breastfeeding e.g. fathers'
Included first experience of breastfeeding	Only mothers with previous experience of breastfeeding
English language	Not English language
Study with qualitative design	Quantitative research study with no qualitative element
Study conducted in the UK	Conducted outside the UK
Published in peer reviewed journal	Not published in peer reviewed journal
1999 - 2009 inclusive	Before 1999 or after 2009

Table 1 Inclusion and exclusion criteria

3.2.2 Electronic search strategy

An electronic search strategy was employed in 'mySearch' through Bournemouth University's subscription covering journals and bibliographic databases including CINAHL Complete, MEDLINE Complete, ScienceDirect, SocINDEX, SPORTDiscuss, and JSTOR

Confidence in the search strategy was vital and therefore the 'SPIDER' (Sample, Phenomenon of Interest, Designs, Evaluation, Research type) tool for qualitative evidence synthesis (Cooke et al. 2012) was used. Boolean operators 'AND' and 'OR' were used to optimise the search along with truncation techniques to ensure that papers using similar words such as breastfeed, breast feed and breast-feed were not missed. However, despite carefully following the guidance for the SPIDER tool, the initial search produced an unmanageable body of evidence with 1,172 results. Thus, the tool was adapted with a different order of combining keywords which proved more effective with fewer irrelevant abstracts. With an emphasis on appraising peer reviewed papers only, 425 papers were retrieved, resulting in 250 individual abstracts (Chart 1). All abstracts were screened using

the inclusion and exclusion criteria (Table 1), leaving 25 papers. Further exclusions occurred because papers were either not relevant in content (topical screen) or to the research question (practical screen) and did not meet design suitability (methodological criteria) (Pate 2009). The names of key authors were individually searched to ascertain whether all the relevant research was located. Reference checking located two further studies, resulting in 27 qualitative research papers included in this review (Chart 1 and Appendix 2).

3.3 Critical appraisal of evidence

There is much debate in the literature as to how to appraise qualitative literature with various tools to assist this process (Critical Appraisal Skills Programme (CASP) 2013; Dixon-Woods et al. 2007; Sandelowski and Barroso 2002; Spencer et al. 2003; Walsh and Downe 2006; Yardley 2000). I used the updated version of the CASP tool for qualitative research (Critical Appraisal Skills Programme (CASP) 2013) alongside Walsh and Downe's checklist (2006) which provided extra prompts (Appendix 3). However, because prescriptive tools can exclude valuable contributions to the body of knowledge as researchers have been limited by journal requirements, word allowance and inappropriate use of research terminology (Sandelowski and Barroso 2002), apparently weak studies were included but appraised accordingly. No papers were so seriously flawed that they had to be excluded. During this appraisal process, key details of each paper were recorded on a table along with my appraisal including strengths and limitations (Table 6/Appendix 4). I then returned to the papers one by one together with the table, to analyse the key themes, using quotations when needed. This involved both descriptive and interpretive synthesis to see how key themes related or contrasted with one another.

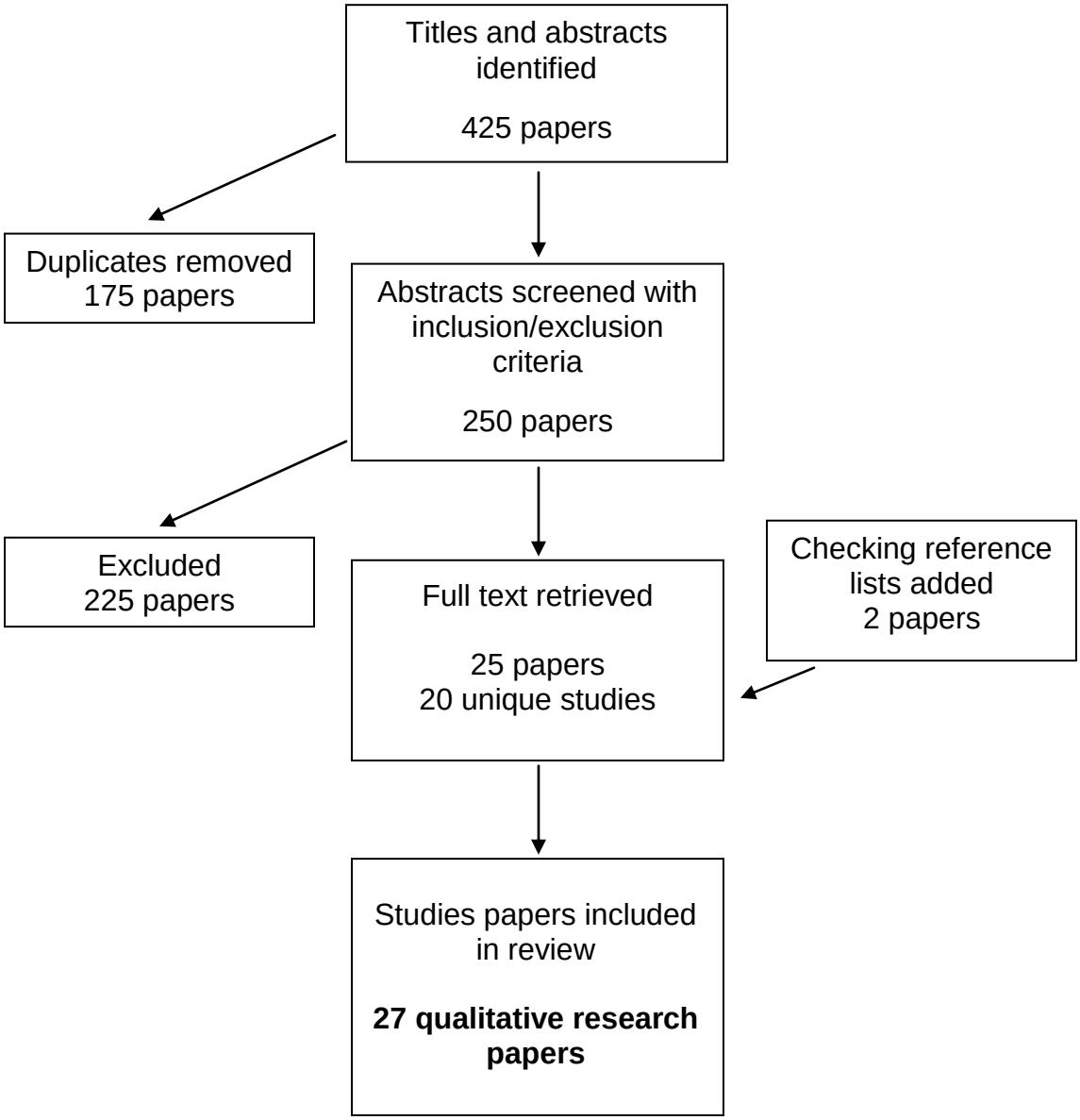


Chart 1 Flow chart showing searching and selecting the literature

3.4 Findings

Twenty-seven papers representing 22 qualitative studies exploring women's experiences of breastfeeding in the UK, published between 1999 and 2009 were included. Five studies were the subject of two papers each, mostly presenting different perspectives on the same study. While the quality and depth of the detail about the methodology varied in each paper, all included the basic components including purpose, participants, data collection methods, approach to analysis and ethical considerations. Only Crossley (2009) did not discuss the latter, possibly because this study was auto-ethnographic and involved the researcher herself alongside her partner and no other participants, but the absence of an ethical discussion is noteworthy.

While some studies were aimed specifically at exploring women's or parents' experiences of breastfeeding (Bailey et al. 2004; Bailey 2007; Dykes and Williams 1999; Dykes 2002; Dykes et al. 2003; Earle 2000, 2002; Hawkins and Heard 2001; Mahon-Daly and Andrews 2002; McFadden and Toole 2006) others explored women's experiences of infant feeding which included breastfeeding, formula feeding and a mixture of both (Murphy 2000; Pain et al. 2001). One study used the principles of "critical auto-biography" to reveal the author's own lived experiences of breastfeeding (Crossley 2009, p. 79). One paper reported specifically on the embodied experience of expressing breastmilk but did not include breastfeeding itself (Johnson et al. 2009). Other studies explored specifically how support influenced and affected women's infant feeding experiences (Cloherty et al. 2004; Dykes 2005a, 2005b; Hoddinott and Pill 1999, 2000; Sachs et al. 2006; Scott and Mostyn 2003; Simmons 2002). Two papers reported on women's experiences of breastfeeding whilst exploring the experience of postnatal dysphoria (Baker et al. 2005) or postnatal depression (Shakespeare et al. 2004).

The participants varied but always included women who were breastfeeding or who had some experience of breastfeeding. Sometimes studies explored experiences of breastfeeding from specific groups of women such as adolescents

(Dykes et al. 2003) or women of low socio-economic status (Hawkins and Heard 2001; Hoddinott and Pill 1999, 2000; Scott and Mostyn 2003). One included ethnic minority groups (McFadden and Toole 2006) and other papers included only first-time mothers (Bailey and Pain 2001; Bailey et al. 2004; Dykes and Williams 1999; Dykes 2002; Hawkins and Heard 2001; Hoddinott and Pill 1999, 2000; Johnson et al. 2009; Pain et al. 2001).

Although studies were initiated with different approaches coming from varying academic disciples such as geography, psychology, sociology, maternal and infant health, mental health, nutrition and medicine and used various methods to collect data, they were largely based on interviews (Appendix4), with two using focus groups (McFadden and Toole 2006; Scott and Mostyn 2003) and one using questionnaires (Graffy et al. 2005). These studies were all conducted in retrospect which arguably introduces an element of mothers' experiences having been reworked creating meaning after the event.

A number of studies combined interviews with observation in the clinical environment such as the postnatal ward and child health clinics, or community spaces such as peer support groups (Cloherty et al. 2004; Dykes 2005a, 2005b; Mahon-Daly and Andrews 2002; Sachs et al. 2006) or interactions between health professionals and mothers during postnatal or clinic appointments (Marshall et al. 2007). While data for these studies were collected in real-time and included observations, they did not capture audio-visual data that could be repeatedly observed for analysis. Furthermore, data were not collected in the participants' own homes without the presence and influence of a member of the healthcare team.

One study combined interviews with written diaries (Hawkins and Heard 2001) and one with audio-diaries (Johnson et al. 2009). Arguably, collecting data via written diaries also relies on retrospective memory (Cotton et al. 2010; Dinsmore 1996). While audio-diaries collect data in real-time and in the participants own home, the visual element was missing with no potential for observation. Thus,

there is need to visually capture mothers' experiences and 'meaning making' in real-time within their own socio-cultural environment and without the healthcare team's presence.

3.5 Themes

Four themes were discerned within the qualitative papers reviewed. The first was the 'emotional turmoil' that resulted from mothers feeling that they had a moral obligation to breastfeed. The second was about how mothers worked on 'producing a happy healthy baby'. The third was how women 'negotiated a new identity' by breastfeeding and how this was re-negotiated as their circumstances changed. The final theme identified how breastfeeding mothers 'fitted in or fell outside of cultural norms'.

3.5.1 Emotional turmoil

The 'breast is best' mantra created a feeling amongst women of moral obligation to breastfeed successfully, to be considered by themselves and by society as 'good mothers' dominated many studies (Bailey and Pain 2001; Bailey et al. 2004; Baker et al. 2005; Crossley 2009; Dykes 2005b; Earle 2000, 2002; Hawkins and Heard 2001; Johnson et al. 2009; Marshall et al. 2007; Murphy 2000; Shakespeare et al. 2004). Mothers expressed their desire to breastfeed recognising the biomedical advantages (Bailey 2007; Dykes 2005b; Hawkins and Heard 2001; Johnson et al. 2009; Marshall et al. 2007; Murphy 2000) with some acknowledging that benefits extended further than nutrition (Bailey 2007; Crossley 2009; Earle 2000; Hawkins and Heard 2001; Murphy 2000). Expectations about breastfeeding also included it being natural and easy (Dykes 2005b; Hoddinott and Pill 2000; Scott and Mostyn 2003; Shakespeare et al. 2004), 'unproblematic' (Hoddinott and Pill 2000; Marshall et al. 2007; Scott and Mostyn 2003), painless (Dykes 2005b; Hoddinott and Pill 1999; Shakespeare et al. 2004), and that it would increase the 'emotional bond' with the baby (Crossley 2009; Johnson et al. 2009) and produce happiness and contentment (Hoddinott and Pill 1999; Scott and Mostyn 2003).

Despite feeling a moral obligation to breastfeed, there was a dichotomy in the literature about mothers' intentions. Some suggested that mothers did not demonstrate full commitment to breastfeeding, expressing an initial 'give it a go' or 'try it' philosophy, revealing doubt because breastfeeding was thought to be difficult, to restrict freedom and could present problems (Bailey et al. 2004; Dykes and Williams 1999; Dykes 2002; Earle 2000, 2002; Hawkins and Heard 2001; McFadden and Toole 2006; Murphy 2000). Bailey and colleagues (2004), used the phrase "give it a go", on a study of 16 low-income women who realised the health benefits of breastfeeding, but most expected to fail due to problems out of their control. This suggested that the 'give it a go' philosophy was a self-protection measure where women could be seen to be 'trying' with a 'get out' clause when breastfeeding became too difficult. Similarly, McFadden and Toole (2006) conducted seven focus groups with 35 women, aged 17-40, in an area with high levels of deprivation and found that many made tentative decisions to breastfeed doubting their ability to succeed. Hawkins and Heard (2001) also found entrenched beliefs amongst mothers from low socio-economic groups that they would fail to breastfeed, because it was demanding, painful and they did not trust their body to produce enough milk. These studies recognised the pervading formula feeding culture that supported misrepresentations of breastfeeding and influenced women's decision making (Bailey and Pain 2001; Hawkins and Heard 2001; McFadden and Toole 2006). When breastfeeding was successful, however, a sense of surprise that it was not as difficult as anticipated and women experienced a sense of achievement (Dykes and Williams 1999) or enhanced emotional attachment to their baby (Hawkins and Heard 2001).

The 'give it a go' philosophy, was also demonstrated in interviews with a range of other socio-economic groups in two longitudinal studies (Dykes and Williams 1999; Dykes 2002; Earle 2000, 2002). Whilst claiming 'breast is best' for both child and mother, women experienced emotional turmoil from feeling that they may be considered "a horrible mother" by health professionals if breastfeeding was unsuccessful (Earle 2000, p. 327) and implied scepticism with their tentative answers of "I'll try anyway" (Earle 2000, p. 325). Additionally, women mistrusted

their own body's ability to breastfeed successfully and others had a strong need for privacy believing it to be embarrassing to breastfeed in front of people. For these mothers, it was an unrealistic method of feeding (Earle 2002) which was sometimes endorsed by health professionals (Dykes 2002).

Some studies suggested that mothers initiated breastfeeding under the duress of health promotional messages such as 'breast is best' but had not realised the realities of breastfeeding. Using interviews to explore antenatal expectations and postnatal experiences with 21 urban women with low incomes and low educational levels, Hoddinott and Pill (1999) revealed undue pressures from staff to commence and continue breastfeeding without adequate preparation and support. This was coupled with a feeling of secrecy because mothers perceived that health professionals and other breastfeeding mothers had concealed potential expectations in the first few weeks. Scott and Mostyn (2003) conducted focus groups with 19 breastfeeding women in a deprived area and concurred with Hoddinott & Pill (1999), suggesting that this 'cover up' meant that when women faced difficulties, their confidence was undermined and they felt they had failed. Additionally, a larger qualitative study involving 720 women completing questionnaires, agreed that the strong promotional message to breastfeed coupled with lack of realistic preparatory information, often felt more like coercion to the mothers than encouragement (Graffy et al. 2005). Perhaps mothers were set up to fail, because they had not been offered informed choice with a "true" picture of the realities of breastfeeding (Graffy et al. 2005, p. 182).

Conversely, other studies suggested that when mothers felt they had a moral obligation to breastfeed it came from within themselves, as well as pressure from society. These mothers were fully committed and passionate about breastfeeding, preparing beforehand by accessing multiple sources of information, believing it to be natural and easy, but they still met many unforeseen difficulties, which resulted in failure and subsequent feelings of guilt (Bailey and Pain 2001; Crossley 2009; Marshall et al. 2007; Pain et al. 2001; Shakespeare et al. 2004).

Bailey and Pain (2001) explored 11 first-time mothers' experiences of feeding using interviews and suggested that, despite mothers' best efforts, nothing could have prepared them for the realities of breastfeeding. This meant that women who failed, underwent the emotional turmoil of dealing with personal grief, loss and sense of failure, as well as dealing with "value judgements"' made by others (Pain et al. 2001, p. 266). Crossley (2009) used critical auto-biography to reveal her own lived experiences, highlighting the emotional turmoil she faced when breastfeeding. This included feeling the strong moral obligation to breastfeed in order to be "doing motherhood the right way", alongside the realities and tensions of contemporary society (p. 76). Her partner, the baby's father audio-recorded a "dialogical interview" to stimulate discussion, introspection and reflection related to her breastfeeding experiences (Crossley 2009, p. 74). Arguably, using her partner in this way may have caused tensions particularly as conflicting ideals were already apparent. With data collected retrospectively, after breastfeeding had ceased, Crossley (2009) admitted that both she and her partner, found it difficult to recall actual details. This study represents just one British woman's individual experience of breastfeeding, and with minimal information to explain her analysis; the findings need to be read with caution. Interestingly, she challenges the reader to judge its validity against their own and other people's breastfeeding experiences. Indeed, the emotional turmoil around difficulties or when giving up were also described in other research. This included expressions of failure (Hoddinott and Pill 2000; Shakespeare et al. 2004), guilt (Bailey et al. 2004; Marshall et al. 2007; Shakespeare et al. 2004), isolation (Dykes and Williams 1999; Hoddinott and Pill 2000), depression (Shakespeare et al. 2004), reduced emotional attachment to the baby (Shakespeare et al. 2004), and feelings of being a bad mother (Hoddinott and Pill 1999; Marshall et al. 2007; Shakespeare et al. 2004) resulting in reduced confidence and self-worth (Hoddinott and Pill 1999; Marshall et al. 2007; Shakespeare et al. 2004).

This theme suggests that most women who start feel a moral obligation to breastfeed because 'breast is best'. However, some do this with ambivalent feelings that they will 'give it a go' but anticipate difficulty beyond their control and

thus are ‘ready’ to give up. Other women responding to the health promotional message, thinking it is natural and easy, stumble at the first hurdle, being unprepared for the realities, which in turn sends them into emotional turmoil. Some prepare themselves for the challenges of breastfeeding but still meet unexpected realities which result in difficulties causing emotional turmoil and self-blame. The UK statistics show that mothers who exclusively breastfeed beyond the early weeks are a minority (Bolling et al. 2007; McAndrew et al. 2012); this could explain why there is little evidence of successful breastfeeding in the studies reviewed. Thus there is a gap in our understanding about whether women who do manage to breastfeed experience the emotional turmoil described above. It would be necessary to follow mothers on a daily basis to witness any emotional turbulence they experience and how they deal with it. It would enhance our understanding further if we could find out how mothers who do continue breastfeeding reconcile any turmoil they feel.

3.5.2 Producing a happy healthy baby

Many studies suggested that the moral obligation to breastfeed felt by mothers was driven by their aspirations to produce a ‘happy, healthy baby’ (Bailey 2007; Crossley 2009; Dykes 2005b; Earle 2000; Hawkins and Heard 2001; Johnson et al. 2009; Marshall et al. 2007; Murphy 2000). The meaning of a ‘happy, healthy baby’, however, was frequently challenged by significant others, particularly if breastfeeding was incessant, weight was not gained or baby’s behaviour was unsettled (Marshall et al. 2007). Then women looked for credible reasons for their baby’s unpredictable behaviour, such as feeding in a strange environment or growth spurts (Marshall et al. 2007).

Perceived happiness of a baby was directly related to the baby’s behaviour and became a critical factor in determining mothers’ self-esteem and confidence (Dykes and Williams 1999; Dykes 2005b; Dykes et al. 2003; Hawkins and Heard 2001; Hoddinott and Pill 1999; Marshall et al. 2007). For most mothers to feel confident that breastfeeding was successful, their babies needed to be “good, passive and docile”, “not too demanding” (Dykes 2005b, p. 2289) “contented and

sleeping" (Hoddinott and Pill 1999, p. 562), establishing a routine with signs of early independence and potential separation from mother (Dykes 2005b). Mothers therefore rapidly lost confidence in breastfeeding if they perceived their baby to be unhappy because they were feeding frequently, crying and staying awake, or using their breasts as dummies for comfort instead of food (Dykes 2005b; Dykes et al. 2003; Hawkins and Heard 2001; Hoddinott and Pill 1999; Marshall et al. 2007; Murphy 2000).

Frequent crying or feeding were cited by mothers as signs that their baby was hungry and thus they were not producing enough milk or that the quality of the milk was inadequate (Dykes and Williams 1999; Hawkins and Heard 2001; Hoddinott and Pill 1999; Marshall et al. 2007; Murphy 2000).This perceived inadequate milk supply was sometimes endorsed by health professionals (Dykes 2005b; Marshall et al. 2007). Only the small minority of mothers who deemed themselves successful recognised that frequent feeding was a positive sign because it resulted in more milk being available (Dykes and Williams 1999). Whilst Hawkins and Heard (2001) suggested that women need to be informed that frequent feeding is a normal newborn strategy for sustaining an ample milk supply, Marshall et al. (2007) noticed that mothers found it disconcerting to be told that frequent feeding is normal, as it suggested that this behaviour might be permanent. Explanations about growth spurts were far more acceptable as they suggested a temporary state of frequent feeding, providing reassurance that this was healthy but not permanent (Marshall et al. 2007).

The contented, happy baby was not just important for a mothers' self-confidence but also could be proudly presented to family and friends as a sign that she was able to satisfy her baby through breastfeeding (Hoddinott and Pill 1999). Conversely, if the baby was unsettled, it would be enough to prompt ambiguous and disparaging comments about breastfeeding from her social circle, further undermining her confidence in breastfeeding (Marshall et al. 2007). Indeed, despite including women from a range of socio-economic and ethnic backgrounds Marshall and colleagues (2007) found mothers in emotional turmoil

with competing pressures. They felt judged as a ‘good or bad mother’ by professionals who “equated breastfeeding with a healthy baby” (Marshall et al. 2007, p. 2150), and their family and friends who needed to see a “contented and thriving” baby as demonstrated by the baby’s behaviour (Marshall et al. 2007, p. 2158). This sometimes resulted in mothers adjusting conversations to suit whoever was listening to them (Pain et al. 2001).

Thus, mothers needed observable evidence that breastfeeding was not just producing a happy baby but a healthy one too, which meant growing. Mahon-Daly and Andrews (2002) realised that the main reason mothers attended the child health clinic was to weigh their baby. Several studies reported on mothers’ emphasis on baby’s weight gain as the decisive factor indicating whether breastfeeding was working (Bailey 2007; Crossley 2009; Dykes and Williams 1999; Dykes 2002; Marshall et al. 2007). With a particular focus on the practice of weighing babies and its effects on breastfeeding, Sachs et al. (2006, p. 5) noted the weight plotted on the growth chart was regarded as the “authoritative, definitive measure of infant wellbeing by both mothers and professionals”. Not putting on enough weight, or not following the centile curves caused mothers angst about their milk supply which was compounded when health professionals shared their anxiety and doubt or expressed empathy. Indeed studies demonstrated that the authority of the growth chart, coupled with reactions from health professionals, resulted in a range of measures being suggested to improve growth which were not always conducive to exclusive breastfeeding including introducing supplements of formula or solid food (Dykes and Williams 1999; Dykes 2002; Mahon-Daly and Andrews 2002; Sachs et al. 2006). With health professionals using weight surveillance as a quality control measure, Mahon-Daly and Andrews (2002) reported on how the biomedical discourse of breastfeeding threatened mothers’ confidence in breastfeeding. This resulted in mothers feeling that they had failed their babies by putting their health in jeopardy and the contradictory messages of ‘breast is best’ and ‘breastfeeding is failing’ caused further emotional turmoil and guilt (Mahon-Daly and Andrews 2002; Marshall et al. 2007).

Producing a happy, healthy baby while breastfeeding was very challenging for many mothers who felt a huge sense of responsibility (Crossley 2009; Marshall et al. 2007; Murphy 2000). This meant that they needed to make judgements in the 'here and now' because their baby's perceived happiness (Murphy 2000) or being a healthy weight (Crossley 2009) was more important than the apparent risks of formula feeding. This resulted in a reassessment of their perspective on infant feeding. When this occurred, endorsement by expert opinion from a health professional (Murphy 2000), or personal support from a family member (Crossley 2009) was particularly valued, perhaps because it made mothers feel less guilty and less solely accountable for the decision making. Nevertheless it also required a reappraisal of their identity as a mother. This was because 'good mothering' for many meant that breastfeeding was going well and babies were happy and healthy whereas 'bad mothering' was an unhappy baby or a lack of weight gain which undermined their confidence in breastfeeding (Marshall et al. 2007).

To enhance support for breastfeeding mothers, we need to understand better the detail of the daily challenges that mothers face in relation to producing their 'dream baby' who is 'happy and healthy'. There is a gap in the literature that provides us with real-time evidence of how mothers respond on a daily basis to their family and friends when they feel under pressure to produce a baby that behaves in a 'happy and healthy' way, especially when they perceive that this is not happening. Furthermore, although there is strong evidence that the biomedical approach to infant feeding can negatively affect mothers' confidence, there is a lack of knowledge as to how mothers respond to the medicalised approach in real-time. Providing these insights will enhance our understanding of how mothers make meaning of the pressures and challenges they feel on a daily basis.

3.5.3 Negotiating a new identity

As mothers dealt with the unexpected challenges relating to the realities of breastfeeding they negotiated a new identity, which involved considering their status as breastfeeding mother. All studies suggested that mothers either carried

on breastfeeding through sheer determination or their perspectives on infant feeding changed, and they moved to formula milk. One of the main reasons for discontinuing breastfeeding in the first week cited in successive National Infant Feeding surveys was ‘painful breasts or nipples’ (Bolling et al. 2007; Hamlyn et al. 2002). This was lived out by women in some of the studies reviewed (Dykes et al. 2003; Johnson et al. 2009; Pain et al. 2001) and was described as ‘extreme pain’ when bleeding nipples were experienced (Murphy 2000) and affected infant/mother attachment (Shakespeare et al. 2004).

Dykes (2005a, pp. 2288–9) suggested that breastfeeding mothers on the postnatal ward often felt challenged because of the unpredictable and time consuming nature of breastfeeding, with loss of freedom and independence, creating a dislike of the intense mothering that appeared to infringe on their “spatial” and “temporal boundaries”. This corresponded with Cloherty and colleagues (2004) who noticed that some mothers changed their views of infant feeding in the first few days after birth, offering supplements of formula because of exhaustion and the frequency and time consuming nature of breastfeeding. Exhaustion and tiredness were mentioned by all social groups as an unexpected yet ongoing problem related to strong feelings that breastfeeding was time intensive (Bailey et al. 2004; Dykes et al. 2003; Graffy et al. 2005; Marshall et al. 2007; Shakespeare et al. 2004).

These factors, which did not fit with the fast pace of contemporary living, were not expected by women and therefore were all reasons to review their new identities as breastfeeding mothers (Dykes et al. 2003; Graffy et al. 2005; Johnson et al. 2009; Mahon-Daly and Andrews 2002; McFadden and Toole 2006; Pain et al. 2001; Shakespeare et al. 2004). Adolescent mothers reported feeling “out of control”, being particularly vulnerable when the frequency of feeding did not match their expectations (Hoddinott and Pill 1999, p. 562). Shakespeare et al. (2004) explored breastfeeding difficulties by drawing on interview data collected from women with probable postnatal depression. With a strong commitment to succeed, 15 of the 37 women who initiated breastfeeding reported unexpected

difficulties. It is important to recognise these data are retrospective, relying on women's memories during a particularly emotional time in their lives, but noteworthy that they also reported feeling "out of control" and "failing as mothers" (Shakespeare et al. 2004, p. 256). These unexpected difficulties did not match the image of their new identity as a "good mother" with a "perfect little baby" who slept through the night (Shakespeare et al. 2004, p. 255).

Feeling out of control and yearning for time away from their baby often resulted in mothers re-evaluating their perspectives on infant feeding and their identity as breastfeeding mothers (Earle 2000). Sometimes, this meant putting strategies in place to overcome the moral dichotomy of good and bad mothering and to regain some control over feeding by providing breastmilk in a bottle rather than using formula (Johnson et al. 2009). Dykes (2005b, p. 2290) noticed this occurring before discharge from hospital, with women suggesting expressing as a method of getting back to "normal life". Johnson et al. (2009) suggested that women used expressing to negotiate a myriad of issues to resolve and control their new identity as breastfeeding mothers. These included managing pain; quantity control by measuring breastmilk when "inefficiencies of the maternal body" were suspected; maintaining a "sense of bodily control" by speeding up the feeding process with electric pumping; enabling flexibility to feed in company of others; and as a method to gain independence away from the baby to cope with the realities of contemporary life (Johnson et al. 2009, pp. 903–5).

Negotiating a new identity which maintained their status as breastfeeding mothers but enabled freedom meant that expressed breastmilk in a bottle could be given by a significant other (Bailey et al. 2004; Bailey 2007; Dykes et al. 2003; Earle 2000; Johnson et al. 2009; Marshall et al. 2007; Pain et al. 2001). Marshall and colleagues (2007) suggested that juggling the everyday activities of contemporary life caused mothers to go to extreme lengths to maintain their new identity as breastfeeding mothers. Sharing responsibility for feeding therefore was considered important for many to reduce the feelings of being restrained by the baby, maintaining some life balance and providing more control in their new

identity as a breastfeeding mother (Bailey et al. 2004; Bailey 2007; Dykes et al. 2003; Earle 2000; Johnson et al. 2009; Marshall et al. 2007). Furthermore being part of the feeding team was rewarding for fathers (Bailey 2007; Marshall et al. 2007).

Putting strategies in place to cope with the demands of feeding meant that some mothers resorted to formula feeding or mixed feeding, causing their perspectives about infant feeding to change. Re-negotiating their new identity as formula feeding mothers came at a price, as studies suggested that mothers often felt they had failed and subsequently experienced a deep sense of guilt and emotional turmoil (3.5.1). Crossley (2009), identified an identity crisis where internal conflict occurred. This tension was between feeling a moral obligation to become a good mother by abandoning her sense of control and trusting in her ability to breastfeed and a yearning to take control and get back to her former identity, comprising of an orderly life and an athletic body. When she finally ceased breastfeeding this caused emotional turmoil with feelings of failure and guilt mixed with a "secret sense of relief" (Crossley 2009, p. 84).

Murphy (2000) conducted 12 interviews to explore how mothers dealt with threats to their identities as 'good mothers' because of their infant feeding choices. The author suggested that women's choices about infant feeding are initially manipulated by scientific discourse relating to health risks associated with formula feeding. This paper highlighted some important issues that new mothers faced as they tried to negotiate failure to breastfeed by dealing with their own distress, as well as being called to account for their decisions by others. Murphy (2000) claimed that mothers defended their introduction of formula milk to preserve their identities as good mothers. Reasons included ensuring their distressed baby was happy and content replacing any previous concerns about preventing future illness through breastfeeding; exceptionally unusual situations beyond the mothers' control; having a physical inability to produce milk and blaming others. By rationalising decisions in this way, mothers re-negotiated their identity by protecting themselves from accusations of being selfish or

irresponsible, becoming the victim of circumstance, rather than the guilty mother (Murphy 2000).

This theme presents findings that demonstrated how women negotiated their new identities as breastfeeding mothers which sometimes had to be renegotiated to meet the realities of their breastfeeding experience. Much of the evidence in this review was based on observing unexpected crises such as maternal exhaustion on the postnatal ward, or retrospectively at interview when mothers would have had opportunities to rethink and rework their identities in relation to their changing circumstances. Some real-time data through audio-diaries produced some valuable insights as to how mothers renegotiated their identities by expressing breastmilk. This literature review has exposed a gap in knowledge and understanding about how mothers' identities evolve in real-time on a daily basis without a specific focus on expressing breastmilk. Studies suggested that mothers experienced emotional turmoil when their identities changed. The extent and frequency of the emotional turmoil on a daily basis is not evident from this review of the literature. Audio-visual evidence collected on a daily basis would enhance this understanding.

3.5.4 Fitting in or falling outside of cultural norms

Breastfeeding mothers found themselves constantly fitting in or falling outside of cultural norms associated with infant feeding.

Due to a well-known association between higher breastfeeding rates and women from higher socioeconomic and educated groups (Bolling et al. 2007), some mothers experienced stereotyping where they felt wrongly identified and labelled by value judgements made by health professionals about infant feeding. Dykes et al. (2003), exploring adolescent mothers' experiences of breastfeeding found that health professionals assumed they would be bottle feeding. Conversely, Bailey and Pain (2001, p. 311), calling it "peer group coercion", suggested that professional women experienced overwhelming unspoken pressures to breastfeed, producing an enormous sense of guilt if they failed. Murphy (2000)

alluded to the same pressures suggesting that mothers feared judgement from their own social circles if they admitted to not breastfeeding.

The culture within the mothers' families and social networks significantly impacted on their experiences of breastfeeding. The more exposure to, experience of and embodied knowledge about breastfeeding that they could tap into from family, friends or peer supporters, the greater the chance of a successful outcome (Bailey 2007; Hoddinott and Pill 2000; Scott and Mostyn 2003). Having a good role model and valuing embodied knowledge of breastfeeding over theoretical knowledge, was likened by Hoddinott & Pill (2000, p. 230) to "apprentice style learning". Successful breastfeeding was much easier if mothers fitted into the cultural norm so that they could draw upon the experience and expertise of other breastfeeding mothers. Dykes and Williams (1999) found that positive affirmation and encouragement from their own mothers with personal experience of breastfeeding had the biggest impact on mothers' self-confidence and continuation. Similarly, Marshall and colleagues (2007, p. 2157) found that mothers increased their confidence by accessing support from "allies" with breastfeeding experience. Bailey and Pain (2001) suggested that the persistent formula feeding culture that is passed from generation to generation within some families negatively influenced mothers' confidence in breastfeeding; if they did initiate breastfeeding they fell out with their cultural norm. This meant that mothers soon switched to formula feeding because that was what was familiar and known. Hawkins and Heard (2001) concurred, that mothers had faith in formula feeding because it was their cultural norm. Mothers without positive breastfeeding influences within their families were often surrounded by a culture of formula feeding (Bailey and Pain 2001; Bailey 2007; Hawkins and Heard 2001; McFadden and Toole 2006; Scott and Mostyn 2003). This resulted in formula feeding rules being applied to breastfeeding such as scheduling feeding and establishing a routine, which were counterproductive for successful breastfeeding and ended in early weaning (Bailey and Pain 2001; Dykes and Williams 1999; Dykes 2005b).

Studies reported that breastfeeding mothers described their sense of isolation, if they fell outside the cultural norm, because everyone else was formula feeding around them (Bailey et al. 2004; Murphy 2000; Scott and Mostyn 2003). These experiences were felt by women early in their breastfeeding journeys on the postnatal ward, feeling ‘unusual’ because they were the “lone breastfeeder” (Bailey et al. 2004, p. 246). Scott and Mostyn (2003) conducting a qualitative evaluation of peer intervention found that most of the Glasgow women recruited were the first known member of their families to breastfeed. Falling outside the cultural norm meant that they were (unwittingly) subjected to undermining attitudes from family and friends which sometimes involved advice which was intended to be supportive but often was perceived to be judgemental and critical (Scott and Mostyn 2003).

Many studies distilled the theme of breastfeeding in front of others noting tensions between breasts being publicly viewed for sexual pleasure and the private nature of breastfeeding with many mothers feeling a huge sense of embarrassment or revulsion at the thought of anyone seeing them breastfeed (Bailey and Pain 2001; Dykes et al. 2003; Earle 2000, 2002; Hawkins and Heard 2001; Hoddinott and Pill 1999; Ingram and Johnson 2009; McFadden and Toole 2006; Pain et al. 2001). Mahon-Daly and Andrews (2002) observed mothers in the postnatal clinic performing rituals to ensure they positioned themselves in a way that ensured privacy during breastfeeding. Whilst this might have been to gain some intimacy with their baby, it appeared that even in the supposedly safe confines of the postnatal clinic, breastfeeding in front of others felt culturally abnormal. Indeed, mothers felt tensions in their own homes because of the overwhelming embarrassment of breastfeeding in front of family and friends, particularly males (Bailey and Pain 2001; Mahon-Daly and Andrews 2002; McFadden and Toole 2006).

Mothers from low socio-economic groups appeared to be particularly challenged by breastfeeding in front of others, perhaps because most mothers were formula feeding around them. Two studies suggested that embarrassment was a key

factor in giving up breastfeeding altogether because of the restrictions it posed on everyday activities (Hawkins and Heard 2001; McFadden and Toole 2006). Hoddinott and Pill (1999) found that mothers isolated themselves by keeping breastfeeding a secret, rarely discussing it even with family and friends. Thus for many mothers, feeding in public was completely out of their cultural norm and they went to extreme lengths to maintain privacy, by using public toilets or baby changing areas or avoiding going out altogether causing further isolation and restricting exposure to other breastfeeding mothers (Earle 2000; Scott and Mostyn 2003). Managing feeding in public by expressing and using breastmilk in a bottle became a practical solution for some (Johnson et al. 2009; Scott and Mostyn 2003). Once some had gained experience and confidence in breastfeeding, they realised their isolation was self-inflicted and breastfeeding in public was not their problem but that of those who disapproved (Scott and Mostyn 2003). These mothers persevered, sensing but ignoring disapproval (Bailey and Pain 2001), and a small number reported being unperturbed and ready to be challenged hoping that the more people who see breastfeeding in public, the more likely it will become everyone's cultural norm (Scott and Mostyn 2003).

The biomedical approach to support for breastfeeding mothers by healthcare workers was evident in many studies and described by Hoddinott and Pill (2000, p. 229) as "breastfeeding centred" rather than "woman centred". The way support was provided by healthcare workers could assist mothers to fit into the culture of breastfeeding or hinder the transition. Hospital ward culture, noted in many studies, suggested that mothers faced many challenging encounters with health professionals because of their medicalised power and authority (Baker et al. 2005; Cloherty et al. 2004; Dykes 2005a, 2005b; Graffy et al. 2005; Hawkins and Heard 2001; Marshall et al. 2007; Shakespeare et al. 2004; Simmons 2002). Baker et al.'s (2005, p. 315) paper "I felt as though I'd been in jail", explored the impact of care provided by maternity staff partly focusing on support for infant feeding. They found that breastfeeding mothers fell out of their cultural norm, because they felt under attack needing to defend themselves, or felt isolated and inadequate. This was because of staff attitudes and behaviour that were

controlling, intimidating, bullying and pressurising, or because they did not receive any support at all (Baker et al. 2005). Dykes (2005a), as a participant observer on the postnatal ward, witnessed time pressures on staff which affected how mothers felt about breastfeeding support, including mechanised ward routines, disengaged communication, little individualised support and limited, rushed information. Furthermore a number of studies identified the way mothers felt particularly out of their cultural norm, when health professionals invaded their personal space by touching their breasts to provide hands-on support with attachment and positioning (Dykes 2005a; Hoddinott and Pill 2000; Marshall et al. 2007; Murphy 2000).

Mothers, who were supported to fit into a new cultural norm of breastfeeding talked about health professionals building up a relationship with them, taking time to listen to their feelings, being non-judgmental and encouraging, observing feeding, providing practical individualised support and information, esteem building with positive affirmation and showing empathy. When this occurred, women felt valued as breastfeeding mothers and they were encouraged to continue (Dykes 2005a; Dykes et al. 2003; Graffy et al. 2005; Hoddinott and Pill 2000; Marshall et al. 2007). Scott and Mostyn (2003) found that a peer support service was invaluable for mothers who had no friends or family with experience of breastfeeding. The empathetic encouragement from volunteers with the experience of breastfeeding was described by mothers as “a lifeline” (Scott and Mostyn 2003, p. 274).

Mothers continued to feel out of their cultural norm when receiving support following discharge from hospital by the healthcare team who used a medicalised approach within the child-health surveillance programme (Dykes and Williams 1999; Dykes et al. 2003; Mahon-Daly and Andrews 2002; Sachs et al. 2006; Shakespeare et al. 2004). Conflicting advice and opinions were a particular problem highlighted in many studies, causing confusion and mistrust of breastfeeding (Dykes and Williams 1999; Graffy et al. 2005; Hoddinott and Pill 2000; Marshall et al. 2007; McFadden and Toole 2006; Shakespeare et al. 2004;

Simmons 2002). The biomedical approach to support meant that mothers rarely talked about practices suggested by health professionals that supported the natural flow of breastfeeding. Rather they spoke more about practices that undermined breastfeeding, including using a bottle teat or nipple shield to tease the baby onto the breast (Graffy et al. 2005; Simmons 2002), and encouraging formula supplements for a 'perceived' hungry baby (Graffy et al. 2005; Hawkins and Heard 2001) or to improve infant weight gain (Sachs et al. 2006).

Recognising the power and authority imposed on them, some mothers used strategies to maintain control of their own decision making in relation to infant feeding, perhaps keeping themselves within their own cultural norm. This included deciding when and when not to seek support, (Hoddinott and Pill 1999; Shakespeare et al. 2004), lying to avoid conflict (Hoddinott and Pill 2000) and making considered assessments of advice before accepting or rejecting it (Marshall et al. 2007). Hoddinott and Pill (2000) noticed that mothers were often passive about seeking support, waiting for health professionals to offer it first.

The studies in this review have highlighted how mothers easily fell out of their cultural norm as most of their friends and family had no experience of breastfeeding, health professionals used a biomedical approach that was alienating, and feeding in public was embarrassing and sneered at by others. This suggests that mothers who continue to breastfeed face many challenges. To gain enhanced insights into how these challenges impact on mothers' daily experiences of breastfeeding, rather than a retrospective view, research needed to focus on the real-time experience of mothers.

3.6 Summing up the research

Much of the qualitative research exploring women's experiences of breastfeeding within the UK used retrospective interview data. Leff and colleagues (1994) argued that the reliability of such findings is dependent on women's memories and ability to recall their breastfeeding experiences including their thoughts and emotions felt at the time. It is valuable to gain a retrospective view on experiences

and it is insightful to see how long women's memories, emotions and feelings last (Hegney et al. 2008), however, these memories could be influenced by subsequent events, providing a different perspective on the experience from how it felt at the time. Indeed many studies included women who had given up breastfeeding who might well have had an altered view at the time of data collection, compared to how they felt when they were feeding.

Seven of the studies collected data contemporaneously, thus avoiding the necessity to rely on participants' memories. Cloherty and colleagues (2004) and Dykes (Dykes 2005a, 2005b, 2006) both undertook participant observation and interviews to explore women's experiences of breastfeeding on postnatal wards. These studies provided valuable insight into how women start their breastfeeding journeys in the UK. While the Hawthorne effect, due to being observed might have positively influenced interactions between midwife and mother (Rees 2011), these studies highlighted important evidence about how the medicalised environment impacted on the care provided for women and the resultant effects on their breastfeeding experiences (Cloherty et al. 2004; Dykes 2005a, 2005b). However, the findings reflected women's experiences within the hospital setting and might not be transferable to the home.

Research exploring women's experiences of breastfeeding in the community observing interactions between breastfeeding mothers and health professionals provided valuable insights about what was perceived as good and bad support (Marshall et al. 2007). It also highlighted how women's infant feeding choices were influenced by multiple factors including concerns of a social, practical and emotional nature (Marshall et al. 2007). However, the observations appeared to have been recorded at one episode of interaction with each woman, and whilst 22 women were subsequently interviewed, the research did not provide a continuing exploration of each woman's breastfeeding experience on a daily basis over a period of time. While some of the observational data were collected during postnatal visits in the mothers' own home, health professionals were always present.

Another study explored women's breastfeeding experiences based on participant observation in a child health clinic and interviews with women and health visitors (Sachs et al. 2006). Like previous ethnographic studies, the Hawthorne effect might have affected interactions between health visitors and mothers but did not hide the biomedical approach with the emphasis on weighing babies as a way of judging breastfeeding success (3.5.2). Whilst observational data were collected contemporaneously, this was in the clinical environment and not in the mothers' own socio-cultural environment.

Mahon-Daly and Andrews (2002) in a longitudinal study also combined participant observation at a mother/baby support group with interviews. The observer was a breastfeeding mother herself, but in order to focus on the sessions she did not take her baby to the group. Taking her baby with her and breastfeeding alongside participants might have encouraged participants to open up with someone with experience to empathise with them. The researcher, however, exchanged stories instead, which might have put mothers at ease but could potentially have led conversations down a certain path affecting the findings. The study suggested that data were taken more from the discussion in the group, not unlike a focus group, than from observation.

Of particular relevance to this research study, one study combined interviews with written diaries (Hawkins and Heard 2001) and one with audio-diaries (Johnson et al. 2009). Hawkins & Heard (2001) used a multiple case-study approach to explore the entire breastfeeding experience of ten women from low socio-economic backgrounds, where breastfeeding was not considered the norm. Participants were interviewed in pregnancy and again at two weeks, four and six months following the birth and were encouraged to write thoughts and any issues in a diary between interviews. Whilst the authors suggested that each diary was "used as evidence in its own right" (Hawkins and Heard 2001, p. 522) there was little discussion about how well the diaries were used by participants and quotes were not used in the findings. This could suggest limited use of the diaries by participants, perhaps influenced by the particular participants who might have

found writing onerous. A particular strength of the diaries was that they were used as prompts at interviews and they aided some triangulation along with the researchers' diaries thus strengthening the findings (Hawkins and Heard 2001).

Johnson et al. (2009) explored first-time mothers' lived experiences of breastfeeding during the first postpartum month. This longitudinal study provided insights into the ongoing breastfeeding experiences of predominantly affluent first-time mothers. The research was conducted in two stages: participants were invited to record audio-diaries twice daily at one week and three weeks after discharge from hospital for a week at a time either during breastfeeding sessions, or as soon as possible afterwards. Each period of audio diary recording was followed by a semi-structured interview. The wider study included examining the difficulties mothers encountered when breastfeeding for the first time (Williamson et al. 2007) but the paper in this review focused on 16 women's embodied experiences of expressing breastmilk (Johnson et al. 2009). Eight of them used audio-diaries to record their experiences although there is no mention about compliance. While some of the data were recorded in real-time, there were fewer quotes from the diaries than the interviews which may mean there was limited data from the diaries. This paper focused exclusively on discourse, including verbal and linguistic detail in the data relating to expressing breastmilk, but there was no visual data to enhance our understanding further. Recent papers reporting on the wider research question (Johnson et al. 2013; Leeming et al. 2013; Williamson et al. 2012, 2015) will be integrated into the Methodology (Chapter 4) and Discussion (Chapter 8).

A narrative review of qualitative research on breastfeeding in the UK by Miller and colleagues (2007) was purposefully not included in this review as I did not want it to influence my appraisal of the literature. It is included in the discussion chapter.

Not included in this literature review is research by Ryan and Alexander (2007) who interviewed 49 mothers and two fathers in the UK from a variety of ages, social backgrounds and ethnic groups to explore beliefs, perceptions, customs and practices around the fullest possible range of breastfeeding experiences.

This research collected both prospective and retrospective data, as women described their plans and expectations to breastfeed and/or their breastfeeding experiences following birth. The interviews were not conducted before 14 days postpartum. The videoed narrative interviews provided valuable insights into a range of issues that women faced when breastfeeding as published, and illustrated by video clips, on the award winning website Healthtalk (Ryan and Alexander 2007). Further theoretical analysis of the data has been published since this literature review and will also be referred to in the methodology and discussion chapters (Ryan et al. 2010, 2013).

It is apparent that research exploring women's experiences of breastfeeding to date has either been undertaken with the researcher actually present, or it has focused on verbal discussion of breastfeeding rather than combining it with visual components, or it has been based upon retrospective interview data. There is a paucity of evidence exploring women's experiences of breastfeeding as they are actually happening in the context of their everyday lives, on an ongoing basis using both visual and verbal data, without the intrusion of the researcher being present. Furthermore, the ethnographic and observational studies included in this literature review have explored women's experiences in the context of receiving care from healthcare workers either in hospital or in the community (Cloherty et al. 2004; Dykes 2005a, 2005b; Mahon-Daly and Andrews 2002; Marshall 2011; Sachs et al. 2006).

The key themes from this literature review are positioned within a wider global context where comparable findings from 17 international research studies exploring women's breastfeeding experiences, were analysed together in a meta-ethnographic synthesis in 2008 by Burns et al. (2010). The metasynthesis of the studies conducted in Australia, New Zealand, Canada, USA, England and Wales correlate with this literature review, demonstrating together that women's breastfeeding trajectories are set within a complex culture in the western world, with many women feeling a moral obligation to breastfeed to be a "good" mother but often failing to succeed or persisting under undue pressure when they meet

unexpected problems (Burns et al. 2010, pp. 208–209). This literature review also concurred with findings from the metasynthesis which together showed that mothers have an overriding passion to produce happy, healthy babies, because they believe “breast is best” (Burns et al. 2010, p. 205) which is the main reason why they initiate breastfeeding. This literature review showed that this is often used as a reason for discontinuing when the baby is perceived as unhappy or not thriving within the biomedical culture of the child health surveillance programme. This also concurs with international research with many women across the Western world lacking faith in their own bodies to produce enough milk and using the biomedical approach of weighing to determine their baby’s health (Burns et al. 2010, p. 211). Another key theme from this literature review demonstrated how women negotiate and renegotiate their identities as good mothers depending on how well breastfeeding is going and whether they needed to manage infant feeding in a different way. Burns et al. (2010, p. 214) also highlighted the mother’s inclination to “blame the baby” when breastfeeding did not go to plan. Also consistent with findings from international research, this literature review demonstrated how breastfeeding mothers often fall out of their cultural norm because they are usually surrounded by friends and family with formula feeding experience and where breastfeeding in public is frowned upon (Burns et al. 2010, p. 211). This literature review found that the health service in the UK provides a medicalised service which is judgemental and authoritarian. This was a recurring theme across international studies in the Western world with two metasyntheses highlighting the same issue with health care provision (Burns et al. 2010; Schmied et al. 2011).

There was no research within this literature review that provided visual evidence about how mothers cope 24/7 with the multifaceted nature of breastfeeding in the context of their own home environments over the first few weeks. There was no research that provided audio-visual information about what trials and tribulations challenge breastfeeding mothers 24/7 and how they respond. There was no research that provided audio-visual data of the evidence of the emotional turmoil that mothers face when they are breastfeeding and how they deal with that

turmoil. This gap in the evidence provided the impetus for this study, enabling for the first-time the collection of visual and audio data of daily breastfeeding experiences from the mothers' perspective until they considered their feeding method to be established.

The final section in this chapter outlines the research question.

3.7 Research question

In the spirit of qualitative research, which is that of exploration (Holloway and Wheeler 2002) the overall research question is:

What are the everyday experiences of mothers who are breastfeeding their first baby in the early weeks following birth?

The next chapter discusses in detail the methodology and methods that addressed this research question.

4 Research Methodology and Methods

4.1 Introduction

The literature review exposed a gap in research in that no one had captured the early day-to-day experiences of mothers as it is happening and unfolding within their socio-cultural environment at home. The review also showed a paucity of audio-visual evidence of the daily challenges that breastfeeding mothers face and how they respond to these. Furthermore, whilst there is an appreciation of the emotional turmoil related to breastfeeding, there is a dearth of audio-visual evidence that captures the extent of this emotion and how mothers deal with this on a daily basis.

Designing a research study to answer the research question was imperative and challenging. It necessitated considerable planning to ensure that data would be useful and could be analysed in a meaningful way and that no harm would come to mother or baby from data collection. In this chapter, I will begin with a brief outline of the research project (4.2), and will then discuss and justify the research process, with three main phases, philosophical perspective (4.3), theoretical framework (4.4), and methods used to collect and analyse the data including ethical considerations (4.5).

4.2 Outline of research design

The ‘video diary’ method was used, to enable first-time mothers to share their experiences of breastfeeding as they were occurring in their own home environment. Five breastfeeding mothers were each supplied with a camcorder and asked to keep a video record for the first 2-8 weeks of their babies’ lives or until their infant feeding method was established. Mothers were requested to film anything and everything that related to their breastfeeding experiences, including a daily monologue when they spoke to the camcorder. Mothers were shown how to view and edit their videos prior to providing data to me for analysis. Data, stored on memory cards, were collected from mothers’ homes every 7 to14 days,

and a new memory card was provided. Brief field notes were made after each visit. A strategy to analyse the data was developed using NVivo, which included viewing and logging the content of the video data to maintain a sequential storyline of events. Remaining close to the data, to ensure visual elements were not lost, repeated viewing enabled me to look for similarities and differences between codes to form patterns of meaning, which were connected to form categories and subthemes and merged further to produce three themes.

4.3 Philosophical perspective

My philosophical perspectives and positioning as a researcher within this research study are explored below.

Two of the central ideologies in empirical research are the quantitative and qualitative paradigms whose approaches are characterised by opposing philosophies and underpinned by contradictory methodologies (Punch 2014). Quantitative approaches focus on the ontological assumption that there is a single reality which can be revealed by statistics (Crotty 1998; Robinson 2002). The qualitative paradigm, uses an ontological perspective that embraces multiple realities from different perspectives (Creswell 2013).

In qualitative research, the researcher aims to gain subjective knowledge from participants by coming alongside them so that their perspectives can be explored or witnessed (Creswell 2013). This epistemological perspective underpinned my study as it focused on the way people make sense of their lived experiences, particularly exploring behaviour, perceptions, feelings, past experiences and what lies at the centre of their lives (Holloway and Wheeler 2002). The qualitative approach was selected so that new understandings could be constructed about the challenges mothers face in the early weeks following birth, including emotional and social aspects of daily living that impact on breastfeeding.

An axiological perspective involves recognising the researcher's roles and values related to the research study. This perspective involved me reflexively

considering my own positioning within the research process because it is well recognised that the researcher's approach to undertaking a study and to analysing the findings is shaped by their own culture, values, personal beliefs and experiences (Creswell 2013). However, aiming for "empathetic neutrality" (Ormston et al. 2014, p. 8), I endeavoured to be neutral and non-judgemental in my approach. This involved an increased awareness and reflexivity that my experiences and values as an experienced midwife, midwifery lecturer, breastfeeding mother and advocate of breastfeeding might influence both mothers participating in the study and my own interpretations of their perspectives on breastfeeding. This was facilitated by my fervour to hear mothers' unadulterated experiences of breastfeeding within their own social environments, where their opinions, values and feelings could be shared spontaneously as they occurred, and then listened to and respected with minimal influence from me. Thus, although my identity as a midwife was disclosed to participants, my keen interest in learning from and respecting mothers' experiences of breastfeeding was emphasised before they commenced data collection. As discussed in the strengths and limitations of this study (8.6), my transparency about being a midwife might have influenced mothers' performances and representations of themselves. However, asking the mother to film her own experiences using the camcorder engendered a closeness between the researcher and the participants, because they knew that I would watch and listen intently to the videos whilst simultaneously distancing myself physically from the participant, so that my presence as a midwifery researcher was not overwhelming or detrimental to data collection. Additionally, I made concerted efforts to remain close to the data by interpreting, analysing and representing mothers' experiences using their own words.

Being reflexive also enabled me to realise that my advocacy for breastfeeding was centred on the widely researched evidence that demonstrates breastfeeding to be the optimum feeding method for both mothers and babies (Horta and Victora 2013; Ip et al. 2007). While I was careful this did not impact on my communication with mothers, it highlighted that any discussion related to this

within my thesis was not rooted in my own value-laden beliefs but on previous research already undertaken.

Designing a research study to explore mothers' daily breastfeeding experiences required me to identify my philosophical perspective further. Assumptions underlying the social constructivist framework do not include a single reality but rather reality is viewed as socially constructed (Green and Thorogood 2014). As discussed in 2.3, many mothers give up breastfeeding soon after birth despite there being widespread understanding in literature that 95-99% of mothers can physiologically produce enough milk (Arke 1990). This one example demonstrates that there is 'no single reality' as to why mothers face so many challenges to breastfeeding in the UK. Instead, there are multiple perspectives which are socially constructed around historical, social, cultural and political factors.

From an ontological perspective, a social constructivist framework enabled me to keep the research question broad and to explore the experiences of breastfeeding from mothers' own perspectives and representations of their situation in their own life setting. As suggested by Creswell (2014), this approach enabled me to record a diverse range of perspectives and experiences, so that I could analyse the multi-faceted and nuanced nature of breastfeeding rather than reducing meanings to a precise topic area.

The epistemological perspective within the social constructivist framework (Creswell 2013), views knowledge as co-constructed between the researcher and her participants. Whilst this is often achieved through interaction with others, such as during interviews, in this research study it was achieved by interaction with the camcorder (Chapter 5). Thus, my focus on exploring mothers' breastfeeding experiences was achieved by handing over control of the camcorder, and therefore data collection, to them so that they could represent themselves and film what was important to them about breastfeeding. This then resulted in me applying an interpretive analytic approach to the video data recorded by mothers, as I watched, analysed and interpreted their perspectives of breastfeeding to gain

enhanced insights into the socio-cultural nature of breastfeeding. Thus, social constructivism was used to “inductively develop patterns of meaning” (Creswell 2013, p. 25) from mothers’ experiences of breastfeeding as recorded in their video diaries.

4.4 Theoretical Framework: Ethnography using video diaries

Ethnography is described as a qualitative approach to inquiry where a specific cultural group of people is studied over an extended period of time within its natural habitat using data collected from observations made in the field and interviews (Bryman 2012; Creswell 2014). Ethnography has its origins in cultural anthropology which was first used as a research approach in the early 20th century by anthropologists to explore and interpret human activities within primitive tribes or societies (Creswell 2013; Donovan 2006; Rees 2011). These early studies were thought to be objective truths of the reality because researchers were observing culture within remote areas of the world about which little was known (Murchison 2010). However, ethnography evolved when sociologists modified methods of field work to explore culture within their own societies of the United States and the Western world and then moved into psychology, human geography and swept along in a multidisciplinary movement of contemporary qualitative research methodologies (Hammersley and Atkinson 2007). This movement has enabled researchers to value the importance of interpreting multiple perspectives of people’s subjective experiences (Murchison 2010) and to apply the data to a range of theoretical frameworks such as feminism, Marxism, social constructivism, and post modernism.

Ethnography is thus concerned with understanding the everyday cultural contexts of people’s everyday lives by observing their routines, customs, beliefs, conversations that impact on their behaviour and activities (Rees 2011). Indeed, an ethnographic approach prioritises observation as the pivotal mode for gathering cultural information about a group and often involves the researcher using multiple senses (Gobo 2008). Traditional methods of data collection for

ethnography relied on transcribed field notes from the researcher's own observations made at the time or soon after together with the ethnographer's own reflections on what had been observed (Bryman 2012). Observing mothers' behaviours (Creswell 2014) in relation to their breastfeeding experiences appeared to fit this study. However, in practical terms, I could not take up residence and become a 'participant observer' to share and observe the lives of mothers for an indefinite period of time, because this would have been intrusive during a very important transitional period in new parents' lives. I was also keen to gain visual, as well as audio data, and so with camcorder in hand, the intrusion would have been far greater. Hence, tenets of ethnography were used but did not exclusively underpin the research study.

Using an ethnographic approach, I recognised that to gain an enhanced understanding of the culture of breastfeeding, I needed to gain the "emic perspective", which meant mothers' perspectives, meanings and beliefs about their breastfeeding experience by seeing it "through their eyes" (Donovan 2006, p. 175). This put emphasis on the value of each participant knowing more than me because of their unique experience (Pocock et al. 2009) of breastfeeding. Using ethnography, this is usually achieved by interviewing participants (Donovan 2006), however, I was not aiming for retrospective perspectives but was keen to capture these as audio-visual data in real-time as each mother's infant feeding trajectory unfolded. Ethnography also seeks the "etic perspective", by interpreting observations in the mothers' own socio-cultural environment (Donovan 2006). Research studies had already used video as a method for collecting data about everyday life in visual ethnography (Pink 2013). Using ethnography required me, as the researcher, to focus on the everyday aspects of the participants' lives (Denscombe 2014) which would provide enhanced insights into the socio-cultural aspects of breastfeeding that proved challenging.

Ethnography, however, usually starts with a broad theory from which to investigate (Creswell 2014), which was not my aim. Instead I sought to answer a broad research question underpinned by a social constructivist framework.

However, with a holistic approach using an ethnographic stance (Denscombe 2014), I was able to gain a wide range of perspectives about breastfeeding by asking mothers to record anything and everything they wished to share about their breastfeeding experiences, in order to enhance understandings and meanings related to the multifaceted and cultural nature of breastfeeding. Furthermore 'thick descriptions' (Denscombe 2014, p. 86) together with quotations from the mothers' video diaries illustrated the interpretations and meanings of breastfeeding within its social context.

Using tenets of ethnography as highlighted above, I needed to identify a suitable research method to address the research question that could gather visual data and maintain ongoing contact that was not intrusive. Whilst in-depth interviewing is one of the most popular 'natural' methods of collecting qualitative data, and usually used in ethnography, it would not have collected the real-time visual data of daily life required.

Observation 'in the field' used for ethnography, would have involved me watching and listening to events as they occurred in the home, systematically producing field notes for analysis (Marshall and Rossman 2006). Often the observer becomes a 'participant observer' so that the researcher becomes part of the social environment, with regular in-depth contact over a prolonged period of time, providing a deeper understanding of the social behaviour of participants (Creswell 2014). As already highlighted, it would not have been feasible or appropriate for me to have spent prolonged periods of time in new mothers' homes, becoming what Pini and Walkerdine (2011, p. 140) described as a "surveillant outsider", as it would have been intrusive. Thus, an ethnographic approach using video diaries was considered, with mothers recording both emic data and etic data as described above. Studying students on a geographical field trip, Cotton et al. (2010) compared video, audio and written diary methods to collect qualitative data and found the video diary method to be the most popular. Not only did the students produce extensive first-hand accounts of their entire lived experience on the field trip but they also took control, appeared instantly at

ease with the technology, and labelled it “addictive” (Cotton et al. 2010, p. 47). Although these recordings produced rich, vibrant data which were spontaneously captured, they proved extremely lengthy to transcribe and analyse. Written diaries produced more intimate reflections, possibly because they facilitated anonymity and confidentiality. They were, however, limited to retrospective memory because they were written later in the day. Audio-diaries were the least popular appearing brief, formal and inhibited, and less reflective than written diaries suggesting that students felt awkward compared to using video. Cotton et al. (2010) recommended the video diary method for more widespread use, suggesting thematic analysis during the playback of recordings to reduce time transcribing.

Gerver and Segal (2011) compared written with video diaries in two separate studies and found that daily written records about food consumption among Canadian women were scant and lacked depth compared to video diaries collecting data from a large American population of allergy sufferers that were recorded to capture their symptoms and medication use at least twice a day. Arguably, the motivation to participate might have been very different, with allergy sufferers being prompted to participate because of their irritating symptoms. Nevertheless, the visual element provided a “more complete picture”, enabling researchers to gain the etic perspective, witnessing first-hand what each participant was experiencing even if it was not articulated by them. The visual element of the data was considered a significant advantage over both written and audio-diaries (Gerver and Segal 2011, p. 6). This would be an advantage for my study because collecting data would not require my physical presence, and yet visual data in the video diaries would provide the etic perspective, enhancing my insights into the socio-cultural elements of breastfeeding.

Minnis and Padian (2001) recognised that telephone diaries were more effective for collecting sensitive data than written diaries, suggesting that personal information might be easier to verbalise than to write down. Prosser and Loxley (2008) argued that video approaches to data collection are far less inhibiting than

other research methods. Indeed, research undertaken using video diaries suggests that this method offers unique opportunities for participants to voice their opinions which might otherwise be denied to people who have difficulty expressing themselves in writing (Brown et al. 2010; Dowmunt 2001; Pocock et al. 2009; Roberts 2011). This “channel for cultural oratory” identified specifically by Brown and colleagues (2010, p. 423) as an advantage of video diaries inspired me to use this as a research method to gain the emic perspective without the need to gain retrospective data through interviews.

Thus an ethnographic approach using audio-visual records in the form of video diaries, with mothers collecting data to address the research question, was considered further. To do this, I conducted a literature review to ensure this audio-visual method would capture the complexity of life with a breastfeeding baby as well as be practical, ethical, and sensitive. I used the same searching strategy as for my literature review, using ‘mySearch’ (3.2) and plotted my appraisal of the papers and chapters in Table 7 (Appendix 5). My initial literature search found one book, and 25 articles representing 17 different studies. This literature review in 2010 revealed that the video diary method had previously been used either as the sole research method or combined with interviews, focus groups, or questionnaires in a wide range of research studies concerning consumerism (Brown et al. 2010; Sunderland and Denny 2002); feminist geography (Kindon 2003); tourism (Pocock et al. 2009); grieving children (Buchwald et al. 2009); young women growing up (Bloustien 2003); education (Cashmore et al. 2010; Hyde and Jefferies 2009; Noyes 2004); sexualities (Holliday 2004a, 2004b, 2007); longitudinal series for television production (Dowmunt 2001); medical education (Rees 2010); and a range of health and illness (Buchbinder et al. 2005; Chalfen and Rich 2004; Corrado et al. 2004; Gibson et al. 2007; Patashnick and Rich 2007; Rich and Patashnick 2002; Rich et al. 2000a, 2000b, 2005). A further 15 articles were found in a more recent literature review in April 2015 and were added to Table 7 (Appendix 5).

Data collection using camcorders to include a daily diary has been used to record people's perspectives of health and illness. The Video Intervention/Prevention Assessment (VIA) method integrated video technology with qualitative research methods to enhance understanding about what it is like to live as young people with chronic conditions (Rich et al. 2000a), insulin-dependent diabetes (Buchbinder et al. 2005), obesity (Chung et al. 2013; Corrado et al. 2004) sickle cell disease (Patashnick and Rich 2007) and spina bifida (Rich et al. 2005). This video footage has produced first-hand accounts of the illness experience over a prolonged period of time, providing valuable insights into the lived experiences of these adolescents in the context of their daily lives including their attitudes, thoughts, beliefs and behaviours. Providing participants with the camcorder empowered them to create visual narratives that showed the condition as it really was for them, revealing frank information that had not been available to researchers before (Rich and Patashnick 2002).

Whilst the VIA method incorporating video diaries has been used extensively in health related research, other researchers have also incorporated video diaries to explore people's perspectives of health and illness including children's experiences of coping when a parent is dying or seriously ill (Buchwald et al. 2009, 2012); men with muscular dystrophy (Gibson 2005; Gibson et al. 2007) and children receiving anaesthesia for tooth extraction (Rodd et al. 2013). Experienced users of the video diary method suggest that the camcorder highlights issues that the selective memory might have chosen to forget at interview (Rich et al. 2000b). This method would enable me to gain an enhanced understanding of mothers' needs and preferences in real-time. Patashnick and Rich (2007) suggested that it could be applied to almost any human condition including social issues such as violence, teen pregnancy or homelessness. Noyes (2004, p. 198), having used participant observation, interviews and video diaries with schoolchildren found data from video diaries much more "compelling" because children provided more in-depth commentaries in the privacy of a "diary room". My literature search revealed that this research method had not yet been used with new mothers or breastfeeding mothers.

Ethnography or visual anthropology were frequently cited as the underpinning methodologies for studies involving video diaries as a data collection method (Appendix 5). Ethnography using film usually involves the researcher making decisions about where to put the camera, how long to film for and how to angle the frame (Shrum et al. 2005). Thus diversifying from the traditional role of participant observer, I was not intending to be in the field making those decisions, as the camcorder was to be under the direction and control of each mother. Thus handing over the camcorder would be asking the mothers to take up an ethnographic stance, where they could capture social life as a breastfeeding mother, without my intrusive presence.

Bates (2013) used video diaries in her multi-method study exploring the body, health and illness in daily life with people with long term physical or mental health conditions. As she suggested, the camcorder, although a physical object, would act as the "participant observer", with "eyes and ears" for the participants to talk to (Bates 2013, p. 30) and in my study also record the mothers' embodied experience and journey into motherhood with their breastfeeding baby. With an emphasis on holism, ethnography focuses on all aspects of a specific group of people, including social, cultural and psychological parameters (Denscombe 2014). Pink and Mackley (2012, p. 2) explained how ethnographic research using the "video tour" method provided valuable insights into "how the sensory aesthetic of home is experienced, produced and maintained". Applying this to my study, video diaries using an ethnographic approach were thought to offer the opportunity for mothers to express holistically through word and action, their embodied ways of knowing and experiencing breastfeeding within their own cultural environment. However, Pink (2003, p. 55) warned that research videos are *"*not realist representations, but expressive performances of the everyday." Thus, each diary entry might be influenced by how a mother wished to perform and be represented as a breastfeeding mother, rather than how she really was feeling and thinking. While some researchers would suggest this is a limitation (Rich et al. 2000a), I would recognise this as a strength as it provides

opportunities to enhance my understanding of mothers' subjective ways of representing themselves.

Indeed, ethnography focuses attention on how a specific cultural group interpret and make sense of their world including what they perceive about their reality (Denscombe 2014). Thus, I applied Pink's (2013, p. 35) approach to visual ethnography, in order to collect, analyse and interpret data as closely as possible. This included "the context, the embodied, sensory and affective experiences" of breastfeeding mothers alongside their "negotiations and intersubjectivities" in relation to how they recorded their video diaries. Using this approach was important to understand the culture of this small group of breastfeeding mothers by interpreting patterns of meaning shared across the group over a period of time. This ethnographic stance did not just focus on the audio content of the video but used both visual and sensory ethnographic approaches as I focused on analysing mothers' day-to-day perspectives and interpretations of their own breastfeeding experiences. This included observing their verbal and non-verbal behaviours, language, values, and how other people influenced their perspectives including health professionals, families and friends. Interpreting cultural behaviours also involved analysing what mothers recorded in and out of the frame including whether they recorded themselves breastfeeding or avoided this aspect. This ethnographic stance also involved me observing mother's breastfeeding environments including features that influenced and impacted on their breastfeeding experiences including furniture, clothes, equipment and people present.

The daily video monologues that were requested, encouraged mothers to reflect about their daily breastfeeding experiences which often resulted in them 'working it out' for themselves (Chapter 6). Thus this methodological approach embraced the social construction of knowledge and meaning, enhancing my understanding as the researcher. Personalised documentaries, where the main focus is people's therapeutic and confessional subjective experiences, have become popular on mainstream television with video diaries featuring as early as the 1990's (Biressi

and Nunn 2005). Indeed, one of the first documentary series, ‘Video Diaries’, where ordinary British people were given camcorders and editorial control to video their own lives, was broadcast on BBC in 1991 (Biressi and Nunn 2005). Now there are a diverse range of reality TV programmes that appear to share a common aim of producing a

> “social construction—one that uses the seemingly unscripted life experiences of everyday people to create a form of entertainment that the viewing public consumes.” (Orbe 2013, p. 246)

This means that with popular TV reality programmes like ‘Big Brother’, many people are very familiar with how providing personal space and a camcorder to film private thoughts and feelings can result in very revealing data. Furthermore, the rapidly increasing use of digital technology, recording life experiences on smart phones, webcams, tablet computers and camcorders, and releasing them for public consumption on social networking sites, appears to have become common place (Forsyth et al. 2009). This familiarity with speaking to a camcorder and revealing thoughts and feelings provided some context to this study, as it was hoped that mothers would not be daunted by the method. Instead, it was hoped that, as had been reported in some studies, that it would be an empowering process (Dowmunt 2001; Holliday 2007; Roberts 2011) where mothers could speak candidly (Rich et al. 2000b) about their experience of breastfeeding in real-time rather than retrospectively.

4.5 Methods

4.5.1 Pilot study

As this was a new method of data collection with breastfeeding women and for me as the researcher, a pilot study was conducted (van Teijlingen and Hundley 2005, p. 219). Piloting included selecting the most appropriate camcorder, gaining consent for filming and release of data, exploring how the camcorder was used by the participant and developing a method of analysis with audio-visual data.

Selecting the most appropriate camcorder with the funds available was crucial. The Iolanthe Midwifery Trust awarded me the Tricia Anderson Award of £1000 to pay for the camcorders. The camcorder encompassed the main features discussed by Muir (2008), so that it was user friendly, compact, affordable, provided good quality film footage and recorded in a format that did not take up too much computer memory once downloaded. Since I needed mothers to watch and edit their own film footage prior to releasing data, a priority was an 'in-camera editing' function. I initially bought one Canon Legria FS306 camcorder with two 8GB SDHC memory cards for digital recording to 'test' in the pilot study.

The pilot study volunteer, Vicky, contacted me in the early stages of labour for some professional advice. When she contacted me again to inform me about the birth of her baby, she was invited to pilot the study. An invitation letter (Appendix 6) participant information sheet for women and their families (Appendix 7) was sent to her, prior to a home visit by me nine days following the birth to explain the project and to gain her written consent to participate using the 'consent for mothers and their babies' form (Appendix 8). Some studies suggested not providing participants with a topic guide for recording their diary entries to avoid researcher bias (Cashmore et al. 2010; Scott et al. 2012). Others studies found simple guidance with a list of prompts and activities useful as a way of initiating conversation and filming with the camcorder without constraining the imagination or compromising the integrity of the personal experience (Brown et al. 2010;

Holliday 2004a; Rich and Patashnick 2002). Along with the camcorder and its instructions, I provided ‘guidelines for keeping the video diary’ which were not intended to be prescriptive but to act as a springboard for conversation and filming and to reduce “procrastination” (Brown et al. 2010, p. 421) (Appendix 9).

Sampson (2004) found that carrying out pilot work in ethnographic research was invaluable to ensure that the presence of the researcher was accepted. In a similar way, I needed to ensure the camcorder was acceptable to mothers, so finding out how Vicky used the camcorder was an integral part of the pilot. Vicky started filming two days after receiving the camcorder, 11 days after birth. She appeared nervous and stilted in the first few recordings but gained confidence over the first week, producing recordings almost every day for four months and then continued filming less often into the fifth month. She continued to collect data for this length of time as she felt that breastfeeding had not established any earlier. This was an unexpected outcome of the pilot study as it was envisaged that by six to eight weeks an infant feeding method would have been established, with some literature stating this could be as early as four weeks (Jenik et al. 2009). Another surprise from the pilot study was the breadth and richness of data collected from just one person. Vicky recorded 120 video clips over a period of five months, some lasting only a few minutes and others lasting over 30 minutes. It could be argued that Vicky collected an abundance of data wishing to please. Nevertheless, rather than just being acceptable, she appeared to enjoy talking to her new found ‘friend’, the camcorder, greeting it with hello and goodbye at the beginning and end of most entries.

As suggested by van Teijlingen and Hundley (2005), the benefits of conducting a pilot study were multi-fold. These included assessing whether the sampling and recruitment strategy were useful, learning whether the camcorder along with the simple guidance was an effective research tool to collect good quality data and developing the data analysis techniques. It also confirmed that my original intention to recruit in pregnancy to provide women the opportunity to become confident with the camcorder before commencing data collection and filming

naturally was appropriate. Arrangements for delivery of the camcorder as soon as possible after the birth or discharge from hospital were also tested (4.5.4).

The camcorder appeared easy to use, and the quality of video footage was generally good although at times the backdrop of lighting behind the participant made it difficult to see the image. Because I was keen to capture mothers' experiences of breastfeeding in their natural habitat, I did not want to ask mothers to add extra lighting for my viewing purpose alone. Indeed the ambience of a dimly lit room provided the authenticity that I was hoping to capture. However, a simple statement on the guidance sheet was added to encourage mothers to consider where to position the camcorder in relation to natural lighting. Sometimes the camcorder was positioned precariously around the house and it became obvious that a tripod would be useful. Successful use of the camcorder provided me with the confidence to buy a further five camcorders, ten 8GB memory cards and six mini tripods with flexible gripping feet.

Collecting a plethora of data from one mother, helped me reconsider my data analysis method, realising like other researchers using video diaries that full transcriptions of both audio and visual data was very time consuming and would not be feasible (Cotton et al. 2010; Muir 2008). The pilot study enabled me to try out different Computer Assisted Qualitative Data Analysis (CAQDA) software packages to facilitate the analysis, including Transana, MAQDA and NVivo 10 to identify which package suited my needs and any potential problems (4.5.5).

It is argued in the literature that the adaptable nature of qualitative research means that separate pilot studies are not necessary (Holloway 1997) and that the first episode of data collection can inform the next as the researcher gains insights on how to improve collection (van Teijlingen and Hundley 2005). With this in mind, the lessons learned from the pilot study were both integrated into the next stage of data collection and pilot data were included in the main study.

4.5.2 Participants and recruitment

4.5.2.1 Identifying the suitable number of participants

When considering the number of participants for this study, I looked to the literature and found that studies involving video diaries varied from three (Pocock et al. 2009) to 66 participants (Cashmore et al. 2010). Looking at studies where participants have been asked to talk daily to the camcorder, the numbers were smaller, ranging from three to 20, possibly because they collected an enormous amount of data (Appendix 5). With varying sample sizes which were not well rationalised in the literature, I initially proposed that approximately eight mothers would be recruited. The pilot study demonstrated the quantity as well as the quality, breadth and richness of data that could be recorded by just one person. Thus after collecting 121 clips and more than 11 hours of data from the first mother, this number was reduced to five.

4.5.2.2 Inclusion / exclusion

To ensure that mothers understood the study and were able to participate in a meaningful way, only mothers who were considered 'capable' of giving valid consent were invited and given information packs by their community midwives who acted as 'gatekeepers' (Donovan 2006). This involved taking time to meet with local community midwives to explain the project and their involvement (Dockett et al. 2009). Subsequently, I checked that potential participants understood the research and what it involved for them, including the possible risks and benefits. It was essential to confirm that each woman was capable of making a free and valid decision. Women who were not deemed to be competent on the grounds of intellectual or learning difficulties would have been excluded but this was not necessary.

I was specifically interested in mothers who were breastfeeding their first baby since any challenges they faced would be new experiences for them. Furthermore, research suggested that mothers who are breastfeeding their second or subsequent babies are strongly influenced by previous experiences of infant feeding (Dennis 1999). However, mothers were not asked if they were

planning to breastfeed in pregnancy as this is not recommended practice (Entwistle 2013) and it was assumed that mothers planning to formula feed would not put themselves forward to participate.

This study was not exploring breastfeeding experiences of mothers under the age of 16 as they could have been vulnerable, and ethical issues would have been complex. This group of mothers warrant a separate study to consider their breastfeeding experiences because they are likely to be vastly different, perhaps still living with and strongly influenced by parents and having issues arising from being in compulsory full-time education. Since this was the first time this method was being used with breastfeeding mothers, it seemed wise to start with women who were not vulnerable.

Mothers who had given birth to one healthy baby at or after 37 weeks gestation, were eligible for inclusion. Mothers who had given birth to more than one baby were excluded, as were mothers who gave birth before 37 weeks gestation or whose baby needed specialist care. Furthermore, if the woman herself was or had been seriously ill requiring intensive care and/or treatment following birth and required ongoing specialised care and/or treatment following discharge from hospital, including for mental health, then she would also be excluded from the study.

Only English-speaking mothers were included in the study, as there were unfortunately no resources within this PhD study to employ a translator.

I needed to be able to travel easily to mothers' homes to deliver the camcorder and then weekly to deliver and collect memory cards. The participant in my pilot study lived on the borders of my proposed area which made timely delivery of the camcorder and data collection more difficult. Therefore, only mothers within the South of England were included.

Inclusion	Exclusion
Capable of giving valid consent	Unable to give valid consent
First-time mothers	Mothers expecting second or subsequent baby
Aged 16 years or over	Aged under 16 years
Singleton pregnancy – one baby expected	Multiple pregnancy – more than one baby expected
Gestation 37 weeks of pregnancy or more	Gestation under 37 weeks of pregnancy
Baby well after birth	Baby unwell requiring specialist treatment
Maternal wellbeing	Maternal morbidity – serious illness after birth requiring specialist treatment including mental health
English speaking	Non English-speaking
South of England	Outside South of England

Table 2 Inclusion and Exclusion criteria for inviting participants

4.5.2.3 Inviting women to participate

The pilot study participant was not invited to participate until after the birth of her baby and this delayed commencement of data collection as time was needed for her to consider taking part and for delivery of the camcorder (4.5.1). Thus this confirmed the original plan to invite women to participate during pregnancy. I met with local community midwives to discuss the study. These midwives distributed 'invitation packs' during routine scheduled antenatal appointments to English-speaking women (older than 16) expecting their first baby and were 28-30 weeks pregnant. Each 'invitation pack' consisted of an invitation letter with

reply slip (Appendix 6), a comprehensive information leaflet (Appendix 7), and a stamped addressed envelope.

The invitation letter asked the woman to register her interest by returning the reply slip to me within three weeks. If she wanted more information or needed to discuss any aspect of the study further, she could contact me or one of my supervisors, directly by email, phone or post. Since I only received three responses in four months, I attended the concluding part of two parent-education classes where I spoke about the project and provided the midwife with further information packs for attendees. A further four women made enquiries.

Once I had received a response from a prospective participant, I arranged to meet her in her home between 32 and 35 weeks of pregnancy. She was invited to ask anyone else living in the household, perhaps her partner and/or other family members, to attend. At the meeting, which lasted between 60-90 minutes, I discussed the project in further detail including how the video diaries would be used, answered any questions and demonstrated the camcorder, using a set of simple manufacturer's instructions about shooting and filming, changing memory cards, and editing film. It was important at this meeting to begin building "trust and rapport" with potential participants so that they felt comfortable sharing their experiences with me (Dockett et al. 2009, p. 359). Thus, recognising the complexity of this method of data collection (4.4), I took time to explain the importance of conveying what breastfeeding really meant to her and her family, including her dreams, successes, problems, and frustrations. I emphasised that any decision, discussion or action would not be judged.

Each woman was informed that if her baby was premature or there were unexpected complications she would not be included in the study. At the end of the meeting if she was willing to take part in the study, I gained written consent. Learning from the pilot study (4.5.1), I then left the camcorder with the family for one to two weeks for familiarisation, filming practice and an opportunity to get used to talking in front of the camcorder so that it became a natural process. After that time I returned to collect it. Arrangements were made for a family member to

contact me just before discharge from hospital or within 24 hours of leaving. This ensured that filming did not commence within the hospital setting but that, unlike the pilot study, data was captured as soon as possible after leaving.

In the event of the mother exclusively bottle feeding before discharge from hospital, the mother and/or baby becoming unwell, or the baby being stillborn, the parents were not expected to contact me. I had arranged that if I had not heard from them within two weeks following the estimated delivery date, I would contact them to enquire after their wellbeing.

4.5.2.4 Participant profiles

Four out of the seven women who had initially signed a consent form to participate were recruited to the main study. Together with Vicky, this made five first-time mothers who participated (Table 3). Rosie had a planned home birth, Sarah, Sam and Vicky all had uncomplicated births in hospital and Tracey had a forceps delivery. All described themselves as white British. Two were married and three were cohabiting and in long-term relationships with the baby's father. Four participants had parents or parents-in law locally and one had no family nearby. Four worked before the birth of the baby (Table 3) and one was a student. All commenced breastfeeding soon after birth.

Three of the seven women contacted me to inform me they were no longer eligible to take part in the study. One had given up breastfeeding in hospital; another mother's baby was admitted to the neonatal unit; a third mother had a massive postpartum haemorrhage and her baby was in hospital with 15% weight loss.

Mothers discussed their experiences of using a variety of feeding methods during the data collection period (Table 3) including bottles of expressed breastmilk, water and formula milk, with one mother introducing solids at 12 weeks. The length of time for which mothers breastfed was noteworthy. Four out of five were exclusively breastfeeding at six weeks with one breastfeeding alongside formula feeding, thus all were doing some breastfeeding. Sam stopped recording at eight

weeks and was continuing to breastfeed, expressing breastmilk regularly to give by bottle. Vicky was exclusively breastfeeding when she discontinued recording during her twentieth week and Rosie during her tenth week. Tracey abruptly stopped at 12 weeks following a visit to the clinic where she was advised to give formula due to inadequate infant weight gain. Despite mixed feeding because of early breastfeeding problems from 11 days, Sarah persevered with breastfeeding until she had increased her milk supply enough to be fully breastfeeding by 12 weeks. A narrative for each mother is presented in Appendix 26.

4.5.3 Ethical considerations

4.5.3.1 Research Ethics and Ethical Governance

Independent, ethical and scientific review is crucial for all research that involves human subjects (Denscombe 2014) and needs to be applied to all levels of the research process, from planning through to the post-dissemination stage (Creswell 2007). Wiles et al. (2008) suggested that research using visual methods requires even more attention to detail, and this study was no exception.

The World Medical Association's (WMA) Declaration of Helsinki (2001) governs health researchers using key research ethics principles and the Nursing Midwifery Council (NMC) (2015) governs midwives using 'The Code: Professional standards of practice and behaviour for nurses and midwives'. Thus, for this study, ethical issues required utmost attention to ensure any dilemmas with conflicting roles as a researcher and midwife were identified and problems avoided. These dilemmas were highlighted in a publication I co-authored, and are integrated into this section (Ryan et al. 2011).

Participant Pseudonym	Age range	*Occupation before birth	Partner Pseudonym	*Partners occupation	Baby Pseudonym	Birth Type	Feeding method during diary recording	Breastfeeding problems encountered during diary recording
Rosie	25-29	5	Tom	6	Lily	Home birth	Exclusive breastfeeding	Sore nipples wk 1-2
Sam	20-24	10	Ryan	8	Zac	Normal	Exclusive breastfeeding + EBM in bottles wk1 1 x bottle water wk 6	Sore nipples wk1-2
Sarah	25-29	2	Jason	5	Sophie	Normal	Exclusive breastfeeding Nipple shields from day 7 & continued EBM by bottle day 12 Formula & EBM by bottle day 13 Formula, EBM & breastfeeding day 16 Mixed feeding–reducing formula day 20 Exclusive breastfeeding wk 13	Painful nipples from day 3 Engorgement day 5 Thrush day 9 Tongue tie diagnosed day 12 Frenulotomy day 16 Diminished milk supply day 13
Tracey	20-24	6 + 7	Scott	2	Theo	Forceps	Exclusive breastfeeding Introduced bottles of water wk 3 Stopped bottles of water wk 5 Re-introduced bottles of water wk 10 Introduced solids wk 12 Formula feeding wk 13	Sore nipples wk 1-2 Painful 'Let down' wk3-4 Baby's weight down to 50th centile wk 4 Baby's weight crossed centile line to 9th centile wk 13
Vicky	25-29	2	Peter	3	Benjamin	Normal	Exclusive breastfeeding + EBM in bottles wk 5	Sore hard breasts milk coming in Painful bleeding nipples day 18 Mastitis - antibiotics wk 4

***ONS Standard Occupational Classification Hierarchy with Group 10 added**

Group 1: Managers, directors and senior officials
Group 2: Professional Occupation
Group 3: Associate professional and technical occupations
Group 4: Administrative and secretarial occupations
Group 5: Skilled trades occupations
Group 6: Caring, Leisure and other service occupations
Group 7: Sales and customer service occupations
Group 8: Process, plant and machine operators
Group 9: Elementary occupations
Group 10: Unemployed, students, voluntary work

Table 3 Participant's Profiles

Key principles guiding health researchers include ensuring that participants' interests are protected, individual autonomy is respected by gaining informed consent, research is conducted with integrity and avoids deception and the laws of the land are adhered to (Denscombe 2014). Key ethical principles underpinning health professionals' practice are respect for autonomy, beneficence, non-maleficence and justice (Beauchamp and Childress 2001).

Research governance is required for providers of health and social care including the NHS (DOH 2005). Because I recruited participants from within the NHS, an application was submitted to the Southampton and South West Hampshire Research Ethics Committee (SSWHREC) in August 2010. The ethical issues, particularly related to using audio-visual records as a data collection method including loss of anonymity and confidentiality, informed consent, copyright and intellectual property issues, data protection, limits of confidentiality in relation to child protection, and risks, burdens and benefits to the participant.

A research supervisor and I attended the committee meeting in September 2010 and only one clarification was required to ensure that anyone who featured in the videos, other than just the study participant, would be contacted by me to gain informed consent and if this was not gained, data relating to them would be censored out of the video (Appendix 10). The information sheet for friends and family and consent form were amended (Appendix 11, 12). SSWHREC provided a favourable opinion in January 2011 (Appendix 13).

Involving local community midwives from the NHS in the recruitment also involved an application to the Research Governance Department at the local hospital. Written confirmation of a favourable opinion was received in April 2011 (Appendix 14).

Research governance is also a growing concern for Higher Education Institutions although standards and codes of practice vary across the UK (Macduff et al. 2007). Applying the Bournemouth University Code of Practice (2009), I also

gained a favourable ethical opinion from the Postgraduate Committee of the School of Health and Social Care, Bournemouth University (Appendix 15).

4.5.3.2 Respect for individual autonomy: Anonymity, confidentiality

Anonymity relates to protecting participants' identity and confidentiality ensures that unauthorised people do not have access to any data that would identify individuals (Rees 2011). These are core ethical principles for both researchers (WMA 2001) and practising midwives (NMC 2015). Maintaining confidentially and anonymity was problematic, because I was collecting visual data with a rationale for using this method to capture visual images that just cannot be described in words alone (Wiles et al. 2008). Participants who engage in this type of research often want to be identified and have their 'voice' (Tenney and MacCubbin 2008). Therefore, because there was an intention to disseminate this research to a wide audience, participants needed to be aware that once data was released for dissemination, confidentiality and anonymity could not be maintained (Tenney and MacCubbin 2008) and thus they might be recognised by someone who knew them. Explaining this to participants was essential and thus, with the popularity of reality TV programmes in the current climate, I used this as an example so that they could equate this loss of anonymity to something familiar (Appendix 7 and 11).

Additionally, because anonymity and confidentiality could not be maintained, mothers were provided with the opportunity to edit their own tapes before releasing them to me, to ensure that only video footage that they were comfortable about sharing was used (Tenney and MacCubbin 2008). This recognised previous researchers' experience, where it had been argued that recording and editing research material in this way can empower participants to create videos that represent their views, voices and experiences in a meaningful way (Banks 2001; Holliday 2004a), shifting the power balance from researcher to participant (Brown et al. 2010).

Obscuring images using computer software to blur facial or other identifiable features by increasing the pixilation of the image was considered but has been viewed as a method of objectifying people and thus a mark of disrespect (Wiles et al. 2008). Since analysis and interpretation of visual aspects of the data were key features of this study, exploring the physical, psychological, social and emotional aspects of breastfeeding, obscuring faces was avoided as it might have provoked criticism about the integrity of the data or caused offence to participants (Wiles et al. 2008). However, specific requests by participants to obscure their face prior to dissemination would have been met if requested.

I recognised that when mothers were videoing in their own home, there would be an intrusion into their privacy. This reinforced the importance of the participants themselves recording the data (Tenney and MacCubbin 2008). To increase safety and security, information was also given to participants advising them not to record identifiable features such as road names and house numbers (Appendix 7). Very occasionally mothers asked me to edit certain conversations out of their diary entries, because they recognised that they had identified people that they had not intended to. This request was fulfilled on first upload onto the computer.

Whilst anonymity and confidentiality could not be maintained, it was recognised that participants might still wish to be given a pseudonym for dissemination purposes and therefore they were asked if they had an objection to this (Wiles et al. 2008). With no objections raised, all were given pseudonyms throughout this thesis.

To maintain confidentiality, all consent forms have been locked in a University fire-proof filing cabinet and all research data collected including video diaries, notes and logs have been saved and stored on a ‘password protected’ University computer in accordance with the Data Protection Act (1998). Only the researcher and research supervisors have had access to the data. Data were not shared electronically, only at in-depth face-to-face supervisory meetings. All viewing and analysis has been completed in a confidential office with head phones used to

prevent participant's voices being overheard. The Research Governance Department at the local hospital also required that a Data Protection Form be completed and submitted to confirm these actions.

The Nursing & Midwifery Council (NMC 2008, p. 2) stated in 'The Code: Standards of conduct, performance and ethics for nurses and midwives' that:

> "'you must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practicing"

As a midwife-researcher, it was therefore necessary to ensure that all participants were aware that should I become aware of any serious harm being caused to others and/or child protection issues, such as images or discussion on the video diaries about physical, sexual or psychological abuse, then I would be compelled to report such activities to the authorities (Allmark 2002) and to hand over any images as evidence to the police. A short paragraph explaining my duty to report 'child neglect or abuse' or 'serious harm to others' was included on the participant information leaflets and was discussed at the initial meeting (Appendix 7 and 11). Furthermore, if the woman had disclosed through talking to her video diaries that she herself was psychologically distressed and likely to harm herself, I would have referred her immediately for specialist help and data collection would have been discontinued. This did not occur.

4.5.3.3 Respect for individual autonomy: Informed Consent

To adhere to the ethical principle that participants have the right to be autonomous by making decisions for themselves, midwife-researchers have the responsibility of ensuring consent is informed (DOH 2005; NMC 2015). Informed consent for participating and creating the video diary was obtained at the pre-birth meeting at 32-35 weeks of pregnancy when extensive discussion about the project included confidentiality and anonymity issues and risks and benefits of participation (4.5.2.3) (Tenney and MacCubbin 2008).

The option to abstain/withdraw at any stage during the research process without the risk of affecting care from health professionals was emphasised, thereby

making consent an ongoing process and demonstrating my respect for participants and their choices (Dockett et al. 2009; Tenney and MacCubbin 2008). It was explained that if a participant wished to withdraw from the study her data would be deleted from the memory cards and would not be included in the analysis. If a participant wished to withdraw her data after completion of the study, all their material that had been posted on the internet or used for educational purposes would be removed from these resources. However, it was explained to them that there was no control over how that material might have been used prior to its removal. Thus explaining the need for gaining consent for participation in the research and again later for release of the material because of copyright was essential (Rose 2007) (Appendix 7). Written consent for participating was thus sought at the initial meeting (4.5.2.3).

Informed consent also involved gaining permission from any other people recorded in women's video diaries (Wiles et al. 2008) such as family members. Thus, I also discussed the importance of explaining the research and gaining consent before filming any others who were not at this initial meeting. A detailed information sheet about the research and a consent form was left with the participants (Appendix 11 and 12).

I recognised that the legal position involving consent for children participating in research was complex. According to the English legal system valid consent can be given by 'competent minors', children under the age of 16, if they have the ability to understand basic explanations about what it means for them to participate in research (Flewitt 2005). In this study, consent related to 'parental consent' for the newborn baby or any toddlers (Allmark 2002) because they do not have the capacity to consent themselves (Masson 2004). Therefore, the responsibility and decision rested with the parents as to whether they recorded images of very young family members and whether they released them for future use and the consent forms reflected this decision (Appendix 8).

I also made provisions for any other children, younger than 16 years who wished to become part of the mothers' diaries, by specially designing information sheets for the varied age ranges and reading abilities of potential child participants (Appendix 16, 17, and 18). It was proposed that if these children understood the information regarding the nature of the research and why they were going to be videoed, they themselves would have made that decision and assented to being filmed. In this case written consent either as a signature or agreed symbol, along with their parents' consent would have been required (Appendix 19) (Cocks 2006; Tenney and MacCubbin 2008). As there were no children within these age ranges who wished to participate, these documents were not required.

To ensure consent had been obtained by all those recorded in the video diaries prior to research analysis, I checked during my initial viewing of the data that everyone who appeared on the film, tallied with the consent forms received. Following the initial Ethics Committee review recommendation, (4.5.3.1), I contacted everyone who featured in the videos, other than the study participant and her partner, to gain informed written consent and when this was not possible, footage containing them was censored out of the video.

4.5.3.4 Respect for individual autonomy: Copyright & Intellectual Property Issues

According to copyright law in the UK, the copyright of moving images belongs to the person recording the images (Wiles et al. 2008). I originally understood that before I could use the video data for research purposes, copyright would need to be signed over by participants to Bournemouth University (BU). However, with legal advice from the University, I asked participants for a licence to use the data rather than requesting copyright. Whilst I was able to understand and accept the rationale for the legal advice, I was not willing to accept the legal terminology recommended as it was not clear to a lay person (Appendix 20). Tenney and MacCubbin (2008) emphasise the need to build trust between the researcher and participant so that the participant understands the process and is given power to determine what happens to the video footage. Therefore, I was keen to make sure that all forms were written in plain English so that they were easily

understood. Negotiation with the legal department finally resulted in an amendment to the 'Future Use of Video Diaries' form, asking for a licence to use the video material in terminology that was easy to understand (Appendix 21, 22 and 23).

Mothers were not obliged to offer any video data to me that they deemed unsuitable for research purposes, therefore, prior to collection of the video data, they were requested to view and edit out any unwanted material. Each time I collected the material, participants were asked for the licence of their video recordings on a 'Future use of my video diary' form, along with any forms from other people who might have been recorded (Appendix 21, 22 and 23). Gaining a licence to use the data meant that I have consent, to use the data including for analysis, interpretation, and dissemination of the findings and for educational purposes including conference presentations, multimedia publications and health professional training. Seeking informed consent when I collected memory cards meant that it was an "ongoing, renegotiable process" (Dockett et al. 2009, p. 358) depending on what participants wished to share for the purposes of the study and/or dissemination. Thus, to ensure that mothers had the full range of choices about how their material was disseminated, they were asked to select from a list of uses on the 'Future use of my video diary' form. I will not and have not attempted to disseminate the material in any way other than what participants have consented to on this form.

4.5.3.5 Non-Maleficence and Beneficence: Risks, burdens and benefits

The risks to participants were related to the loss of confidentiality, anonymity and privacy once the research was disseminated. Mothers might run the risk therefore of people they know recognising them and judging them on their 'performance'. Whilst some mothers might have found video recording on a daily basis burdensome, mothers in this research found it a very flexible way of recording data, enabling them to choose the time, place and length of time they recorded each day, rather than being restricted to interview appointments (4.5.4). Using my own experience as a midwife, I felt confident that the camcorder would be a

popular method for recording daily life with a newborn baby in the early days following birth, and an excellent means for many mothers to capture their breastfeeding experiences within their contemporary lifestyles.

I recognised that recording the challenges of breastfeeding on a daily basis could have been emotionally draining. Indeed, Buchwald et al. (2009, p. 17) identified the potential of “uncontrollable emotions” being triggered when children shared their personal thoughts and feelings about their sick or dying parent. In this study, because of the flexible nature of the data collection process, participants were reassured that they could record as much or as little as they felt able and that they were not obliged to record anything they were not comfortable with. Viewing and editing tapes also ran the risk of creating some unease and emotion. With these issues in mind, I looked for psychological stress caused by recording and/or editing the video diary both when I visited the family to collect the tapes and within the video footage itself (Ryan et al. 2011). As recommended by Holloway and Wheeler (1995), I recognised my duty of care as a midwife, which would have been to suggest stopping data collection and to offer referral for specialist support. Whilst there were a host of emotions expressed by participants on camera it did not appear to be a result of recording alone, rather a result of their experiences, and as discussed below talking to the camcorder was felt to be a positive cathartic release (8.2).

Collecting the memory cards every one to two weeks might have been difficult for some participants. However, this always occurred at a mutually convenient time. While I endeavoured not to intrude into family life other than to collect the cards, consent forms, clarify anything that I was unsure about on the video footage from the previous week’s diary (4.5.3.6), it was an opportunity to continue to build a “relationship based on trust and rapport” (Dockett et al. 2009, p. 359) and thus encouragement and support in terms of video recording was offered.

Since I was working with the participants in the capacity of a researcher, and not as a practising midwife, it was important that they understood that I would not be

able to provide advice about breastfeeding. This was because I needed to find out in my research what type of support a mother would seek and how easy or difficult that would be. However, ‘wearing my midwifery hat’ meant that I fully understood, that when visiting mothers, my duty of care needed to override my role as a researcher in the name of safety such as an obstetric emergency situation, when I would have been prepared to act immediately and appropriately, calling for assistance as required (NMC 2015; Ryan et al. 2011).

It is important in research to offer a token of appreciation recognising commitment and effort to data collection, although it is considered unethical to provide an incentive that is too good to refuse (Dockett et al. 2009). Therefore to demonstrate gratitude to participants for recording their experiences on a daily basis over an extended period of time, a personal copy of the video footage was offered to each participant at the end of the data collection period. In addition once the whole data set was completed, mothers were offered the camcorder to keep for their personal use but they were not aware until they had completed data collection that this would happen.

4.5.3.6 Justice: Fairness and equality

Since anonymity and confidentiality could not be upheld, it was crucial to ensure that I maintained participants’ dignity at all times. Therefore, to avoid the risk of psychological or negative effects from participating and to continue harnessing the trusting relationship, I reassured mothers that all data would be sensitively reported and I would take particular care not to make any judgements or assertions about their actions or decisions when disseminating the findings. I viewed mothers’ video diary entries in-between visits to ensure I understood their recordings and checked with them if there were any issues that appeared confusing to prevent misunderstanding and/or misrepresentations at my data collection visits. This required me to adopt a sensitive and reflexive approach in all areas of the research study.

4.5.4 Data collection

Four additional mothers who had initially signed a consent form to participate were recruited to the main study. When the mothers contacted me, I made immediate arrangements to deliver the camcorder and the 'guidelines for keeping the video diary' (Appendix 9). Mothers commenced data collection at varying days following the birth despite the camcorder being delivered soon after discharge from hospital, with Sarah starting on the third day, Sam on fifth, Tracey on seventh and Vicky on eleventh day after the birth. Rosie, having not had an opportunity to give the camcorder back in pregnancy captured the first moments following her homebirth as Lily rooted around and attached on her breast.

They were encouraged to talk for as long or as short as they liked and were shown how to view and edit their videos prior to providing data for me to analyse. I collected the data every 1-2 weeks at a mutually convenient time. As already described, prior to every data collection visit, they were requested to view and erase any unwanted material and provide written consent for the licence of their video recordings on a 'Future use of my video diary' form (Appendix 21). The pilot study showed that going more often was unnecessary as 8GB memory cards provided enough memory to last a fortnight and going more frequently could have been intrusive. On uploading to the computer, each diary entry was labelled with the mother's pseudonym, postnatal week, date and time the recording started. However, for the purposes of the thesis just the pseudonym and postnatal week are recorded, thus Tracey1 means that Tracey recorded this during her first postnatal week.

Mothers were requested to maintain their video diaries until they perceived their chosen method of feeding (breast and/or formula feeding) had become established which meant that the data collection period was determined by the mother, and not by me. Since it was anticipated that some mothers might move to exclusive formula feeding during the first few weeks following birth, I was keen to capture this as part of the mothers' experience of infant feeding.

In total participants recorded 291 video entries, lasting 48 hours, 14 minutes and 38 seconds (Appendix 27). Table 4 lists the frequency and length of video recordings, which also varied, with most mothers recording on most days in the early weeks and clips lasting from nine seconds to almost 72 minutes. Sam recorded the shortest amount of time, over the shortest period and spent the shortest average time recording. Conversely, Rosie spent the longest average time recording (18 minutes), but Vicky recorded the most entries at 121 recordings and an average of eight minutes. The diversity in timings, quantity and frequency of recordings demonstrates the commitment of mothers to the research.

Most mothers continued filming beyond the eight weeks expected in the research proposal (Table 4). Sam, who was 'matter-of-fact' about her diary, stopped recording at eight weeks, but all others recorded on a regular basis to between nine and twelve weeks postnatally, with two filming with a long breaks after 12 weeks until 18 to 20 weeks. Indeed, Vicky felt sad when it was suggested that she could stop collecting data when breastfeeding seemed to have become established at eight weeks, and so carried on filming until her twentieth week.

> *when I was told … you've had eight weeks now and you're established in how you are feeding, I felt really sad and I didn't want to stop filming* (Vicky12)

Most mothers recorded less frequently during the latter weeks of data collection suggesting a 'natural weaning' from the camcorder. This is reflected in the numbers of days without recording. Tracey for example had a flurry of filming activity at 12 weeks when she appeared to be in the depths of despair with incessant feeding. Her filming stopped abruptly when breastfeeding stopped abruptly the following week and was recommenced during her nineteenth week to briefly narrate events that caused the transition to formula feeding.

Participant Pseudonym	Average length of a recording	Number of days/weeks recorded over	Commenced recording- date and postnatal day	Last recording date and postnatal week	Max number of recordings in any one day	Shortest recording	Longest recording	Total time recording	Total number of recordings
Rosie	18 minutes	63 days 9 weeks	14 Feb 2012 1 day	17 April 2012 10th week	3	9 seconds	43 minutes 20 seconds	14 hours 59 minutes 35 seconds	51
Sam	4 minutes 48 seconds	48 days 6^{+5} weeks	28th Dec 2011 5 days	13 Feb 2012 8th week	2	1 minute 49 seconds	20 minutes 38 seconds	1 hour 26 minutes 32 seconds	18
Sarah	8 minutes 22 seconds	87 days 12^{+3} weeks	2 March 2012 3 days	28 May 2012 13th week	2	1 minute 10 seconds	32 minutes 48 seconds	4 hours 19 minutes 36 seconds	33
Tracey	12 minutes 33 seconds	130 days 18^{+4} weeks	14 April 2012 7 days	22 August 2012 19th week	6	27 seconds	57 minutes 42 seconds	11 hours 42 minutes 52 seconds	71
Vicky	8 minutes 9 seconds	123 days 17^{+4} weeks	13 Jan 2011 11 days	16 May 2011 20th week	8	17 seconds	1 hour 12 minutes 45 seconds	11 hours 23 minutes 3 seconds	121

Table 4 Video Diary recording details for each mother

4.5.5 Analysis

Using video methods for data collection meant that I needed to consider carefully the approach to analysis. Communication through facial expression, body language, movement and sound was a feature of the video footage, and therefore, I needed to consider more complex analysis than text or photographs alone (Pink 2001).

From my literature review, I identified a range of methods to analyse video recordings, although many were only mentioned briefly or appeared unnecessarily complex. The aim of this research to co-construct, between me as the researcher and the mothers, enhanced understanding of the socio-cultural nature of breastfeeding meant that the analysis required an interpretive approach which was holistic and remained close to the mothers' experiences (Pocock et al. 2009; Rees 2010). Therefore a standardised automated approach using pre-defined codes to a specified framework was not considered (Knoll and Stigler 1999). Analytical approaches involving frame by frame analysis on short, restricted sequences of action have also been used. Svensson et al. (2009, p. 890) used ethnomethodology and conversational analysis of video recordings during "naturally occurring' surgical operations" to explore the way complex activities are portrayed through talk, body language and the use of tools and technologies. Suchman and Trigg (1993) used situated action to focus on the relationship between the individual and the environment over 90 minutes to explore in minute detail the interaction between people and objects. These two approaches were also not considered suitable for the large amount of data in my study.

Goodwin (2000) developed a method of analysing the direction of gaze. Peräkylä and Ruusuvuori (2009) used three changes from the basic straight face in naturally occurring interaction: positive expressions (joy/amusement) involved lifting of corners of mouth and wrinkling of corners of eyes; negative expressions (sadness disapproval) involving slight lowering of corners of mouth together with

pursing of lips and frowning; and surprise involved opening of mouth and raising of eyebrows. Considering these approaches on selected diary entries were useful when mothers shared their emotional experiences but not used on the whole data set.

Mondada (2009, p. 51) proposed the “praxeological approach” to analyse how the camcorder is actually used during film making, including video shooting, camera movements, technical choices such as zooming in and out and individual perspectives demonstrated by what is captured in the frame and out of the frame. This approach was used to examine how surgeons used video for laparoscopy under normal circumstances and then to broadcast to a lecture theatre for teaching purposes (Mondada 2009). In my study it was important to consider how each mother and her family were framing their experiences of breastfeeding, because it provided insights into the socio-cultural context of parenting, including breastfeeding (5.2). However, it was not the sole method of analysis.

Thus, as detailed below, I drew on various aspects of analysis considering direction of gaze, facial expressions, body language and how mothers used and angled the camera frame alongside the words they spoke to develop a multidimensional approach that was then applied to a basic thematic method of analysis to discern patterns of meaning (Braun and Clarke 2006; Hahn 2008).

Knoblauch (2009) used video hermeneutics and discussed the importance of sequential analysis involving the identification of pieces of action and exploring their interrelationships with one another. On the macro level whole scenes were interpreted, and on the micro level, key scenes were interpreted frame by frame (Knoblauch 2009). Paying attention to this, I ensured I developed a method of logging the data to aid to sequential analysis, before commencing the detailed coding required for the thematic analysis.

Thus, as suggested by Collier (2001), I started the analysis process by observing the video clips from each mother sequentially, with little disruption between the diary entries, to gain a sense of each mother’s journey. Watching the data in this

way helped me to become immersed in all aspects of it, by observing activities and interactions in context and the sequence of the mothers' experiences (Braun and Clarke 2013). Rich and colleagues (2002) started their analysis by logging the video tapes using descriptions of the objective observations and subjective accounts of what was seen and heard on the videos. Similarly, on my second watching, I made hand written notes with essential content including, date and day following birth, the woman's environment and verbal and non-verbal behaviour including the content of discussion. I tried not to stop the video too often so as not to disrupt the flow of the entry, crucial in maintaining a sense of sequencing of the whole data set. This ensured that changing attitudes, behaviours and issues were recorded over a period of time and not lost in the analytical process. These handwritten notes were typed up as outline logs in a word document (Appendix 24).

This "familiarisation phase" of thematic analysis, enabled me to think "actively, analytically and critically" about the data to create initial impressions that were pertinent to the research question which also assisted with the identification of connecting and contrasting patterns (Braun and Clarke 2013, p. 205) which I plotted on a large mind map (Appendix 25). Some very early initial impressions included 'using the camcorder as a confidante', 'the emotional side of breastfeeding', 'influence of family and friends', 'performing for family', 'trouble shooting', 'worrying about the future', 'night-time parenting', 'feeding in public', 'what is successful?', 'routine versus baby-led' and 'when is breastfeeding established?'

The next phase involved me undertaking a "complete coding" exercise on the whole data set, including "everything and anything" that might be relevant to answering my research question (Braun and Clarke 2013, p. 206). According to Rich and Patashnick (2002, pp. 249–51) NVivo enabled a multi-dimensional, multi-layered approach to analysis of VIA research. Realising the enormity of my analysis, with a multi-dimensional approach and the large amount of data, I experimented with two different CAQDA software programmes (Silver and Lewis

2007); Transana and NVivo, as they claimed to assist with video analysis. Uploading data onto both platforms, I explored each programme to see which would facilitate my approach to analysis best. 'Hands on' training with ongoing online support was more readily available for NVivo, than Transana which was only available in the United States at the time. Thus, gaining enhanced insights and increasing confidence by engaging in a two day intensive course, I selected to use NVivo 10.

With the advent of research methods used to collect audio data, analysis of textual transcriptions has become the focus of qualitative research (Markle et al. 2011). Transcriptions have continued to be used with audio-visual data despite not providing the complete and vivid picture of people's experiences (Knoblauch et al. 2008). Bezemer and Mavers (2011, p. 193) proposed a multimodal method for transcribing multimedia data using a "social semiotic perspective". They suggested that this transcription method becomes an analytical tool in itself as it relies on the researcher producing "transducted and edited representations" of the video data rather than simply describing or translating them (Bezemer and Mavers 2011, p. 196). Markle et al. (2011, para. 20) agreed that transcribing multi-media data adds an extra level of analysis but argued that its accuracy is compromised because, although spoken words are reported correctly, transcribing

> "fails to capture the individual and collective actions and emotions that provide richness to an event".

Indeed, Markle et al. (2011) further suggested that transcribing is inefficient as it is the most onerous and time consuming aspect of the analysis process, which is compromised further if shortcuts are made such as employing a transcriber. Additionally, one of the major limitations to using the video data method was the extremely time-consuming nature of transcribing (Cotton et al. 2010; Rich et al. 2000b). Therefore before "complete coding" commenced, all video clips were uploaded onto the NVivo programme together with a the outline log describing the

essence of the clip, including people present, environment, main discussions heard, and behaviour and actions seen.

To prevent the potential of loss of a layer of data through transcription (Markle et al. 2011) and embracing the opportunity of repeatedly viewing small segmented clips in an iterative process as suggested by Cotton et al. (2010), “complete coding” was achieved across the entire data set using NVivo. This iterative process ensured my focus of analysis did not centre on the spoken word alone but facilitated my immersion into the cultural aspects of breastfeeding, assisting my ethnographic approach to analysis.

The video diaries presented both objective data which was easily observed, and subjective data such as the emotional content that needed to be identified to interpret the psychological dimension of each diary entry (Rich and Patashnick 2002). The iterative process enabled a multi-dimension approach to the analysis, because I was able to ‘observe’ the verbal content closely together with the visual, so that video clips could be “sliced” and coded multiple times and in multiple ways, through a simple drag and drop system within the NVivo software programme (Bazely and Jackson 2013, p. 72). Codes were labelled with words or phrases that depicted both explicit, “data-derived” codes which were “participant generated”, and interpretive “researcher-derived codes” when I applied my scholarship based knowledge and experience of breastfeeding to make further sense of the data (Braun and Clarke 2013, p. 208). Therefore analysis and coding of emotions and behaviour derived from facial expressions (Peräkylä and Ruusuvuori 2009) and body language (Argyle 1990), along with linguistic detail (Svensson et al. 2009) was undertaken. These codes sat together with each segment of data within the software so as not to lose the meaning. “Slicing” the data and tagging the segments with codes enabled data to be collected together, compared and contrasted (Bazely and Jackson 2013). I applied Braun and Clarke’s (2013, p. 211) motto of “inclusivity”, and worked through each video diary methodically, with my broad question in mind, informed by a social constructivist

perspective. From this process, I derived 170 codes from the data initially. The slices of video data attached to each code ranged from two to 147.

The next phase involved me re-focusing the analysis to identify categories where codes combined and contrasted to form patterns of meaning (Hahn 2008). This active process involved me reviewing the codes and data within them, to find relationships between the codes, and differences where further 'coding on' was helpful. This enabled clusters of codes to be gathered into categories to refine the focus to address the research question in a meaningful way. While each code represented one idea, a category or subtheme had a "central organising concept" which embraced a collection of the codes all related to the one concept (Braun and Clarke 2013, p. 224). The central concept around the category, 'essential paraphernalia' for example was 'equipment that mothers relied on to survive breastfeeding including rationale', so examples of codes were 'specialised teats', 'nipple/ teat confusion', 'breast pads', 'excessive leaking'. By "progressive convergence of ideas" the categories were grouped together to form provisional subthemes (Hahn 2008, p. 7). The subtheme 'surviving', for example had a core concept of 'mothers working out how to survive breastfeeding 24 hours a day' including 'coping with problems' and thus the category 'essential paraphernalia' was an element of the subtheme. These subthemes were organised into broader themes. At the end of this phase, three main themes were identified, with a number of provisional subthemes.

During the next phase, I reviewed and refined the provisional subthemes returning in an iterative cycle to the coded data video extracts to ensure they fitted together within each theme (Haw and Hadfield 2011). Reworking the themes and moving codes and categories around was necessary until a thematic diagram was created for each main theme (Braun and Clarke 2006). This process often caused much deliberation as I agonised where codes and categories sat in the wider socio-cultural nature of breastfeeding and hence how the subthemes and themes were finally discerned. A theme or subtheme was not discerned by the frequency of coded data but more by whether patterns of meaning provided fresh

insights into the daily experiences of the breastfeeding mothers. Defining, refining and renaming the themes involved writing up the 'essence' of each theme, determined in particular, by the aspects of data that revealed something new to report in the research findings. The essence of the theme 'Working it out' for example, one of the themes, was 'mothers working out issues related to breastfeeding by discussing, reflecting, sharing thoughts and feelings and/or filming experiences which showed them moving from being a novice to a more confident breastfeeding mother.

From the analysis of the data, three themes, seven subthemes and 27 categories were discerned from the original 170 codes. In the analytical process themes, subthemes and categories were not distinct entities but had many meaningful interconnections between them, as presented in a thematic map (Chart 2). The three themes form three separate findings chapters: 'But what I really wanted to tell you…mothers using the camcorder' (Chapter 5); 'Working it out' (Chapter 6); and 'The Support Conundrum' (Chapter 7). Using an illustrative approach, as described by Braun and Clarke (2013), I have provided a detailed interpretation of each theme, together with its subthemes using rich, thick descriptions, data quotations and still images to illustrate my analysis (Brown et al. 2010) within the findings chapters (Chapters 5, 6 and 7). Creswell (2013, p. 252) proposes that "rich, thick description" enables the reader to determine whether findings can be transferred to other situations with mutual characteristics. Tracy (2010) emphasised the need to use specific detail and participant quotations to produce thick descriptions so that in-depth socio-cultural understandings can be compared with other theories and perspectives of breastfeeding, thereby enhancing credibility. It was during this phase that full transcriptions of the illustrative data quotations to be used were prepared for the purpose of the thesis. Mothers' quotations are presented in italics, and '…' indicate where quotations start mid-sentence, or speech is omitted. Text in square brackets has been added to clarify quotations or to describe visual activity occurring at the time.

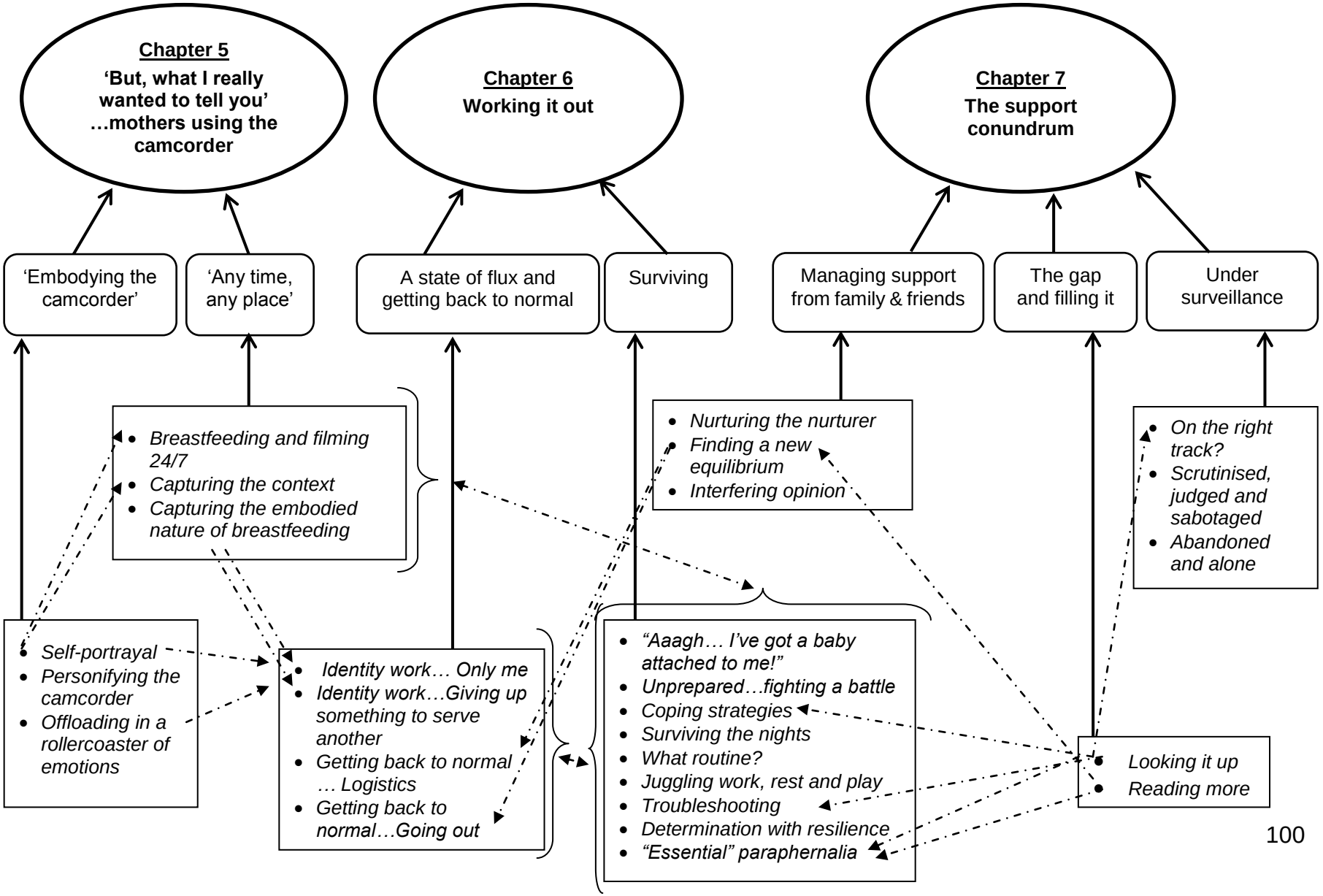


Chart 2 Thematic map showing themes, subthemes and categories

The final phase of analysis involved me returning to the complete dataset so that the findings from the themes were viewed again within the larger context of the international literature relating to mothers' breastfeeding experiences, providing further understandings of the significance of their experiences of breastfeeding (Braun and Clarke 2013). I identified five important areas which drew on the main themes including interconnections between subthemes and categories which are presented in the discussion (Chapter 8).

The next chapter presents the findings from the first theme, discussing the way in which mothers used the camcorder to film their video diaries.

5 ‘But, what I really wanted to tell you’… … mothers using the camcorder

5.1 Introduction

In this chapter, I present the findings from the theme ‘But, what I really wanted to tell you…mothers using the camcorder.’ The first subtheme is mothers’ perspectives in relation to turning the camcorder on ‘any time, any place’. Three categories were included in this subtheme: *‘breastfeeding and filming 24/7’*, *‘capturing the context’* of the breastfeeding environment and *‘capturing the embodied nature of breastfeeding*’. Discussing the three categories that form the second subtheme ‘embodying the camcorder*’,* I explore how mothers represented themselves in front of the camcorder in their *‘self-portrayal’.* Secondly, I examine how mothers talked in video diaries by ‘*personifying the camcorder’*. And finally, I demonstrate how mothers embodied the camcorder *‘offloading’* experiences by letting go of their emotions and inhibitions in a ‘*rollercoaster of emotions’* to fulfil their own needs as well as those of the research.

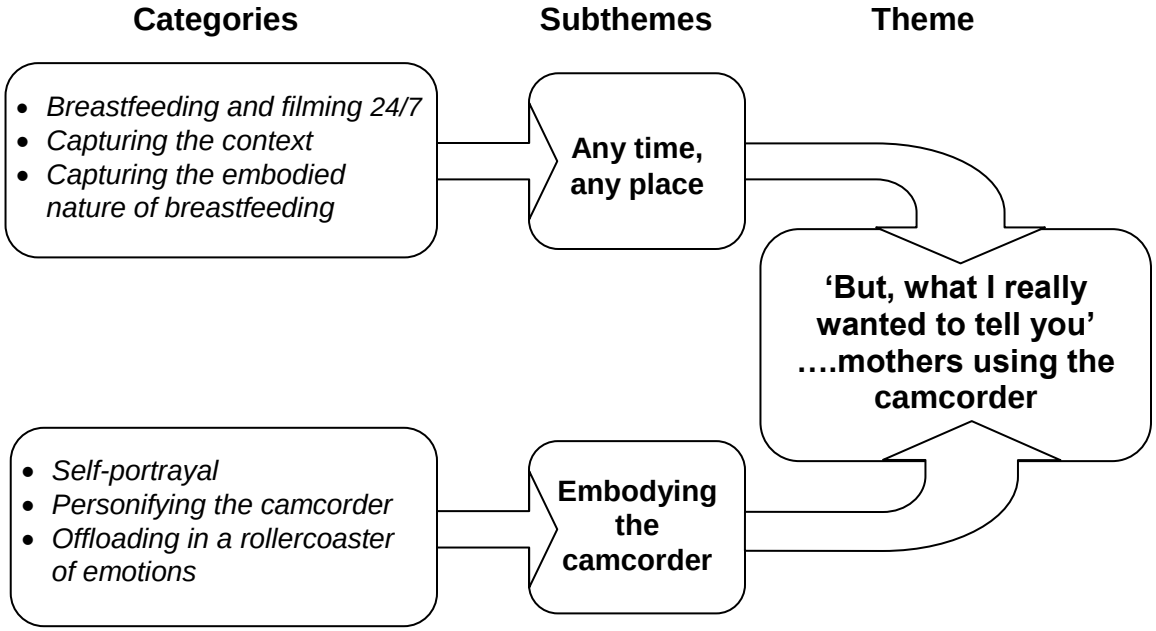


Chart 3 Categories, subthemes and theme: “But I really wanted to tell you” …mothers using the camcorder

5.2 Any time, any place

Entrusting the camcorder to mothers enabled them to self-direct their video diaries and to decide when and where to record. This was particularly important as new mothers often experience serious time constraints (Dykes 2009); they were able to record what they considered was important at any time.
Self-directing their filming enabled them to determine length, depth and level of personal detail that they wished to share. The mothers demonstrated their commitment to the research by turning on the camcorder at all hours, *breastfeeding and filming 24/7*, in a variety of places. This subtheme explores how mothers used this time and space to record their experiences, providing valuable cues about the environment of feeding as well as unique visual insights into the embodied nature of breastfeeding.

5.2.1 Breastfeeding and filming 24/7

The date and time were recorded by the camcorder, which provided detail of when and how often recording took place and the length of each recording. Some mothers made it a routine to turn the camcorder on at a certain point in the day, whilst for others it appeared to be random, possibly when they could fit it in around breastfeeding and other daily activities and sometimes in their 'hour of need'. Sometimes, when life was particularly difficult or hectic, this was more than once a day, and when mothers missed filming for a day or two they often apologised. This demonstrated a genuine sense of responsibility towards something/somebody (perhaps the research project, the researcher or themselves) and a feeling that they had let them/it down.

> *I'm sorry it's a bit of a rubbish video for today, but I don't know where the day's gone again … sorry you didn't get a video yesterday, but I will endeavour to do a decent video tomorrow* (Sarah2)

Self-directing their video diaries also gave mothers a voice to report what they thought was important at a time most convenient to them. All but Sam turned the

camcorder on at random times in the 24-hour cycle. The random recordings, particularly at night, sometimes demonstrated a sense of urgency to report the latest experience. On other occasions it was because mothers needed the camcorder to witness what they were experiencing at a particular time.

It was crucial to mothers to record that breastfeeding continued around the clock and what that experience felt like. By recording action related to breastfeeding as it was happening, mothers provided the viewer with a 'real-time' perspective of breastfeeding that has not been captured on camcorder before. Sometimes mothers appeared to be falling asleep as they were speaking despite battling to stay awake. The spontaneity of recording provided evidence of the impulsive nature of turning the camcorder on anytime to talk without any sense of planning or forethought. Mothers' appearances in the way they dressed and presented themselves, for example, often seemed to correspond with the timing, changing priorities and spontaneity of filming.

> *This morning…had a plumber round to fix …tap ...at 9 and was still in bed and I don't really care anymore, people can see me how they want to see me, I'm clean, not going to smell or anything but I've just had a newborn baby and I'm not going to be as vain as what I was and get all dolled up just for a plumber, I'm still in my pyjamas and I'm quite comfortable and I know my hair looks like a scarecrow and everything but I don't really care…* (Tracey3)

The level of spontaneity when recording was also demonstrated as mothers turned the camcorder on when they were unwell. Vicky, for example, had gastroenteritis and filmed in bed with a flannel on her head in between vomiting episodes. The visual cues as well as the verbal data provided valuable insights into what it was like for her to continue breastfeeding as she not only sounded ill, having difficulty speaking, but looked ill too (Figure 1). It was crucial to mothers to portray that they were still breastfeeding despite illness and to explain how they were coping. Seemingly the 'show must carry on', not just in terms of

breastfeeding 24/7, but in terms of filming too, which further demonstrated their commitment.

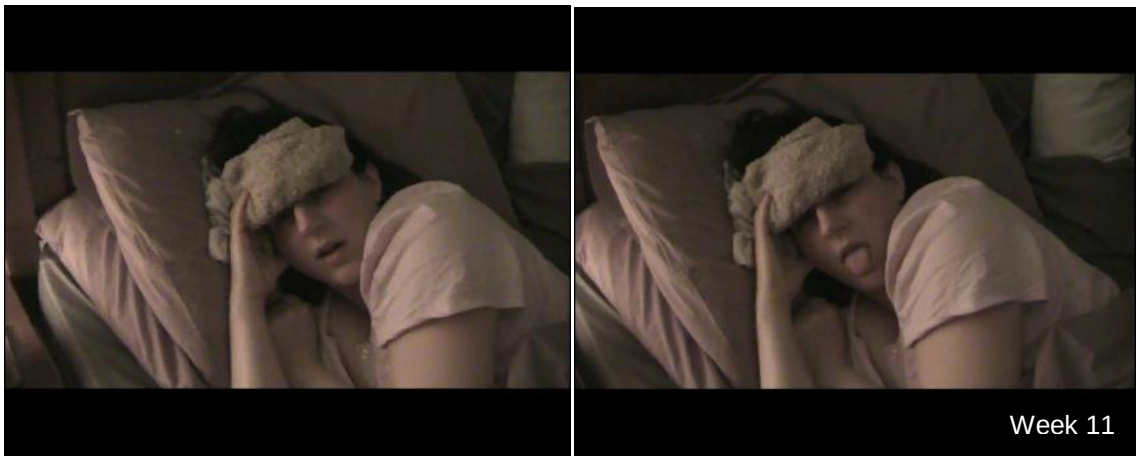


Figure 1 Filming any time, any place included during illness

Self-directing also meant that mothers decided what detail to omit and when not to record. Brett (1987) argues that omissions in written diaries are significant because writing about emotional turmoil can sometimes cause further anxiety. In this study, omitting to film for a few days also seemed important. It was noticeable that sometimes mothers did not film when there were breastfeeding problems. The delayed recording was perhaps not always deliberate because life had been hectic while they were trying to resolve the problem. Conversely, the decision to delay filming may have been intentional because they were too disappointed or emotional to record. At these times they later recorded what had happened together with the eventual consequences. Perhaps because they knew the outcome of the problems, it was an easier story to tell and emotions were not running so high. On other occasions they said they had purposefully not recorded in a distressed state and had waited until they felt calmer.

> *I missed yesterday again ...had a traumatic 48 hours, so much has happened …I'm not feeding anymore at the moment until I'm healed and until the infection has calmed down a little bit* (Sarah2)

Didn't film last night because I was crying, like sobbing, aaagh, just because I couldn't get him to go to sleep (Vicky6)

The sense of urgency to record on other occasions, however, was tangible, as mothers turned the camcorder on at the first possible opportunity to talk about what was happening and how they were feeling. When these points of crisis occurred, frequency of filming often increased up to five times in one day (5.3.3). Sometimes, the increased number of recordings was related to disturbances during filming such as the baby crying or the telephone ringing. On other occasions, they needed to *'offload'* and explain how they were feeling in the moment because of what was happening at the time (5.3.3) and at other times it was because they had forgotten to say something that they considered vital for the research.

[Turning camcorder back on] I just remembered one more thing I wanted to say, breastfeeding in a way gives me the sort of security because nobody else can do it...(Rosie1)

[Turning camcorder back on] I forgot to say two things in the previous video, I said I have got a microwave steriliser to sterilise my breast shields which I've done…but I was just thinking how difficult will it be in the middle of the night…(Sarah1)

Self-directing enabled mothers to stop and start filming whenever they wanted. This resulted in sometimes stopping the camcorder abruptly mid-flow in a conversation and there was not always an apparent reason. What they were saying, however, sometimes seemed important but the topic of conversation was never spoken about again. This could be considered as a particular strength of this research method as mothers did not feel pressurised to say something they did not wish to share. On other occasions, however, the persistence and urgency to continue an interrupted conversation was very evident and the clip would restart with *'Like I was saying...'* (Tracey5)

5.2.2 Capturing the context

Self-directing enabled mothers to record wherever they felt most comfortable, and that meant that most mothers filmed in their own home or garden. Initially, partners sometimes operated the camcorder but for most recordings mothers filmed themselves, although partners and other family members sometimes passed by, joining in the conversation or just making a random comment. They often recorded in the living area during the day and bedroom in the morning or evening. This gave the impression that filming became integrated into daily life so that, for example, filming just before getting up or going to bed was often done in the bedroom.

There was sometimes a purposeful decision to film alone and thus a suitable environment was selected, usually the bedroom. This provided valuable visual clues about sleeping arrangements for the baby, sometimes purposefully showing me, and sometimes caught as they panned the room with the camcorder. Once babies were asleep they were left undisturbed (Figure 2).

Two mothers filmed in the bathroom whispering in hushed voices for fear of being interrupted or overheard. Vicky wanted to record her daily entry but because it was late and her partner was in bed asleep, she retreated to the bathroom. Conversely, Tracey wanted to disclose something and didn't want anyone to hear. On both occasions she did not use the camcorder to talk about breastfeeding but instead used it as a confidante to talk through what was troubling her. She used this private space to whisper about personal issues, changing personal relationships, giving a clandestine feel to her diary entries.

Figure 2 Babies sleeping

Self-directing video diaries empowered Vicky to take her camcorder almost everywhere she went so that she rarely missed making a daily diary entry in the early weeks. Daily life for Vicky was not constrained to her own home, so her commitment, for example, involved taking the camcorder and using it on a family weekend break. It was important for her to record what it felt like to stay somewhere different with her baby, breastfeed in front of others and what she experienced in relation to opposing views regarding parenting styles and breastfeeding. This provided valuable insights into the socio-cultural context of the wider family with mothers feeling pressure from family and friends when 'nuggets' of wisdom were shared from outdated infant feeding practices.

> *...It's fascinating, it's such an emotive topic, everybody's got something to say about it [breastfeeding]* (Vicky8)

> *…when I was feeding, she told me that her girls just had five minutes on each side and every four hours and they did fine….when he was crying…she said let him cry himself to sleep, 15 minutes should do it.* (Vicky8)

Mothers used contrasting methods of showing life with a breastfeeding baby. Vicky enjoyed recording her conversations with others in their homes and gardens. Filming in different locations provided visual information about the social context of infant feeding. A bottle of milk on the coffee table, for example, provided visible cues that not all Vicky's friends were breastfeeding. Tracey gave the camcorder a tour around her kitchen pointing out dirty crockery left in the sink and then pointed the focus into her fridge identifying food that had been bought which she perceived to be good or bad for breastfeeding. Sometimes, without any words from mothers, these visible clues provided valuable insights into the level of support available to mothers including peer and practical support.

Sometimes lighting in the room was very low which caused visual difficulties, but for me this reflected life as it was with a breastfeeding baby. Rosie's recording at night in the dark showed faint movements as she rocked her baby for the entire

two diary entries lasting 31 and 27 minutes. It again suggested the sense of spontaneity and authenticity in the diaries. Indeed the breastfeeding environment was sometimes only evident through the visual element of the data. As discussed later, mothers' dependence on special cushions, chairs and other equipment such as nipple shields, pads and shells was seen in the early days but as they gained confidence most of these disappeared (6.2.9). Other pieces of furniture like a rocking chair were introduced later which demonstrated how mothers were developing coping strategies to survive life with their unsettled baby. Rosie filmed an entire diary entry with herself bouncing on a 'space hopper' which was evidence of a rather unusual strategy to create the movement required to keep Lily settled (6.2.9).

Rosie's dependence on a sling witnessed in the early days, progressing to a different way of wearing it in later diary entries, confirmed her parenting philosophy of keeping her baby close. With her hands free and her mind-set on multi-tasking, she often filmed herself doing other jobs such as laundry folding, cooking and gardening whilst chatting to the camcorder. She appeared completely comfortable *'rambling'* for at least half an hour while she breastfed or did jobs around the house or garden. Possibly, by multi-tasking she was able to spend more time chatting to the camcorder. Contrastingly other mothers talked about 'putting their baby down', and took pride in showing cribs, cots, bouncy baby chairs and baby gyms. These pieces of equipment were all used by the mother to gain some distance and space from her baby and time to engage with other activities which included stopping to record her video diary. Tracey was sometimes seen gulping energy drink which would never have been known without it being witnessed on camcorder. Seemingly this was one of her ways of coping with the extreme exhaustion that had set in a few days after having her baby. Thus the different parenting styles and ways of coping were displayed as much through the visual cues within the environment as through what the mothers shared through conversation (Figure 3).

Different coping strategies and parenting styles observed

Figure 3 Visual cues in the environment

Mothers' states of undress provided further insights into the challenges of breastfeeding. Mothers were sometimes seen topless while breastfeeding in the early days suggesting a need for them to be able to clearly see what they were doing as they attached their baby and continued to breastfeed. They were often seen in nightclothes, sometimes because it was the appropriate time of night or day but at other times it was simply that they hadn't found the time to dress, or they had chosen to stay in more relaxed clothes. While mothers' discussions about the importance of wearing the right clothes for breastfeeding was valuable (6.2.9), the visual data provided extra insights about how clothes impacted on breastfeeding. Mothers were seen grappling with layers of clothing, bra straps and catches. This awkwardness was more obvious in the early days (Figure 4). As they gained confidence it became less of an issue both in their verbal expressions and in what was observed.

> *Because I was having a t-shirt and a jumper which I had to pull up and then, I was sort of holding them under my chin, like that, and then try and see what I am doing and they keep falling down. So today, I've put on this cardigan with the buttons and also a top that is sort of low enough that I can pull it down…it seems like really little things like that make a massive difference to whether it feels difficult and stressful or not.* (Rosie1)

Figure 4 Visual evidence of the early struggles with layers of clothing

5.2.3 Capturing the embodied nature of breastfeeding

The video diaries offered me a unique presence of being there with mothers. For some mothers, an intimate relationship with their baby was seen simultaneously developing with their growing confidence in breastfeeding and motherhood. The sensual, embodied, visceral nature of breastfeeding involved a reciprocal relationship with the baby, so that the intimacy, connectedness and enjoyment were observable on camcorder. When mothers appeared relaxed and happy, they would be caressing, crooning and rocking their babies, with conversation with the video diary and loving chatter with their baby being intertwined. Sometimes that reciprocal relationship could be seen with the baby staying attached to the breast and relaxing into the feed. Then a feeling of mutual harmony was evident. This embodied experience was also witnessed visually when the baby came on and off the breast during the diary entry (Figure 5 & 6). Rosie, for example, giggled with Lily when she was snuffling around trying to find her breast and again when she came off the breast and milk sprayed everywhere including on Lily's face.

Diary recording involves talking to the camcorder as well as breastfeeding and chatting to baby
Figure 5 Breastfeeding during diary recording

Figure 6 Camcorder is focused directly on breastfeeding

Vicky summed up what this intimate side of breastfeeding meant for her during one of her last diary entries:

> *… he sort of rests his little hand on my breast, and the little noises he makes, it's so lovely and you sort of have a rush of love for your baby…and he like flutters his little eyes and when he's really tired you see his eyes rolling back, and when he goes to sleep I have to say there is nothing more wonderful, it is lovely* (Vicky18)

Contrastingly, some mothers, while feeding sometimes appeared tense and exhausted, with disjointed and distracted conversations with their video diary, and facial expressions that portrayed physical discomfort. Tracey, for example who winced momentarily, flinched and stopped talking temporarily to look down to see what was happening, before looking at the camcorder again as if to say, 'did you see that'. These mothers, appeared to be constantly checking attachment, and the visual element displayed a sense of pain, disorientation, disharmony, frustration and despondency with their breastfeeding experience (Figure 7). This was then sometimes borne out in their conversations about breastfeeding as they became more ambivalent about the relational, child centred, embodied aspects of

breastfeeding, because it remained incessant, painful, exhausting, draining and stressful. Indeed the visual elements corroborated verbal evidence and are discussed from a different perspective in 6.2 when mothers felt like they were fighting a never ending battle of relentless feeding.

Facial expressions provide clues: wincing, stopping momentarily to look down at breastfeeding before continuing with the conversation
Figure 7 Capturing the embodied nature of breastfeeding

Capturing the embodied nature of breastfeeding meant that there were occasions when a dissonance between what mothers were saying and what I could see also occurred. Sometimes mothers were talking about how well their babies were breastfeeding, and I, with a 'health professional's eye' could see suboptimal attachment or positioning (Figure 8 & 9). Maybe this explained incessant feeding or problems like sore nipples that mothers perceived were normal.

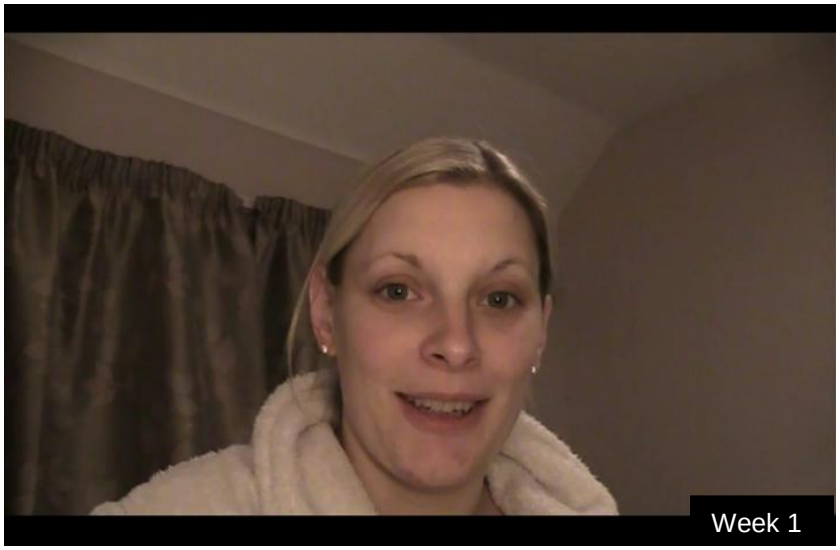
Mother is holding baby's head. Optimal positioning is to support the shoulders enabling baby's head to tilt back, and so the chin leads onto the breast (UNICEF UK Baby Friendly Initiative 2012a)

Figure 8 Suboptimal positioning of mother and baby

Baby's nose is pressing into breast and chin is clear of breast. With optimal attachment, the baby's head would be extended, the chin would be indenting the breast and nose would be clear of breast. (UNICEF UK Baby Friendly Initiative 2012a)

Figure 9 Suboptimal attachment of baby on the breast

It was rare to observe facial expressions that did not match the verbal content of the diary, such as when mothers were smiling while discussing some very frustrating moments (Figure 10), or crying when they were happy. When this did happen it might have been because they were putting on a brave face or were defensive about what had happened and trying to protect themselves from getting more upset. Alternatively, perhaps the emotional turmoil that new motherhood brings, produced surprise emotions even though a feeling of contentment was being expressed.



I feel like the luckiest person in the world despite my body not doing what I want it to do, and being sore and a bit [brief pause] of a mess (Sarah1)

Figure 10 Mixed emotions caught on film

Watching the video diaries sequentially enabled me to view how mothers settled into recording their video diaries and also how they developed confidence in their 'breastfeeding'. Thus for some the enjoyment and reciprocal nature of breastfeeding was evident at the beginning of their breastfeeding trajectory, for others it developed over time as their breastfeeding experience improved and they appeared empowered and proud of their success. For other mothers, however, it was always a battle, a painful unpleasant experience that made them feel disorientated and disillusioned. Thus the visual elements usually

corroborated the verbal elements of the video diaries illuminating the embodied nature of breastfeeding.

5.2.4 Summing up – any time, any place

This subtheme demonstrates how mothers were empowered to self-direct their video diaries by turning on the camcorder in any place at any time to talk about their breastfeeding experiences. The video diaries showed how mothers set up the environment for feeding and how this was developed and revised as they learnt how to cope with the demands of breastfeeding 24/7. The need to turn the camcorder on and talk in the immediacy of the moment was particularly demonstrated by mothers recording their diaries both day and night. Mothers knew they could not get a response from the camcorder and yet they still wanted to record 24/7. The visual data also provided valuable insights into the embodied nature of breastfeeding, showing what and how the mothers were feeling and experiencing during their breastfeeding trajectory, becoming more confident or disillusioned and disorientated as time progressed.

The next subtheme will explore how mothers 'embodied' the camcorder.

5.3 Embodying the camcorder

All mothers embodied the camcorder, enabling them to share experiences, feelings and emotions. This subtheme first explores mothers' '*self-portrayal'* as they sought to represent themselves using the camcorder. It also examines how they '*personified the camcorder'* so that experiences and emotions could be shared and '*offloaded*' with their perceived audience, fulfilling their own needs as well of that of the research.

5.3.1 Self-portrayal

Handing over the camcorder to mothers meant that they could use it to create self-portrayals. Seemingly, portraying themselves, did not appear daunting, although for some it took a few recordings before they felt relaxed.

> *I was a bit nervous to start with, I found myself not telling you very much, but as I got more practiced at it, it became easier to chat to the camera*…(Vicky12)

As mothers became used to turning the camcorder on, they became creators of their own representation and, not unlike reality TV, they chose different ways to portray themselves. Controlling the camcorder enabled them to make choices about how much they were prepared to reveal, not just about their own emotions and experiences but also about their bodies and identities. These choices made consciously or subconsciously might have been informed by what they thought 'their audience' needed to hear and see, as discussed in the next two sections and the discussion chapter (8.2).

Mothers (except Vicky) practised using the camcorder in pregnancy, which was identified as important for gaining confidence in filming themselves following the pilot study. Using the technology did not appear to deter mothers filming their video diaries, although Vicky and Tracey started by using partners to shoot the film. They used this opportunity for joint conversations which helped them reflect on the order of events since birth. Once their partners returned to work they appeared more confident to use the camcorder without someone else to shoot the film or converse with. Partners, and in Vicky's case, friends were however still included in some occasional conversations during filming episodes. When someone was present mothers portrayed themselves as positively buoyant whereas sometimes when they were alone it was less positive, appearing downhearted, angry or emotional. Seemingly the influence of another's presence prevented the mothers opening up to the camcorder and thus perhaps the self-portrayal in front of a known 'other person' over-rode their capacity to be frank. This added to the clandestine feel to the diary entries (8.2.1).

What mothers chose to frame for their video diary varied from mother to mother but most were found adjusting the camcorder at the beginning and sometimes later to ensure the image they desired was of use. Rosie in particular, who tended

to be active during filming, spent time pointing the camcorder at the right angle to get everything she was doing within the frame. Other mothers were seen arranging their hair as they set up the camcorder. Some laughed about using the camcorder as a mirror. They could clearly see their own image during recordings and hence they witnessed their self-portrayal in real-time. Mothers sometimes apologised for their appearance giving the impression that they did not approve of what they saw, perhaps thinking, that '*looking rough'* meant that their standards had dropped since having a baby. Not being perturbed by this, they still submitted their video.

> *I look a bit rough because it is first thing in the morning and I haven't got any makeup on and I'm still in my pyjamas, so sorry about that* (Sarah6)

> *Sorry I'm looking at myself in this filming and I think [smiling] I just look so rough* (Tracey9)

Tracey often remarked on her own image (Figure 11). Seeing herself in the camcorder triggered self-reflection about her physical, emotional and psychological wellbeing. It often made her reflect on how she had changed from who she was before giving birth and she admitted that she did not like who she saw. Despite these reflections, it did not deter her from submitting her self-portrayal for research analysis.

Broken out in a load of spots, like around here…which I know is hormonal …because I'm an international skin care specialist, whooooo, well I used to be before his little one …and I'm getting quite spotty here and dry here which means it's emotional and psychological and also hormonal. (Tracey11)

Figure 11 Using the camcorder stimulated self-reflection

> *I'm just looking at the picture of like me filming this and this just isn't me, this isn't who I am, I'm not somebody that's like angry all the time…* (Tracey12)

All mothers could edit their video diaries but all told me that they had chosen not to edit them. Most had not even re-played the video as they felt no need to review it before handing it over.

> *I think it would be hilarious to watch it back because we've done no editing, I've not watched any back*...(Vicky12)

This lack of editing demonstrated confidence in their self-portrayal as it was. One mother asked me to keep some of her conversation about 'politics at work' confidential but had not edited this herself. This demonstrated the 'trusting relationship' engendered between participant and the researcher (4.5). It also suggested that work politics were still important in relation to the social context of breastfeeding. Providing real-time data to be analysed, which had neither been reviewed nor reworked, assured me that the mothers thought their self-portrayal, recorded at the time, in its rawest form, to be essential.

Mothers used a range of approaches and styles to create their diaries including short structured planned recordings with notes written beforehand, demonstrations with their babies and/or equipment, long '*rambling*' reflective discourses, ranting shouts for help and tearful emotions. Although they portrayed themselves in different ways the participants always included a discussion within the diary entry of how breastfeeding was going and how they were coping with life and motherhood. Some mothers, particularly Sam, switched the camcorder on to describe exactly what was happening in relation to breastfeeding and rarely went off the point. More like a 'performance' (Pink 2003), than the other participants' videos, Sam was the only one who kept notes which she used as prompts to ensure nothing important was missed. She rarely produced impromptu recordings but appeared to have a time slot dedicated to filming, treating it more like a news report, or possibly a student research project rather than a

spontaneous, extemporaneous diary entry. Maybe this was a reflection of her still being a student who took little maternity leave. Sarah regularly used the research crib sheet and referred to it to prompt her conversation. Once she was prompted, however, she allowed her mind to contemplate her breastfeeding experience in more depth. Sometimes this meant that she was overcome with distress when she reflected on what was happening to her or what had previously occurred. In this way she was able to express her own thoughts and feelings about whatever mattered to her at the time. She was quickly able to bring her thoughts and conversation back, however, by revisiting the crib sheet before her. This appeared to fulfil two agendas, one for her role as participant, and one as a mother seeking to share her experiences with little control over the overwhelming emotions that she had at the time. The other three mothers switched the camcorder on and just talked about what was going through their head which involved revealing what was really important to them in the 'here and now'. This spontaneous conversation included how breastfeeding was going but also other discussions about life in general, relationships with family, friends and health professionals, how they were developing strategies to cope with frequent feeding, and their crying baby and what they were doing or planning in subsequent days, weeks and months.

An important part of the analysis included what was in and out of the camcorder's frame. An element of mothers' self-portrayal was exposure of their bodies, especially their breasts while breastfeeding or expressing. This perhaps highlighted their own perceptions about their identity as a breastfeeding mother. These perceptions might have reflected vulnerability about whether they perceived their breasts as sexual objects and breastfeeding a part of normal everyday life, or whether it was a separate activity for a defined temporary period of time which should not be seen in public. Tracey made a concerted effort to ensure her breasts were never exposed by only showing her head or by using a blanket to cover up. She was seen to panic if she thought her partner was pointing the camcorder anywhere near her body when she was breastfeeding (Figure 12).

Tracey: [sighs loudly and looks down behind blanket] I'm feeding him at the moment and he seems to…[breaks off]

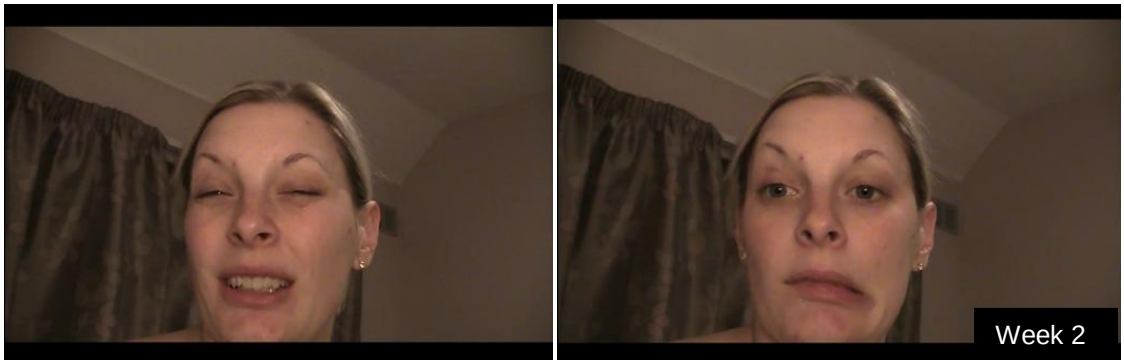
[Scott moves angle of camcorder lower…Tracey instantly pulls blanket up higher].

Tracey: No don't film that!

Scott: There's no boob in the shot! (Tracey6)

Figure 12 Controlling the 'camcorder's gaze' on breastfeeding

Sam never breastfed or expressed in front of the camcorder and Sarah ensured the camcorder always focused on her head if she was breastfeeding or expressing. For Sarah, it may have been daunting to film when it was so painful which was further complicated with using nipple shields. Showing her bleeding cracked nipples on film was not a happy contemplation as her words and facial expressions demonstrated (Figure 13).



I would show you my nipples but …..
…you might be frightened and I don't think I want it on camera (Sarah2)

Figure 13 Facial expressions confirm thoughts and feelings

Vicky was initially shy of exposing her breasts to the camcorder, but soon relaxed and often purposefully focused the camcorder to demonstrate how breastfeeding or expressing was going, asking questions as if needing an answer. Once she overcame her initial inhibitions she, like Rosie, did not think twice about breastfeeding in front of the camcorder and thus the embodied nature of breastfeeding was captured (5.2.3). Seemingly for them breastfeeding was a natural and normal thing to do whether filming or not.

Without any words from mothers, the self-portrayal of breastfeeding in and out of the camcorder's shot provided valuable insights into the diverse nature of culture and beliefs about what is acceptable and not acceptable to do in front of others. As with the research by Bates (2013), the control of how much body to expose was with the participant and this was an important choice for them.

All mothers chose to film their babies although the amount of time varied. Sam

only ever provided one shot of a reasonably contented baby. Some mothers filmed their baby, sometimes unintentionally, when they were screaming and crying. This provided insights into the strategies mothers used to calm and to cope in these circumstances without them even realising it, such as rocking, baby holding, talking, singing, nappy changing and feeding. At other times they purposefully turned the camcorder on to show what it was like living with a crying baby or to demonstrate what approaches they were using to calm the baby (Figure 14 & 15). Occasionally, mothers described their screaming baby retrospectively, explaining that filming would have been impossible because the crying was incessant, which distressed them greatly at the time.

> *It [baby's crying] really got to me last night, if I'd had to film last night I would have been crying… just lost the plot, well I didn't lose the plot but was crying lots* (Vicky4)

Self-portrayal in these circumstances might have been constrained by whether mothers felt in control and relatively calm in what they were doing. Thus when they were feeling out of control and 'losing the plot' they would prefer to tell me about it later or the next day. Nevertheless, mothers used the camcorder as a vehicle, to ensure that what they had to cope with was recorded.

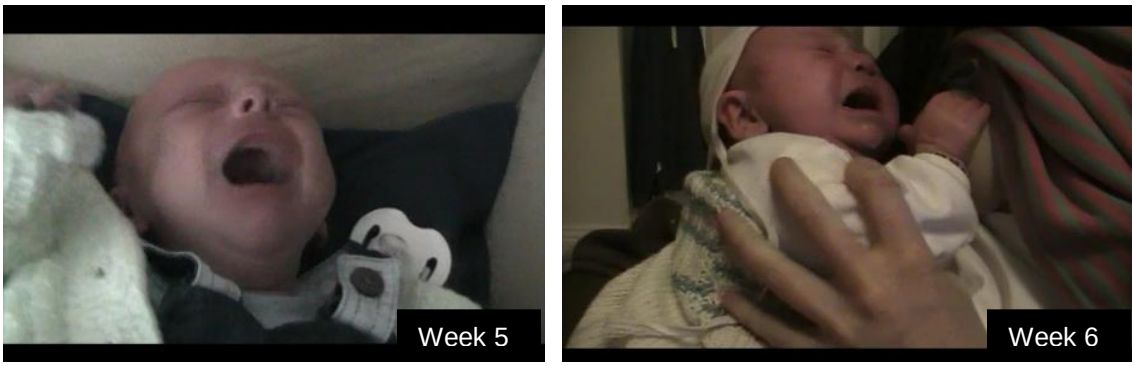


Figure 14 Recordings of babies crying

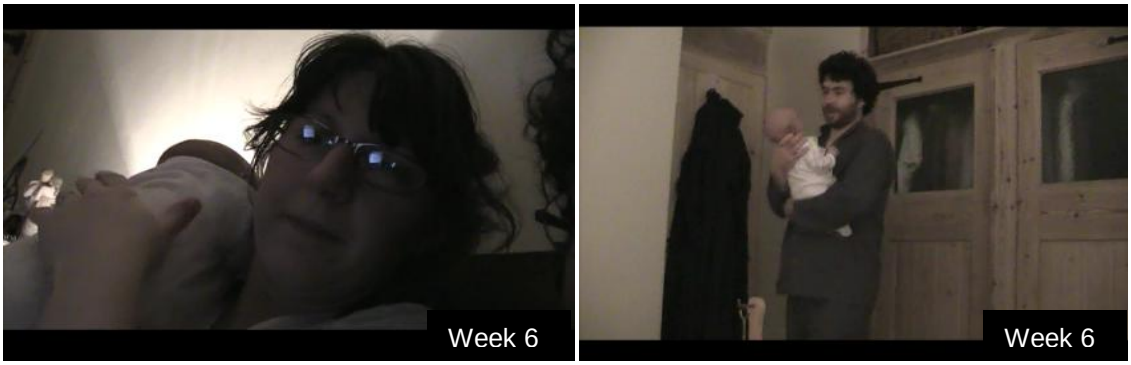


Figure 15 Coping strategies caught on film

Mothers were also keen for the camcorder to witness their baby's stages of development including when they were content and happy. Self-portrayal included moments of affirmation about how well their babies were doing, reflecting on their own ability to mother, boosting self-esteem and confidence.

Self-portrayal as a breastfeeding mother also included visual demonstrations of items that were considered important as their '*essential paraphernalia'* for breastfeeding (6.2.9). For all mothers, apart from Rosie, expressing was a vital feature of breastfeeding although for very different reasons. There has been much discussion about the reasons for breastmilk expression in the literature (Ryan et al. 2013) and this study provided many examples. Mothers' self-portrayal included expressing breastmilk because it was important to them. Not unlike their feelings about breastfeeding in front of the camcorder, they adopted a similar approach with expressing, with Vicky demonstrating how it was done using an electric pump and others only showing the equipment or the output (Figure16).

Figure 16 Expressing was part of mothers' self-portrayal

The visual reinforcement of seeing the milk, including presenting it to the camcorder, brought a sense of achievement, pride and self-actualisation that they were indeed feeding their baby with their own breastmilk.

> *They tell you do it for three minutes, now, this is just on one side right, so as you can see that it is almost half an ounce…self taught…well I'm proud of myself yeh* (Tracey5)

Visual demonstrations also included aspects that did not involve breastfeeding but were seemingly an important part of the mothers' self-portrayal. Rosie spent filming time demonstrating how to put on washable nappies using all the eco-friendly paraphernalia including washable wipes. This suggested she was very keen to portray herself as an eco-friendly environmentally sound mother. Tracey proudly paraded her finger and toe nails in front of the camcorder because they had been specially coated with shellac during one of her rare outings without her baby. She craved her former self when beauty treatment was regular. Getting her nails treated was an achievement in itself which she felt was well deserved. These demonstrations gave additional insights into how each mother wished to portray herself in front of the camcorder and the philosophy that sat behind that self- portrayal providing enhanced understanding of how breastfeeding sits within its own social context.

5.3.2 Personifying the camcorder

All mothers personified the camcorder by directly addressing it*, 'I have an update for you today'* (Sam2), *'Ok, I'll speak to you soon, alright bye…'* (Tracey3). Indeed, for the majority of diary entries, mothers talked to a person or people, using salutations at the beginning and end of diary entries. Rosie addressed the camcorder in a personal way and never wavered from this position, making certain that I knew she was addressing me; *'Morning Alison…'* (Rosie1). On occasions, she referred to me during the diary entry by asking Lily to '*show Alison',* or referred to a time when I last saw her to collect data. Indeed, for most mothers in this research, the principal audience was me as the primary researcher and main contact for collecting the video recordings.

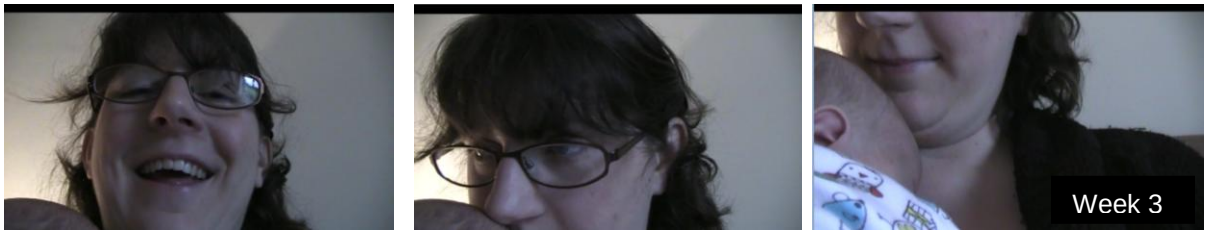
Whilst this was also true of Tracey for some of the time, she developed a varying relationship with her audience through the camcorder, as she was not consistent about who she was talking to. Sometimes she was directing her conversations to me as the researcher. On other occasions, she was talking to a number of people possibly unknown to her, with greetings, such as '*Hi Guys'* (Tracey6). She did not appear deterred by the idea of multiple viewers, indeed it appeared to give her the flexibility to talk to whoever was on her mind at the time. This meant that sometimes instead of talking to me or an unknown audience, she vented her anger directly at a known person or group of people with whom she was annoyed, such as health professionals whom she had encountered. The 'apparent audience' for Tracey would often change between each diary entry and at other times it switched within the entry itself, as if at one moment she was complaining about someone to me and the next making accusations directly to the person she was complaining about.

> *I think it shows how this lady was very nice but didn't meet any of my expectations at all [shaking head, pursing lips] You WERE crap, ok? Because you gave me a chart that apparently isn't right* (Tracey6)

Tracey was not the only person who did this. During one of Vicky's diary entries, she also captured herself changing direction in a conversation with me to rant at a book author. This was a particular strength of this research method as this changing perspective and accompanying depth of emotion may not have been captured during an interview or focus group, with visual as well as verbal emotions expressed in the immediacy of the moment. Additionally, whilst participants could have expressed their anger in a questionnaire, it would not have provided mothers with the same opportunity for 'interaction'. They changed rapidly between the people they were talking to, as if they imagined them all to be in the same room. Whether this was a conscious or subconscious decision it is difficult to identify but the conversation was not stilted and flowed from one person to another seamlessly and understandably. Sometimes it became evident that their recordings were a set of private conversations with me and at other times they appeared to be presented for public consumption, where their voices could be heard by a much wider audience. '*Personifying the camcorder'* empowered them to take control of who they wanted to talk to. This meant that they were able to embody the camcorder, sometimes as a confidante and friend, but sometimes as an adversary, criticising the service they had provided.

As mothers could set up their camcorders by turning the screen around, they could see their own image and talk to themselves. This enabled them to make eye contact with themselves not unlike the mutual gaze that occurs in a natural conversation with a real person. In this case the camcorder was embodied as themselves.

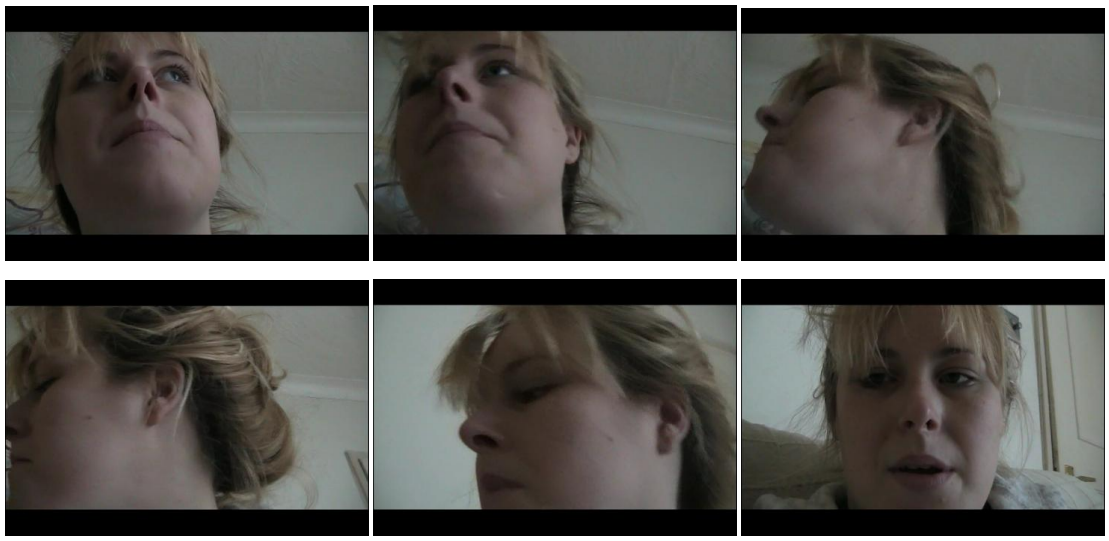
When mothers were feeling sad and tearful, especially when breastfeeding was not going well, they moved the camera frame away from their face to regain composure (Figure 17), or barely looked at the camcorder, looking all around the room instead (Figure 18). When they were angry or when they were joyful they looked directly at the camcorder (Figure19).



I was crying yesterday because [voice wobbling] it is very hard, [silence] and I can see why people don't do it all the time (Vicky 3)

Figure 17 Controlling the camera to avoid the camera's gaze

Tracey became fed up with breastfeeding when Theo was feeding frequently and it became painful. She needed to share this feeling but found it difficult to say, possibly knowing this study was about breastfeeding or perhaps because she was disappointed with herself. Therefore, like Vicky, she also avoided the gaze of the camcorder but she also looked all around before directly turning to the camcorder to say what she felt (Figure 18).



I'm tired, last night really sore and full of milk and err, really, um…
[pauses while looking around the room, then looks directly at camcorder]
…fed up with breastfeeding to be quite honest with you (Tracey5)

Figure 18 Avoiding the 'eye' of the camcorder until ready

Contrastingly, when Tracey was angry, she looked directly at the camcorder screen. She moved the camcorder's focus from a position at the side to a position in front so that she could deliver her message directly to the health professionals who had upset her (Figure 19). The strength of feeling that Tracey portrayed would have been very difficult to capture in any other way than when she filmed herself in these diary entries. The visual data enriched the audio element while she ranted at the camcorder, as if shouting and swearing at and eyeballing the very person she was angry with. When mothers ranted at 'imagined others' it was particularly poignant for me.

…I can't let this go….so all you medical people out there who have just given me a load of crap, beware, because I'm writing a letter of complaint yeh…(Tracey6)

Figure 19 Controlling the camera, to glare at a specific person in mind

All mothers seemingly personified the camera making conversation and using mutual gaze with their own image as part of normal social interaction, to discuss and debate issues that were troubling them. Sometimes it was because they were in a quandary receiving conflicting messages from the people around them including the media. As discussed in Chapter 6, mothers used the camcorder as a 'sounding board' to 'think out loud' to make decisions about how to approach motherhood and breastfeeding but sometimes it was more about offloading.

5.3.3 Offloading in a rollercoaster of emotions

Personifying the camera meant that whatever the conversations were about, mothers were able to 'open up' and 'offload' their feelings in words and emotions that were both heard and seen in their daily diary recordings. Sometimes it seemed obvious that they had planned to talk about something, typically saying something like, *'I know what I was going to say*' or '*I need to tell you about this'*. However, mostly it seemed that as they relaxed into using the camcorder, absolutely anything that popped into their head was shared. Mothers particularly shared how they were feeling in relation to anxieties and problems. Usually they were alone when they used the camcorder in this way, and as highlighted in 5.3.2, it sometimes felt very secretive as if they were using the camcorder as a confidante.

The clandestine feel to the video diaries in this study was particularly evident when mothers poured out their hearts about how they were feeling about breastfeeding within the context of the new transition in their social lives. These confessions included talking about changing relationships within the family, changing lifestyle and the huge shift from orderly everyday routines to a chaotic disorderly existence that merged from one day to another. Some of the intimate detail mothers divulged was highly confidential because it related to members of family or friends and for ethical reasons cannot be shared with a wider audience. However, what this highlighted was the need for 'new' mothers to talk 'any time, any place' with someone, and in this research, personifying the camera meant that talking to someone behind a video camcorder was a convenient avenue for this. Indeed, by the time breastfeeding had established they were still finding it helpful to talk to the camcorder.

> *I felt like you are my diary and someone I can talk to about what I was going through, and it was a cathartic release, that I could get problems off my chest and that once I had told you about my night it would feel a bit better and different things like that…* (Vicky12)

As seen in this quote, Vicky used the camcorder as a confidante, to ‘offload’ and once she had ‘got things off her chest' she 'felt better', having experienced a cathartic release. Tracey, who on occasions turned the camcorder on up to five times in one day, particularly when she was angry or frustrated with someone, confessed that she used the camcorder to ‘*vent’* and expressed her gratitude many times during the whole course of her data collection, thanking ‘someone’ behind the camcorder, despite not always knowing who she was speaking to. Turning on the camcorder and ‘*offloading*’ fulfilled a genuine need so that some of the angst that was bottling up inside her could be relinquished. On some occasions, it seemed that time was needed before she was able to ‘offload’ all her feelings and frustrations, but at other times it appeared to be forcefully expelled very fast before a sense of calm prevailed. Whichever approach she took, she appeared grateful as it had been helpful. This strength of feeling might not have been communicated to a real person for fear of an adverse response. Talking to the camcorder with no opportunity for it to answer back may have provided valuable opportunities for mothers to vent their anger, which possibly prevented a build of emotions that might have otherwise been difficult to control or deal with.

If I didn’t have this camera to talk to I would have gone a bit potty really

(Tracey8)

> *I’m hoping to offload today, and get a little bit off the camera, feeling better already and it’s only seven minutes in…[30 minutes later]..I’d better go and talk to my little Theo but it was nice talking to you because I haven’t spoken to an adult in about three hours* (Tracey11)

> *I feel like in some ways I’m losing my mind a little bit. And I don’t know who you are or where you are watching me, but I’m grateful for allowing me to vent, because I think if all this was penting up inside of me, I think I would have exploded a long time ago*…(Tracey12)

For some, the camcorder helped alleviate the isolation they were feeling as a new mother ‘trapped’ within the confines of their own home. The camcorder replaced

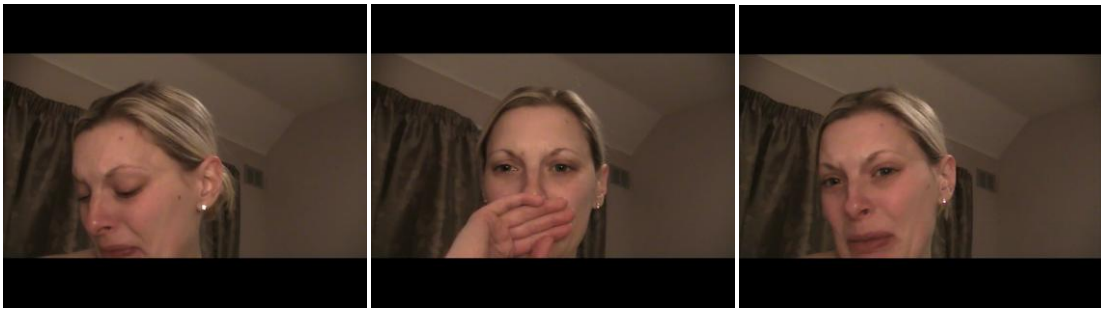
the adult conversation that they were accustomed to and craved. On one occasion Tracey purposefully thanked the person behind the camcorder for this, while Scott was present, perhaps hoping she would be overheard by him and understood.

> *Ok I'll speak to you tomorrow, thank you for listening whoever you are on the other end of this video recording, it's nice to speak to people [looking at Scott] whilst my partner is at work because I feel quite lonely* (Tracey11)

When mothers 'offloaded' they felt empowered to talk about what mattered to them. They all found the relentless feeding day and night difficult and craved for some order in their daily lives. When they reflected on their lives before childbirth they realised how chaotic it had become. Mothers 'offloading' the trials and tribulations that they were experiencing displayed a rollercoaster of emotions. The first stage of analysis, logging the sequential data for each mother, demonstrated this rollercoaster, with a gamut of emotions expressed over the entire length of time that each mother recorded their diaries. This study provides the unique and added value of witnessing the depth of emotion experienced by mothers' everyday in real-time through both verbal and visual cues. Some of these emotions spontaneously surfaced as mothers reflected on their experiences, crying when things were going wrong or laughing at the comical side of breastfeeding. Sometimes mothers described their emotions retrospectively, not unlike writing a diary, but at other times they expressed their emotions in real-time, at the very moment the video was recording. These reflections triggered an emotional response that could not be controlled. These raw emotions appeared to be naturally occurring, straight from the 'heart' as mothers 'offloaded' and opened up to their diaries. Their emotions 'yo-yoed' back and forth with positive emotions demonstrated when mothers felt proud of themselves because breastfeeding was going well, and negative emotions brought on by experiences that made them feel desperate because they doubted whether breastfeeding was working and whether it was even possible to continue. The range of emotions varied from day to day, and sometimes they changed even

within the video clip itself. On most occasions a cluster of emotions was evident rather than one single emotion resulting in the ‘emotional rollercoaster’ (Hinsliff-Smith et al. 2014).

Thus, when mothers ‘offloaded’, the body language and visible emotions alongside the verbal detail of diary entries provided powerful evidence of the stark reality of breastfeeding that mothers were experiencing on a daily and sometimes hourly basis. Sometimes the ‘emotional rollercoaster’ was demonstrated within one single diary entry from extreme stress to a sense of peace and determination as mothers worked through what was happening to them. Sarah, for example experienced severe pain from infected and cracked nipples and was advised to ‘rest’ her nipples by expressing after feeding and giving her expressed milk by bottle. The decision to follow this advice caused nervous tension as she was worried about the effects of introducing a bottle. However, this worry faded into insignificance when her milk dwindled and she could no longer express from either breast and felt compelled to give her baby formula milk. The deep emotional pain and anguish as she told her story with tears dripping down her face that she was no longer breastfeeding was then followed by another ‘rollercoaster of emotions’ as she wrestled with feelings of relief juxtaposed with words of determination to try again. This rollercoaster was caused by tension between desperately wanting to breastfeed and wanting permission to stop. This demonstrated the cognitive dissonance experienced when mothers were attempting to reconcile opposing emotional forces (Figure 20). ‘Offloading’ provided powerful visual data which, when analysed alongside the verbal data, revealed compelling evidence of the depth and range of emotions felt by mothers in such a short space of time.



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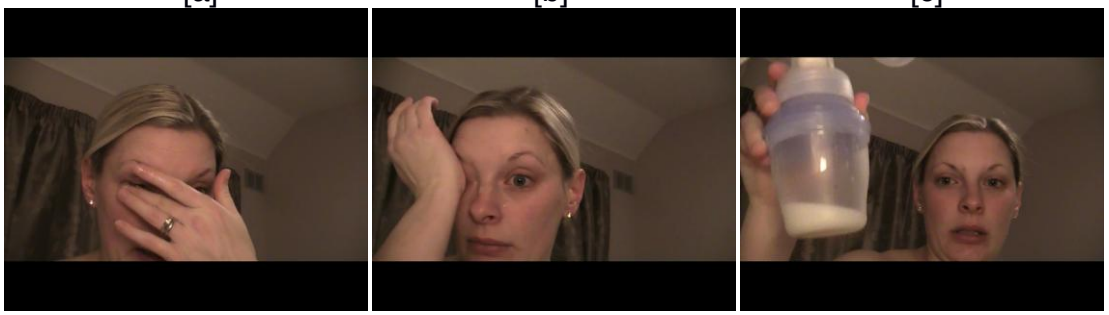

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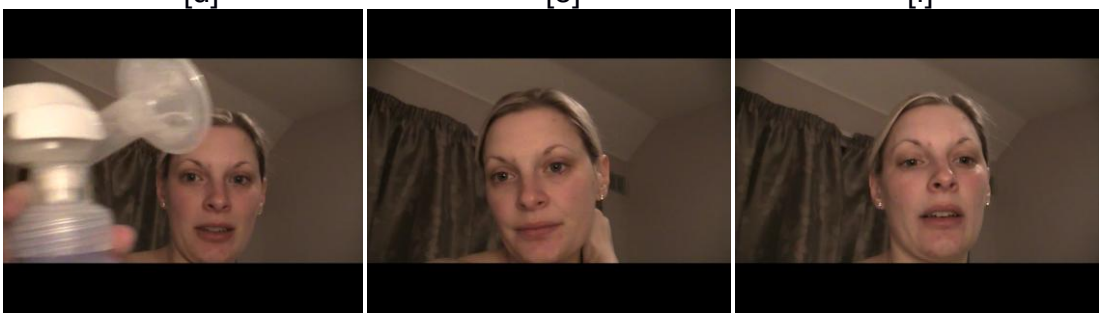


[g] [h] [i]

Everything that I felt I worked for…went down the drain this morning when I gave her formula...so my experience of breastfeeding…[a] has been pretty miserable [b] because I'm not breastfeeding anymore [c]…I still quite like the connection we have when I bottle feed her because she does look in your eyes [d] ...yeh the problems I've told you about [e] and I'm having to use this breast pump [f] …quite good colour, good vintage [g]…also feel a bit relieved today that I've been given permission to use a bottle and to take things easier on myself [h] and that's it's not the end of the world if I do feed her with a bottle, just need to get her back onto it as soon as possible …so my aim is for Wednesday if I can heal myself …sorry for getting upset…just feel like I've failed but I'm going to get back to it [i]. (Sarah2)

Figure 20 Audio-visual detail portrayed a rollercoaster of emotions

‘Offloading’ involved all mothers sharing their vulnerability including confessing their feelings and expressing their emotions sometimes through unexpected moments of joy but at other times it was because they felt they had failed their baby. The video provided the visual element that extended the verbal data aiding my understanding of the emotional elements of breastfeeding that would have been missed with verbal data alone. Rosie, seen in the two clips (Figure 21 & 22), is quietly weeping after reflecting, first when she is feeling content as a breastfeeding mother, and later feeling bad about caring for Lily. Without the visual data, these emotions would have been missed as no crying noises were heard in the silence.

I am the only one that can feed her and that really establishes that she is MY baby…and she has to come back to me and that is a really good feeling (Rosie1)

Figure 21 Silent emotions caught on film

That made me feel like I'm terrible and not looking after her properly and she's got a sore neck and a sore bottom and I think it could happen to anybody [long pause, blinking away tears] it's not that I'm doing anything dreadful or neglecting her, but it all comes together and it makes me feel a bit bad (Rosie5)

Figure 22 Silent emotions caught within conversation

Experiencing breastfeeding problems in addition to the frequency and intensity of breastfeeding and exhaustion, sent mothers spiralling downwards emotionally. 'Offloading' enabled them to share their deep emotional pain and feelings of guilt. Indeed, feelings of failure or guilt that they had done something wrong were expressed, at some point, by four out of five mothers.

> *I feel like I can't help my baby and I feel like I'm failing as a mum, which obviously isn't true but you do feel quite sensitive…if somebody told you, your baby isn't putting on enough weight, I am sure you would be worried as well …and it really does wear you down emotionally which then affects you physically, like I hardly got any sleep last night …I did feed him for about twenty minutes but the rest of the time I just stared at him* (Tracey5).

Mothers particularly experienced a 'rollercoaster of emotions' when breastfeeding problems were prolonged. When healing of sore nipples did not happen quickly, Sarah blamed herself, and when she perceived her milk supply was slow to return she continued to doubt herself thinking that she had to be doing something wrong. As Sarah 'offloaded' it was evident that feelings of frustration and misery

dominated her breastfeeding experience at this time as she battled between wanting to and dreading to breastfeed and giving her baby another bottle.

> *I'm just feeding Sophie, bottle, unfortunately…I managed to mess up quite badly…felt I was on the edge of making it to just breastfeeding and then I went to a friend's house for five hours and ended up feeding her three bottles while I was there because she was so hungry…which was a stupid mess up…and I'm really kicking myself for messing up and was thinking I've got to start all over again with increasing the breastfeeding again* (Sarah6)

Nevertheless, the 'emotional rollercoaster' witnessed on camcorder also included high points. When mothers described a glimmer of some routine in their daily life, they visibly became more confident and a sense of freedom was evident (Figure 23). This was revealed in the mothers' demeanour which either became more buoyant and tangibly positive or more relaxed and peaceful.

[Sophie crying in background] I'd better go! Now that the stress of breastfeeding is over I do feel really good about being a mum. I just love it…I'm just enjoying myself and it's getting easier everyday (Sarah6)

Figure 23 The high points of the emotional rollercoaster

Sometimes when mothers relaxed they could actually see the comical side of some of their breastfeeding experiences and laughed and joked about these moments, but for most, these moments were short-lived and rare (Figure 24).

[Lily crying, Rosie chats to her and reattaches her to her breast] It [breastmilk] really sort of rained on her face [laughing]…quite often at the end of a feed I'm still dripping, and if not, there is milk round her face…she just rubs her face into my nipple [demonstrating] and then [laughing] gets milk all over (Rosie4)

Figure 24 The comical side of breastfeeding

As mothers shared stories during the day and at night, 'offloading' on a daily basis, the exhaustion that hit them became evident in both visual and verbal detail demonstrating in real-time the everyday 'reality'. Apart from frequently repeating that they were tired, some mothers also lost track of their conversation apologising for their lack of focus due to tiredness. The visual element of the entries, the uncontrollable very deep sighing yawns and the rubbing of eyes and brows alongside almost falling asleep as they spoke to the camcorder were more telling signs of the extreme tiredness that was consuming them. With their voices slowing down, becoming less animated and words almost slurring together and their eyes closing during recordings, the exhaustion was unquestionable (Figure 25).

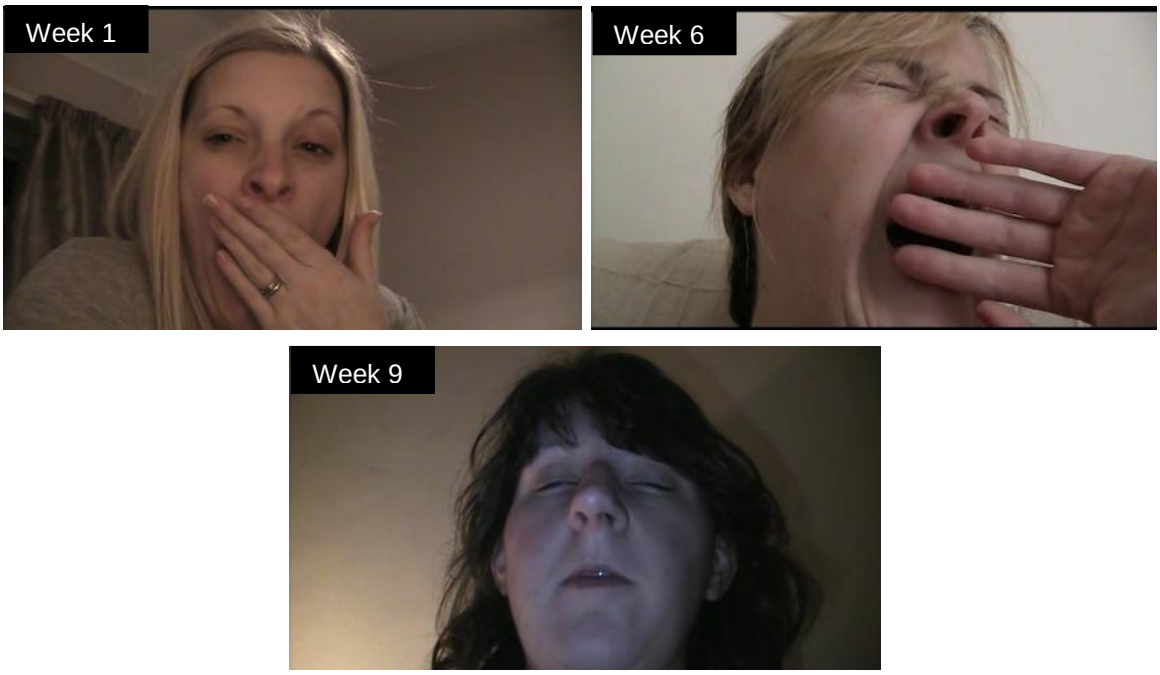


Figure 25 The visible signs of exhaustion caught on film

It might have been expected that exhaustion would cause the mothers not to film, but instead mothers turned on the camcorder and spoke of how they felt. 'Offloading' provided an opportunity to share how they felt physically, mentally and emotionally. The exhaustion was not just confined to the early weeks but continued for the entire data collection period. The inadequacy they felt because they could no longer do the simplest things like cleaning, cooking, shopping and safely carrying the baby around the house was recognised and felt to be deeply frustrating.

> *I don't manage to do anything and just spend my whole life trying to sleep and doing breastfeeding and flopping about ...I'm just still quite tired and I've got into a mode where the days just drift along and I don't know what time it is.* (Rosie2)

> *[Standing rocking Lily back and forth] But then when she's still not asleep…and I'm just dropping with exhaustion and it makes my back ache just carrying her like this for two hours solid and I'm so tired, if I close my eyes I just instantly feel like a bit dizzy, I almost feel it's dangerous, I feel like I don't want to walk downstairs because I can easily lose my balance* (Rosie6)

When mothers managed small jobs alongside breastfeeding they were delighted and sharing their achievements was important (6.2.6) forming part of the 'emotional rollercoaster' witnessed on camcorder.

> *[Smiling broadly] Baby's now asleep and I'm freeeeee to do a bit of cleaning* (Tracey3)

> *Yeh, checked the emails, finished messing round with the credit card statements yeh and just really [smiling broadly] nice that sitting about and reading a bit of newspaper or the internet and telling each other about it and having a bit of a laugh.. (*Rosie5)

Despite feeling inadequate and deeply frustrated because of tiredness and an inability to complete household chores, mothers still prioritised recording their diaries. 'Offloading' took precedence over their other needs, perhaps this was because mothers felt a sense of responsibility to the research project or perhaps it provided the cathartic release that they needed to enable them to carry on.

With exhaustion and tiredness coupled with relentless feeding night and day, mothers spoke candidly of their irritability with their babies when they would not settle especially late evening and at night. Most admitted this was short-lived but were surprised that they felt this way.

> *…it's distressing to see her distressed, it's such a painful noise to hear, but also I was SO tired after that 2-3 hours being up in the middle of the night, in the end I just get to feel cross and impatient, then it's even harder because from somewhere you have to find that loving patience that has just disappeared because you're so tired and frustrated and I say to her, 'just tell me what it is and get it sorted and then just be quiet', but of course she can't* (Rosie5)

In order to 'offload' it seemed important to record in real-time what was happening, and this meant that what mothers were saying in words was backed up with evidence, for example the babies' crying bouts were witnessed on camcorder. The tension and exhaustion brought on by these screaming episodes often culminated in turmoil and tears as there appeared to be no easy answers to make it all stop. This made some mothers feel like they were very near to 'losing the plot' which sometimes resulted in their partner suggesting formula milk (7.3.2).

5.4 Conclusion – But what I really wanted to tell you…

Self-directing their diaries empowered mothers to use the camcorder in any way they wished. They filmed in a variety of environments which provided valuable insights into the multifaceted nature of breastfeeding within individual and very different socio-cultural contexts, including what equipment and clothing they relied on to manage the demands of frequent feeding. Mothers used the camcorder 24/7, and often filmed alone, sometimes sharing very personal information about changing relationships with family members or political issues at work. This gave a clandestine feel to the diaries demonstrating a unique use of the camcorder as a confidante as mothers needed to talk day and night in a safe 'place' where they felt they would not be judged. Mothers created their video diaries embodying the camcorder in the process. As a result they personified it, often having a person in mind as they spoke which helped them to build up a relationship with the camcorder.

The spontaneity of filming enabled mothers to '*offload'* their emotions in real-time as events were unfolding with candid and sometimes outspoken ways of expressing themselves, instead of waiting to talk at a later date. This meant that mothers did not rework their thoughts and feelings for their diary entries and did not rely on memories that may have been sanitised at interview or in a questionnaire. The video camcorder allowed participants to ignore their usual social reservations that would normally prevent them from "venting spleen" (Brett 1987, p. x).Thus, the 'emotional rollercoaster' already identified in the literature (Hinsliff-Smith et al. 2014) was witnessed on a daily basis with the visual element expanding our understanding of the daily emotional turmoil that mothers endured. 'Offloading' their thoughts, feelings and emotions provided a cathartic release which might have helped mothers continue to breastfeed.

6 ‘Working it Out’

6.1 Introduction

The video diaries provided mothers with a platform for ‘Working it out’ by discussing, reflecting and sharing thoughts and feelings about breastfeeding. Mothers spent a great deal of the recording time working out a wide range of issues. For most this helped them move through the transition from being a novice breastfeeding mother to feeling confident about their feeding method when it had established some weeks later. This theme has been derived from two subthemes related to the issues that mothers spent time working out, ‘Surviving’ and ‘A state of flux and getting back to ‘normal’’ (Chart 4).

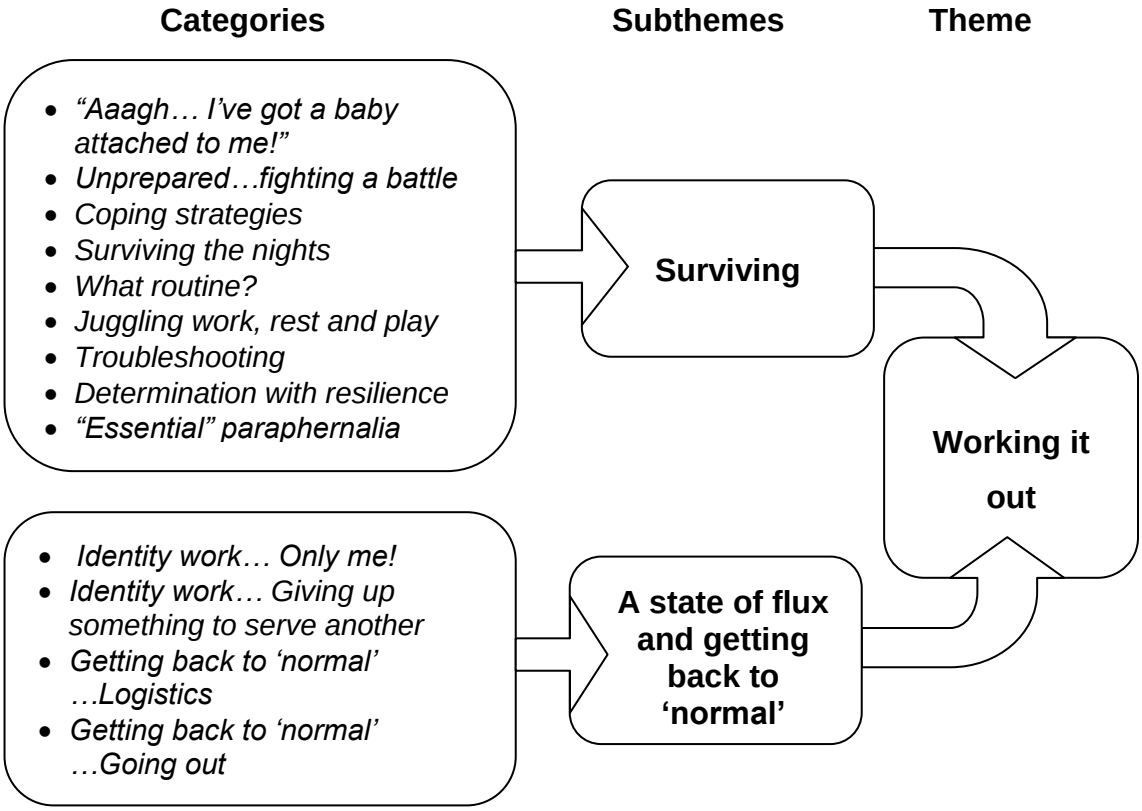


Chart 4 Categories, subthemes and theme: “Working it out’

6.2 Surviving

The mothers shared how they were ‘surviving’ by troubleshooting when problems occurred and talking about coping strategies as problems developed. They spent recording time working out how to survive their new role as breastfeeding mothers, discussing issues that were pertinent to them.

6.2.1 Aaaaagh…I've got a baby attached to me!

Most mothers conveyed a sense that their babies were continually attached to them and this feeling was discussed repeatedly throughout the duration of filming their diaries.

> *I didn’t think it would be as draining as this; he’s literally been on me all day, not a lot of break in between.* (Tracey3)

> *I think just the feeling of well not chomping but you know like sucking on you all night, just got to me a bit….aaaaagh I want to tidy up and I can’t tidy up because I’ve got a baby attached to me, and I felt a bit down and emotional.* (Vicky5)

Trying to work out why their baby was incessantly feeding or wouldn’t settle occupied mothers’ discussions within the first two weeks following the birth. Although they all mentioned ‘demand feeding’, they seemingly did not realise that their baby would need feeding frequently ‘24/7’. For most it was a gruelling experience, and just thinking about it made them feel emotional. No-one had prepared them for this. They did not realise that it was normal, and this meant that they spent time trying to work out why it was happening and how to deal with it. They thought about things they had done in the day or environmental factors that might be affecting their baby as if their baby’s behaviour was not what they had anticipated.

He seems a bit restless today [looking at him, pausing] and waking up every time I put him down. Maybe I've drunk too many cups of tea? … Or maybe it's a bit too warm? Or maybe he's just fed up today? [The environment is calm with low lighting and gentle music playing in the background, Vicky is in bed holding her baby in her arms] (Vicky2)

6.2.2 Unprepared…fighting a battle

Despite all mothers having attended antenatal classes, this lack of preparation or understanding about the frequency of feeding for some had a long lasting impact and they felt like they were fighting an endless battle. During the sixth week, Tracey was still incensed that she was not made aware of the incessant feeding needed to establish her milk supply in the first couple of days and ranted about the healthcare team.

If someone would have told me initially when you give birth you have to feed and feed and feed and feed and feed and feed and feeeed your baby until you cannot feed anymore to stimulate your milk, I'd have gone: right, I'm up for a challenge! (Tracey6)

Her initial lack of insight initially regarding how frequently her baby needed to be fed and the way she learnt about it was stressful producing feelings of resentment about breastfeeding. While she had worked out that frequent feeding was required to enable her breasts to start producing milk, she fought against the idea that frequent feeding including at night was required to sustain breastfeeding and help her baby grow.

I'm feeding him every hour and a half, I need that six hours to sleep, I'm not going to wake up in the middle of the night...(Tracey6)

Surviving meant that mothers turned to books or the internet to work out how to win the battle, and make breastfeeding easier (7.4). Sometimes the results were reassuring, and helped them work out how to enhance their feeding experience but sometimes the information raised self-doubt.

I was reading some of the 'Bestfeeding' book about does my baby feed too looong, or [pause] maybe he has too much wind… so don't know whether I've had him in the crook of my arm too much or not straight enough, maybe he just takes a long time to feed. Part of me was thinking, maybe I don't have enough milk? (Vicky4)

Part of surviving was realising that frequent feeding was not a battle, especially when the frequency seemed more obvious at certain points in the day or night. Then they stopped trying to fight against frequent feeding and relaxed into the flow of feeding. Once that realisation happened the pressure was relieved and they became less stressed and more confident. Vicky's turning point came in her fourth week when she experienced a spate of restless, unsettled evenings culminating in a particularly difficult evening with her baby crying and feeding relentlessly, which in turn made her cry. Having spent 24 hours wrestling with thoughts and feelings about this, she finally worked it out for herself.

Maybe he's just hungry, he's either doing cluster feeding or maybe that's just how it goes, he just stocks up in the evening. So I think I need to be more relaxed and less of, oh nooooo, and try and settle him down, and just, then [smiling and cocking her head to one side] in the evenings I sit and feed, that's what I do. (Vicky4)

Conversely, the constant feeding for Tracey exposed her to feeling so vulnerable that she worked out strategies to survive her battle, even though she knew they were sometimes inappropriate.

I did do something actually very naughty last week, [demonstrating with finger and thumb] a very small amount [of cow's milk cream], when the baby was crying managed to go onto his dummy, and seemed to work [nodding forward] very well, and that happened twice because I was desperate for five minutes of peace and quiet, so I know he was only seven weeks old and you are not really supposed to do that but, it was fresh. (Tracey9)

Despite this, Tracey, could not work out why her baby continued to feed so frequently. It seemed like an endless battle that she was losing, so that by the twelfth week she felt drained both physically and emotionally and turned on the camcorder several times to say so.

> *I've had enough; I'm feeding him for longer and longer. The shortest feed that I've had today is 40 minutes and I've just lost the will to live, I feel like I've been infested by (laughing nervously) something that is draining me constantly*. (Tracey12)

> *[Baby crying in background] the milk fiend is calling, so I have to go [crying continues] and this is just what it's like [crying increases] last time it was ten minutes and now it's TWO minutes, so [long pause, looking away] yeah [wipes hair back from brow with hand, while looking away and then looks back to camcorder], I've just had enough*…(Tracey12)

At 12 weeks, the competing demands between incessant breastfeeding and trying to prepare for self-employment were too much to handle. In these quotes, recorded within ten minutes of each other, Tracey appeared stressed and laughed nervously when she described how she was feeling. Gast and Bailey (2014) suggest that people display involuntary responses, like nervous laughing during conversations, when they are anxious or uncomfortable. Tracey used poignant words to illustrate what her battle felt like and her nervous laughter might have been a protective measure to help her cope with her feelings. Both mother and baby were distressed and frustrated. Tracey was battling between life demands and the frequency of feeds and she felt that her baby was literally draining any sense of life out of her. Her corporal and temporal boundaries were being invaded by her baby and she felt out of control. In this vulnerable state, Tracey could not achieve anything and was coming to the end of her inner resources in terms of physical energy, mental patience, determination and resilience.

6.2.3 Coping strategies

Part of surviving, therefore was about working out how they could cope and mothers all discussed strategies that they were trialling to settle their baby or to deal with the seemingly endless feeding. Sometimes the visual element of the diary entry, as discussed in 5.2, provided as much information about how they were coping with frequent feeding or their unsettled baby. Other video clips visually demonstrated how they were 'working it out' without them telling their diaries how they were coping, such as Vicky and Peter lying in bed discussing their day while dealing with their crying baby, cuddling, rocking, breastfeeding, talking to and then finally changing the nappy, or on another occasion calming their baby with skin-to-skin contact. These diary entries provided the unique visual data that demonstrated their evolving roles as new parents, a shared responsibility as they took turns to coax their baby to sleep (Figure 15).

At other times, mothers turned on the camcorder to show how they were surviving. It was important for them to record the work that they were describing and the strategies of sound, movement and continuous feeding that they were employing (5.2.1). The visual elements here were even more profound as the whole ambience of the room was sometimes tangible. Rosie, for example, recorded in almost complete darkness; a swaying standing figure holding her baby could just be determined and a gentle lullaby was being sung for a full minute and a half before Rosie very softly explained that she and her partner had worked out how to create a calming environment. This diary entry continued for 32 minutes where she quietly reflected on life, before she talked to her baby, believing that Lily was sufficiently settled to return to bed. In a later diary entry she admitted that chatting to the camcorder was something else that calmed her baby.

> *.. we've just got a candle… because someone told us that candlelight is meant to be more soothing or sleep inducing or something.* (Rosie5)

6.2.4 Surviving the nights

For all mothers, surviving the nights was a particular challenge and sleep became a priority. Whether they had actually '*worked it out'* as a deliberate strategy or not, all but one discussed taking their baby into bed at least once in their diaries as a necessity. There was an apparent dissonance between the knowledge they had accrued from the healthcare team, family and friends about not bed-sharing and the difficulties that arose when their babies would not settle. For some, bed-sharing was a suggestion from someone else, (7.3.2) and despite feeling uneasy, it seemed the best option at the time. The feeling of exhaustion and desperation overtook their cognitive thinking and it was only when they discussed it on camcorder later on, that they really realised there was a tension between what they did and what they believed to be safe. Arguably, discussing her thoughts and feelings about this contentious issue during one recording of her video diary, helped Sam work out her personal stance on this and she decided not to repeat this practice. It was never mentioned again in her diary entries.

> *Zac did end up sleeping with us last night ….I don't think it is very safe. I was always led to believe that you don't put a child into bed with you. If you were to roll over you could squash them and they could die?...I wouldn't want to suffocate my own child obviously…but that's what they [peer support group] suggested and last night that did work for us. So didn't think it was a very good idea. Won't be doing that again! We were just so exhausted.* (Sam4)

Having made a conscious decision to only feed Benjamin in her bed rather than sleep with him, Vicky was panicked when he was found in the bed, still feeding, hours later. Mothers who partly co-slept with their babies were more disorientated than those who always co-slept. Because they went into 'auto-pilot', they acted automatically rather than logically, nights blurred and they did not always know what they had been doing, how long or how often their baby had fed.

> *I remember not very much, and it feels like I've fed constantly in the night, but I did wake up at twenty-five past one and he was [high pitched voice] still feeding away….and my boob is quite big today so maybe he did [laughing] just chomp on it all night [grimacing]* (Vicky7)

This type of event was a predicament because they could not work out whether this was helpful or not and how it affected the quality of sleep. Because of this some mothers tried to work out which practical solution worked best, sitting up to feed to stay awake or lying down and getting some sleep.

> *… previous nights, I have fallen asleep whilst feeding him lying down and he's fallen asleep, come off and like, I've soaked the bed, myself and I wake up feeling gross, and I also find I am not sleeping as deeply um, with him next to me as I do when he's in his crib, I just have this sense of um [pause] just not sleeping as well so last night I thought it was worth the effort to sit up, feed him, and put him back*. (Vicky6)

The realisation for some that they were not following advice from health professionals and family members presented a dilemma. Vicky spent time *'looking up'* the evidence to defend her 'bedsharing' strategy so that night-time survival was easier to comprehend and explain to others. With this evidence she felt more confident to continue bed-sharing.

> *It's got some brilliant chapter titles like 'Sleeping: What's normal?'…it seems to be saying have your baby in the bed all the time and all this stuff [yawning] which [family member] is really against because she thinks it destroys your marriage.* (Vicky9)

Mothers discussed the practicalities in relation to how to co-sleep in the safest way possible even though there was a perception that this was forbidden. Because she saw no other option, Rosie brought her baby into bed from the very first night, unable to settle her in any other way, and became dependent on and was very comfortable with this approach to night-time parenting. She rationalised

her behaviour deciding that the benefits from gaining sleep far outweighed the risks, and she discussed the dissonance between safety and what was practical when exhaustion set in and her baby still needed to be fed. Skin-to-skin contact for both of them was comforting and there were fewer cold, wet clothes to deal with when she leaked milk. Her confidence in bedsharing and breastfeeding grew quickly and she soon became more adept at feeding in any position and worked out a way to use both breasts with minimal disturbance to everyone.

> *… and if she kind of finishes one side …just turn myself a bit more, so that she can get the other breast and I was thinking, what is that like for her? Is it…this kind of amazing feeling of sort of being in heaven and milk comes raining down on you? [laughing]* (Rosie3)

In contrast, Sarah chose to leave the bedroom to feed so that she was in good light for effective attachment, and to sit up for fear of falling asleep. Surviving the nights for her was as much about preventing further nipple trauma as it was about coping with exhaustion. She demonstrated commitment and determination to succeed using reasoning rather than relying on her instinct to stay comfortable.

> *...and I'm so afraid that I'm just going to wake up after feeding …with a mess of nipples again ...so I've started coming downstairs, putting some lights on, still low because I don't want to wake Sophie up too much, and putting TV on because I don't want to get so tired that the feeding will be sloppy…* (Sarah4)

Part of surviving at night was about mothers working out strategies to keep their baby asleep as long as possible so that their baby wasn't attached all of the time. Indeed they yearned for a full night of sleep and some envied their friends who were achieving this because they were formula feeding. This triggered debate as early as the third week about concepts such as 'controlled crying' when parents resisted picking up their screaming baby for five minutes, a 'dream feed' when they would lift and breastfeed their sleeping baby before going to bed in the hope they would sleep longer, keeping baby awake during the day to tire them out and,

introducing a bottle of formula milk or expressed breastmilk for the last feed before bed.

6.2.5 What routine?

The routine versus baby-led feeding debate was raised very early in diaries when mothers worked out that there was no daily routine. This was frustrating for most, because there was a strong sense that there should be some structure in the day, to enable them to get back to 'normal life'. They all seemed obsessed with time, reporting on most days how many feeds they had had in the past 24 hours, or how many night feeds they had done. They were particularly exasperated when they started to recognise patterns in feeding over a span of days, and then the pattern changed, making surviving more difficult because it was disorientating and no sense of routine could be established. Mothers repeatedly debated this issue especially when they were the recipients of conflicting opinions from other people, some of whom had instigated scheduled feeding themselves and some who believed in responsive baby-led feeding where no schedules were followed. Consequently they battled with the concept of creating structure and time in the day against how it could possibly work with frequent feeding. These conflicting pressures sometimes made them feel confused or despondent, not meeting the expectations of others.

> *I've got a friend….who did routine of feeding every three hours and then did a formula feed at 10 o'clock at night … and by eight weeks he was sleeping though. I've got this book to read which still daunts me…other opinions, just go with the flow of baby and how the night feed is important to keep your milk going and, it's not for very long in your life…so all these different opinions, don't really know what we are going to do.* (Vicky3)

> *I don't think it's going to change, you know at week four they tell you about how you're supposed to get, you know, your baby into a routine and in a schedule and all that, there's no hope in hell of that at the moment* (Tracey3)

The time-consuming nature of breastfeeding prompted much discussion, thinking and rationalising, because it was unexpected. Talking through the issues on camcorder seemingly helped Vicky validate baby-led feeding, even though her thoughts were still dominated by the idea of establishing a routine, and she claimed she was:

> *Still not decided about the whole demand feed and routine. The demand feeding does make a lot of sense I guess, like the baby's hungry, you know it's not being horrible to you to cry for feed, it's just hungry, it's got a smaller stomach so it's going to feed more regularly. We don't always eat a three course meal, sometimes we snack, sometimes we have a drink, sometimes we have lunch or tea, and like the baby is going to be doing the same, sometimes he'll feed for an hour or twenty minutes or want one boob or want both, so that makes sense. What do you do if you are doing routine and the baby is crying for food? Do you just leave it and does the baby learn that you just don't listen so then surely it gets more emotional and upset?* (Vicky4)

6.2.6 Juggling work, rest and play

The frequent, relentless feeding and the sense that their baby was continually attached to them brought a feeling of being 'tied' to their babies, restricting their activities and achievements, resulting in an inability to enjoy life in the way that they had done before. For some breastfeeding was an intrusion into their daily life. It also brought about a sharp realisation that the responsibility as a parent wasn't going to go away.

> *… it feels like you are very much attached to her, which is fine, but sometimes you want just a little time to yourself, to just go and do something, or [pause] just be freeee, just for a second* (Sarah4)

This created a yearning for 'freedom' in all mothers. Some yearned for just a few minutes to be able attend to personal needs whilst others yearned for more time

and space to engage with activities that they used to do as part of their former identity.

> *If I'm at home by myself …it's exhausting …I can't hand her over, you know, just for the 10 minutes that it takes to fold the laundry or [shaking head] go to the toilet even …it's really limited what I can do and I'm really tied to her.* (Rosie5)

> *I think the thing I'm going to miss the most is DRESSING up to go out, having the time to dress up, because I used to take hours doing it* …(Tracey4)

Thus surviving was also about working out how to juggle 'the work' of frequent feeding and baby care, 'the rest' with opportunities for sleep especially at night and 'the play' which meant having time to do other things including going out, socialising with friends and, perhaps surprisingly, doing household chores. For all mothers a successful day meant some freedom for 'play' and so they set targets for each day and were frustrated or despondent if they were not achieved. They didn't always take stock and appreciate the valuable role they were playing in their new identities as breastfeeding mothers (6.3).

> *We have quite a few things planned for the week. Trying to put one thing that is successful to do every day …Tuesday I'm having a haircut, Weds …I might see my friend… might try and get to Noisy Friday… a group at the library…10 o'clock, quite early, I'll see if I manage it. [Sitting in bed breastfeeding in semi-darkness]* (Vicky4)

> *I haven't really done anything this morning apart from being with Lily, and I managed to chop up a leek and chuck some lentils on top of it to make some lunch and I managed to open the post and fill in a bank form and that really is it [Rocking as breastfeeds baby outside in garden]* (Rosie6)

All mothers appreciated when their babies were asleep, and they worked out how to juggle or do things faster than ever before in order to pack as much in as

possible during what they considered as precious little time for themselves. At times it felt like they had got into ‘supermum syndrome’ trying to achieve the unachievable. When they were successful, however, there was a real sense of achievement (6.2.6/6.3.3). It was at these times that they felt confident and thought that breastfeeding was going well.

> *[Smiling broadly] Fed for over an hour, so when he’d finished I gave him to Peter…and I went into town and speed shopped, went round Sainsbury’s, did the petrol, went to Boots, picked up a parcel, did the post, so came back feeling very successful* (Vicky3)

Juggling work, rest and play for some was about working out what they could do while they were breastfeeding as well as when they weren’t, to make the best use of time. Vicky mused about this, realising that she didn’t always spend time bonding with Benjamin during breastfeeds being distracted with other things to do.

> *I don’t always spend the time gazing into his eyes, like in the night, I sometimes sit with my eyes shut, and in the day I’m sometimes on Facebook or reading a book or on the phone so it’s not like I’m using that time to deeply bond with him all the time, [looking back at camcorder, smiling] although sometimes I do, stroke his head and laugh and coo at him* (Vicky10)

All mothers worked out that sleep was vital to surviving so if they did not get enough sleep at night they considered taking time out in the day to sleep when baby slept. Thus, occasionally when tiredness was overwhelming and their baby was sleeping, they tussled between ‘rest’ and ‘play’ and had to work out what was more important. This meant that sometimes staying at home and resting took precedence over going out or doing other things like housework, which for some was a disappointment but for others felt like a relief of pressure and an opportunity to recuperate.

Yes there's a real trade-off between if Lily's asleep then I sleep and rest, or if Lily's asleep then I don't sleep and get something done, you know, then I can walk around with two hands free and no kind of baby bump on the front…(Rosie6)

At other times, staying at home was because mothers contemplated whether being away from home caused disorientation and fretful behaviour.

*He just gets very disoriented whenever we take him out, it just really puts pressure on his feeding times, and I do feed him when I go out…(*Tracey4)

Of course there's a balance there to be struck between, um, me staying at home all day, getting fed up and lonely and therefore surely Lily is not happy either, and you know, having a nice peaceful gentle time [at home] not over stimulating her. (Rosie7)

6.2.7 Troubleshooting

Surviving also meant working out how to resolve breastfeeding problems and all mothers deliberated over these issues in video diaries. Sometimes, this included working out whether to involve other people like members of the healthcare team, friends or family and the knock-on effects of asking for help or whether to work through the problems themselves (7.3). Sometimes, this meant a delay in seeking support, but once received (7.2), they valued the input and then felt bad for not having sought help earlier.

He isn't latching properly still…he'll really try and search, really frustrated, and then I get upset …I speak to the health visitor about it and all she says is make sure he latches properly, which doesn't really help, because in fact, how do I know that he's latched properly or not, because I've not had a baby before, but no one's checked that I knew or didn't know (Sam2)

When breastfeeding problems occurred, mothers spent recording time working out whether the problem was normal and what to do about it. All five mothers

endured sore or bleeding nipples requiring them to 'work out' what was causing the problem and how to make it better. Other problems included mastitis, thrush and poor infant weight gain. Some realised that their problem could be something to do with how their baby attached to the breast even if they could not understand exactly what the problem was.

Professionals didn't always bring conclusive answers and some mothers were still left in a quandary about what had happened or what to do next. This sometimes led to frustration, stress or a lack of understanding causing self-blame and a further reduction in confidence.

> *I'm now starting to feel a little bit of prrrressure to try and um to get her to latch properly… I'm not sure I understand what I am doing wrong at the moment, but I have to be doing something wrong or I wouldn't be so sore* (Sarah1)

For two mothers, working it out involved showing the camcorder exactly how their baby was attaching and feeding ("*I'm doing this so you can see the swallow suck"* Vicky11), as if questioning or validating what they were actually doing. Whilst this did not necessarily produce answers in itself, it did provide an opportunity for them to think and focus on their baby's attachment and see it from a different angle, the camcorder's viewpoint, helping them to reflect upon what they might do differently to make breastfeeding more comfortable.

Troubleshooting often involved searching out information to 'work out' and manage their breastfeeding problems (7.4). Vicky who had been treated for mastitis with antibiotics was determined that it did not return, so searched for answers, trying out suggestions that made sense to her.

> *…read in this book, that it's good to bathe it in hot water and then feed straight away…which did relieve it a bit* (Vicky4)

> *Applying hot then cold, and doing massage on it, [looking surprised at camcorder], cabbages! Which I've not tried yet* (Vicky4)

The term ‘expert patient’ is used for people with chronic illness (NHS Choices 2014), however, it could equally be used here for breastfeeding mothers who managed their own problems. Thus, as mothers read more and their confidence in breastfeeding grew they helped and encouraged others, two went back to antenatal classes and others supported friends through texting, social media and meeting up.

> *[I] feel so experienced to be able to explain to other people about how to feed their children, you know.* (Sam8)

> *One person asked how is it? Is the breastfeeding that easy? And before I could really think, what I said was…there was a time when it was quite painful, and I said, you know my nipples were really sore and even bleeding at one stage, but now it’s not difficult, now it is easy, it’s just second nature almost.* (Rosie4)

6.2.8 Determination with resilience

Continually ‘working it out’ required commitment and determination. Each of the mothers’ diaries demonstrated how they persevered to overcome their daily challenges. All discussed these challenges in the light of why they were breastfeeding and determined to continue. The moral obligation to continue despite adversity was palpable at times as they explained why breastfeeding was important to them.

> *[Shaking head and frowning] I’m completely exhausted, so much sleep deprivation when you breastfeed. It’s not what it’s all cracked up to be. I do understand and I can see how people give up, but I do also believe that if you give up, then you are giving up on your child and giving up on your child [getting] the best start in life [Dressed in nightwear-18.40hrs]* (Sam6)

This determination to continue breastfeeding stirred up strong emotions (5.3.3), especially when others were challenging why they continued to breastfeed or

suggested to use formula. Such suggestions came from friends and family (7.3.3) or were perceived threats from health professionals.

> *The feedings are going on for longer and longer, I'm losing count, because I'm a bit tired and a bit stressed about things…I'm not going to give up, not at all, because I've come this far with the feeding and I just think why should I? …and there is nothing a health professional can do to stop me feeding my baby until he's able to go on solids* (Tracey10)

Determination was evident on a daily basis as all mothers sought to work out coping strategies. The sequential logging of each mothers' diary entries was a testimony to their determination and endurance. For those who continued to breastfeed beyond data collection, resilience appeared to be an important factor with mothers consistently working out the next step in order to 'survive and thrive' through the daily challenges (Wilson et al. 2012, p. 157). Sarah, in particular was not going to let go of her goal of fully breastfeeding. Her diary demonstrated resilience as well as determination because she was not willing to accept her changed identity as a 'formula feeding' mother having felt compelled to give a bottle because her milk supply had dwindled after 'resting' cracked nipples. Supplementing with formula, she spent 11 weeks trying to boost her milk supply without causing further nipple damage, so that she could get back to fully breastfeeding. With numerous diary entries, she provided a step-by-step testimony of how she regained her identity as a breastfeeding mother, sometimes regressing before progressing again to reach her final goal. Describing how breastfeeding had been the main focus of her mothering experience she explained the awkwardness of using nipple shields to aid attachment and prevent further nipple trauma, the dislike of expressing between feeds to boost her milk supply, the drinking of fennel tea, and the pressure from others to give formula if only at night to help her baby sleep. Despite this her diary entries demonstrated her resilience and finally during her thirteenth week, her determination paid off as she filmed her penultimate diary entry. The empowered feeling as she proudly

announced her achievement of going against the socio-cultural pressures around her was extremely moving.

> *I was getting a lot of pressure from various sources, people telling me how much better babies sleep when they are bottle fed completely, so I've come to a decision [pause] and I've completely got rid of all bottles [laughing], all formula has gone, Sophie is now completely breastfed… I've completely ditched the formula because I'm stubborn and I wanted a breastfed baby and now I've got one, it only took three months, but I got there in the end [laughing] …so I feel very good about it… [Bright-eyed and smiling throughout. Hair colour change, jewellery worn. Breastfeeding not visible but stroking baby's hand throughout]* (Sarah13)

6.2.9 "Essential" Paraphernalia

All mothers presented a wide range of specialised commodities that were considered indispensable for breastfeeding. It did however vary for each mother depending on her circumstances, needs and preferences including approaches to parenting and her own socio-cultural context. Some commodities had been bought before the birth demonstrating some forethought about breastfeeding. In preparation for night feeding for example, Rosie had acquired a special cot that attached to her bed for easy access and breastfeeding. This was never used as Lily would never settle to sleep in it and thus bed-shared.

Dealing with the challenges that mothers faced within their state of flux, including frequent feeding, painful feeding, feeding in front of others and craving time and space away from the baby, meant that they all searched for solutions. This brought mothers into contact with the commercialisation of breastfeeding where they found, and bought between them, an array of equipment from books, nursing clothes and bras, breast pads, breastfeeding covers, baby slings, breastfeeding pillows, bouncing or vibrating cradles and rockers, nipple soothers, nipple shields, breast shells, breast pumps, bottles and teats all claiming to make breastfeeding or parenting easier. Mothers used some of these items only once, mentioning

them in passing because they had not been helpful and therefore they were not considered part of the essential paraphernalia for breastfeeding (Figure 26).

Some mothers, however, became completely dependent on some items, suggesting that they would not have been able to continue breastfeeding without them, even when their infant feeding method had become established.

> *I still use nipple shields because it was too difficult to not, so that's it for now, nipple shields are in*…(Sarah13)

> *I bought this before Sophie was born…it's a breastfeeding cover [showing the camera] …and you are supposed to put it over your shoulder …to sort of hide yourself while you are feeding, which is all very well, but I find it REALLY fiddly, it almost draws MORE attention because it's like a different colour to your clothes, and also it goes over Sophie's head… [demonstrating over her own head]…and I feel like it restricts her movement and makes her feel probably a bit claustrophobic [screwing face up]* (Sarah6)

Figure 26 Demonstrations of breastfeeding paraphernalia

Thinking of buying a pump and bottles was an agonising dilemma for some mothers. Sarah had hoped not to have to face this dilemma, but it was magnified further when she had to give formula milk in the bottles because her milk supply diminished. This caused deep emotional pain as discussed previously (5.3.3). Nevertheless, despite feeling full of remorse and regret for having to take this

approach at the time, once her milk supply was almost re-established some weeks later, she toyed with the idea of keeping at least one or two bottles of expressed breastmilk for her partner to feed to their baby (7.3.2). She had worked out that by doing this it would give her some desperately needed independent time.

> *…mm, not envious of people who have a bit more freedom, but still considering keeping a bottle or two in on the regime* (Sarah6)

This idea was temporary, however, and her thoughts changed again some weeks later when she *'ditched all bottles'* (Sarah13).

The yearning to have independent time and space away from their baby was experienced by all but Rosie, and they spent time working out how to share feeding, how to express and what bottles and teats to use. Searching for equipment on the internet to assist with this and then displaying it before the camcorder highlighted the vast range of commercial products that were promoted to assist breastfeeding mothers to gain the 'freedom' they craved. Various pumps were demonstrated with one mother giving a step-by-step demonstration of how milk was extracted from her breast (5.3.1, Figure 16). Three mothers preferred specific brands that they wanted to promote as the best. This provided evidence of marketing strategies that didn't just attract the mothers to one product but to a whole array of products that they felt they needed. Sam for example bought three pumps, the first she tried did not function well so she bought a second electric pump and a third hand pump which she used at night because it was quieter and did not wake her partner.

Hearing or reading about nipple/teat confusion was a concern for some and so finding the right teat was a particularly important aspect of mothers' breastfeeding experience. They were keen that breastfeeding was not disrupted by using a bottle of breastmilk and needed to also select a bottle feeding system that prevented leakage or waste of breastmilk. Finding the product on the internet they

were keen to show the specialised ‘breastfeeding teats’ pointing out their unique ‘selling features’ to the camcorder (Figure 27).

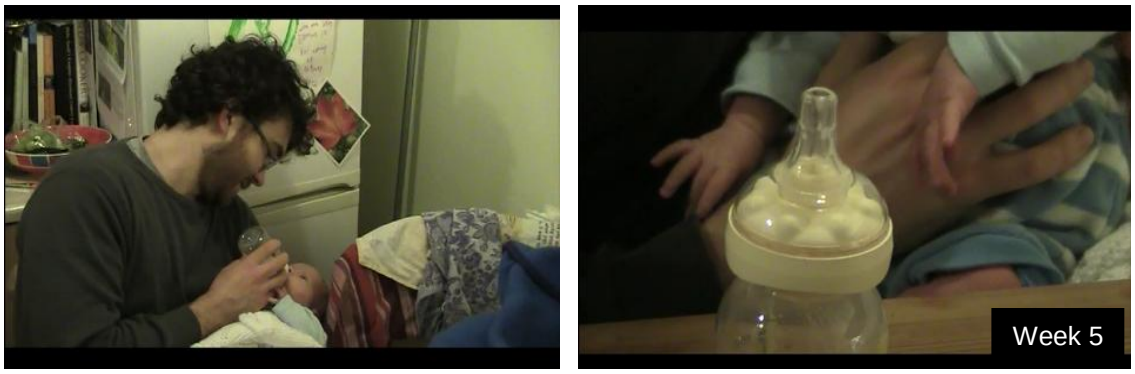
> *...we actually got a specialised breastfeeding teat and bottle which has a main teat and then a little teat inside and that enables the baby to make their own shape inside of the teat, which would be the same way that they form your breast. We have found this is amaaaazing...he can’t spill any of my valuable breastmilk* (Sam3)

Figure 27 Demonstrating essential paraphernalia: specialised teat

Finding the right teat was one issue but working out the right time to introduce the bottle was another. Thus mothers toyed with differing opinions between a need to introduce a bottle within the first few weeks to avoid bottle rejection and an emphasis on not giving it too early for fear of nipple/teat confusion and interference with lactation. Health professionals did not produce the answers they wanted to hear (7.2.2), so to create an impression of compliance, they did not mention it again, and went ahead with their plans.

I talked about expressing milk to [health visitor]. She did the whole, don't do it before six weeks line…because that's the government line… She says it will mess up my milk supply, but I can't fit it in between those two weeks before he might reject it, so I'm going to ignore her [smiling at camcorder] and maybe do it once a week (Vicky4)

Mothers had breast pumps to express breastmilk for many reasons including going back to college and work and enabling someone else to feed the baby so that they could have free time. The notion of giving the father the opportunity to bond through feeding was also important for three families (Figure 28).



Peter: This is the first bottle experience [smiling] it is awesome! …There's not much at all, but we thought we would try it…
Vicky: it's a special teat that makes it go slow [focuses on bottle] (Vicky5)

Figure 28 The first bottle feed is recorded

Making time and space away from her baby was not Rosie's priority, thus bottles and teats did not enter into discussions about paraphernalia. Being attached to her baby by being physically close and by breastfeeding was something she enjoyed and she couldn't really think of anything different (5.2). Spending even the shortest time away from her baby stimulated anxiety about being a mother-infant dyad or two separate entities. For her, breastfeeding was a continuum of pregnancy and she rarely videoed without her baby being attached, either breastfeeding, in her arms or in the sling. Rosie, however, had also worked out that she needed 'essential paraphernalia'. Initially she fed in a special chair with a firm cushion to support her baby. However, she soon became adept at

feeding absolutely anywhere and reflected on her confidence at not requiring the chair and cushions anymore.

Rosie recommended a sling as part of every mother's paraphernalia for breastfeeding, as Lily stayed settled for longer periods between feeds in the sling and Rosie's hands were free for other jobs. Using the one sling, she took great delight in demonstrating how it worked in different ways, keen to record the versatility she had worked out by using it (Figure 29).

Hey, look at this we have just tied Lily up in the sling…But I think she likes it [kneels to camera to show Lily's face] (Rosie6)

Figure 29 Demonstrating essential paraphernalia: the sling

… how fantastic is this sling? …Surely that ought to be part of what the midwife and the health visitors show you or recommend? (Rosie10)

As Lily was usually unsettled in the evening, Rosie's essential paraphernalia grew, as she worked out other strategies to comfort her including long walks outside and using a rocking chair or space-hopper to create the necessary movement to encourage Lily to sleep.

Bras (for good breast support) breast pads (to deal with leaking breastmilk) and clothes (for easy access for breastfeeding) were important paraphernalia. Vicky suffered from mastitis and she had worked out that a strap on her specially designed maternity bra had actually caused it. She cut these straps to relieve the problem and prevent its reoccurrence. Maternity bras and clothes that facilitated

easy access and ‘latching’ were important to mothers. Rosie invested in two tops for easy access, but still grappled with layers of clothes (Figure 30).

…nursing tops have arrived finally…there’s a cross bit, and a bit that comes up…and so far I would say it is really good…(Rosie5)

Figure 30 Demonstrating essential paraphernalia: a nursing top

Shopping was more difficult once the baby was born, but online shopping was confusing with a vast array of bras available. Representations of breastfeeding on commercial websites were considered ironic as these did not reflect the mothers’ reality of breastfeeding.

> *… feel it would be a really good idea to buy some breastfeeding bras…so I was …on the internet and [shaking head] it’s like so baffling there’s so many different kinds…it’s hard to know like what to look for in it …spent quite a long time trawling about on different websites laughing at these incredible models who don’t [laughing] remotely look like nursing mothers and in the end I haven’t bought anything at all yet.* (Rosie1)

Prolific leaking was a problem that some experienced. Fearing the judgement of others while out, some mothers worked out which breast pads were more absorbent and then promoted their favourite brands as if they were appearing on

a television advertisement. They used a variety of commodities, including washable and disposable pads and breast shells that collected milk for feeding by bottle.

> *they are amazing…the actual breast pad themselves [holding up to camera] you probably can't even see, but it is like silk, on the inside, really soft, and I found all the other breast pads leak, if they get too wet, which I don't [shaking head and frowning]…even notice I'm leaking half the time, which is quite embarrassing if I've been out and about and I'm wearing…a top that shows it... these are really good, I highly recommend them … cost a bit more, but it's worth the money* (Sarah3)

Rosie, who admitted that she was not fashion conscious or had previously worn a bra, found that wearing the right clothes and bras was important for make breastfeeding easier and showed various pieces of clothing. She worked out how to deal with her 'very annoying' incessant leaking by wearing woollen jumpers to soak up the milk disguising it from the gaze of others. She was often seen on video grappling with clothes as she attached her baby, and stuffing a muslin cloth into her bra to deal with excess spraying from the other breast. A muslin cloth was never far from her side as she refused to buy disposable breast pads. Moreover Rosie worked out that it was good practice to remove all paraphernalia at least once a day to breastfeed naked.

> *And I was thinking that it's probably quite a good habit to have to at least once a day breastfeed without any clothes on, that you can really see what is happening and also [pointing to breasts] make sure there aren't any swollen bits or hard bits or red streaks or whatever there [sitting in chair in lounge breastfeeding wearing bobble hat]* (Rosie4)

6.2.10 Summing up - surviving

All mothers needed to work out how to survive breastfeeding and to keep going. Once mothers had worked out that frequent feeding was inevitable, they tried to

work out coping strategies to survive, what they felt to be relentless feeding or crying. Such strategies were sometimes explained or observed on camcorder. Sometimes measures included a reprieve from the relentless feeding despite knowing they were wrong. Gaining sleep was a priority and thus night-time parenting strategies such as co-sleeping and giving a bottle at night were frequent topics of conversation.

Mothers also needed to survive the conflicting opinions from family and friends. This was particularly evident when they tried to work out the differences between establishing a routine and baby-led feeding because there was a real yearning for structure in their lives and yet it was at odds with what was happening. Getting a balance between the ‘work’ of continuous feeding and baby care; the ‘rest’, enabling sleep and recuperation; and the ‘play’, giving time and space to do other things, was important. Thus mothers set goals and developed strategies to accomplish as much as possible within a day. Sometimes, however, recognising the importance of sleep or feelings of exhaustion meant they had to make hard decisions to rest instead of play. When they achieved more than breastfeeding and baby care, they felt successful: when they only managed breastfeeding and baby care, they felt down-hearted.

All mothers developed breastfeeding problems, therefore, troubleshooting was vital to surviving. Sometimes this involved others but invariably it involved their own research using the internet and books and discussing it on camcorder to work out an answer. As they became experienced in breastfeeding, they felt confident to help other mothers. All mothers bought breastfeeding paraphernalia, exposing them to the commercialisation and with it a whole host of products to ‘help’ breastfeeding. What they bought varied for each woman depending on her circumstances, needs, preferences and socio-cultural context.

The second half of this chapter focuses on the subtheme of ‘A state of flux and getting back to normal’.

6.3 A state of flux and getting back to ‘normal’

The video diaries provided a safe place to reflect on who they were as breastfeeding mothers in this ‘state of flux’ and to work out how to get back to ‘normal’, which included a reappraisal of their new identities very early within the data collection period. Applying Faircloth’s (2009, p. 15) phrase of “identity work…[the] process of self-making that parents engage in as they raise their children”, I demonstrate how giving birth, motherhood and breastfeeding created a point in the mothers’ lives that triggered existential questions. The video diaries were used frequently sometimes on a daily basis to mull over their thoughts and feelings as they ‘yo-yoed’ back and forth reappraising and repositioning themselves as their identities evolved.

6.3.1 Identity work...Only me!

Part of ‘identity work’ was verbalising why they had become breastfeeding mothers and this occurred throughout their breastfeeding trajectory recorded within the diaries. It was as if they needed to validate their identity and restore self-confidence, particularly during challenging days. The moral obligation to breastfeed was drawn from different perspectives with some believing it to provide the ‘*baby the best start in life’* (Sam2), others protecting their babies because ‘*breastmilk has antibodies’* (Tracey9), and others valuing the embodied aspects because there was

> ‘*something very human about it…building new relationships …natural and real as opposed to fake, constructed and artificial’* (Rosie5).

When mothers realised that their baby fed night and day, they had to grapple with the idea that they were the only ones who could do this. For some, this was a comforting thought, a safety net that whoever wanted to touch or hold their baby, the baby would ultimately be returned to them to feed. The mothering instinct was strong and protective and the embodied connection they felt with their baby made

them feel wanted and needed. This 'identity work' increased self-confidence and self-belief in their maternal role and their reasons for breastfeeding.

> *I want to protect him, and when he's crying and [male relative] is holding him, you just want to scoop him up…and just hold him, and when you know you can be the one who stops him crying it's huge, you know like [opening eyes wider] give him to me!* (Vicky5)

This 'identity work' also helped some value their identity as breastfeeding mothers not just as producers of nutrition but to realise that the embodied nature of the breastfeeding process was a principle factor in continuing to develop a close relationship with their babies.

> *..in a technical sense then, if I wasn't breastfeeding then me and Tom would both be equally able to look after Lily, and do everything that she needs …and would we still have a different type of connection to her? Because we do!...I am sort of much closer to her, physically closer to her and spending more time with her, and …a bit more in tune with her…and experience her more, and Tom experiences me and Lily as a unit, we are one-being in some sense…it's almost like the pregnancy continues but in an external way rather than an internal way…and the breastfeeding is the crux of it.* (Rosie5)

Some mothers, because of this 'identity work' as sole feeders of their babies, noticed that, with the increased sense of responsibility, their identity and relationships with friends and family had changed. Sometimes this was precipitated by the strong mothering instinct. Others felt unnerved as their identity and approach to breastfeeding and mothering was challenged which made them vulnerable to pressure to behave in a way that counteracted their beliefs (7.3.3).

> *Whenever she comes round, she'll want to parent my baby her way, and it's causing conflict, I don't think there is a right way or wrong way, but, as his mother, I think I know when he's hungry*….(Tracey3)

Thus as part of this ‘identity work’, mothers verbalised their changing relationships with other people and what, if anything, they needed to do about those relationships. During Vicky’s filmed conversations, for example, she worked out that parenting approaches had developed over the decades and that might explain the criticism. She spent time critiquing the issues that were being presented to her, to justify her new identity and approach to breastfeeding. Imagining how Benjamin would be if she left him for four hours and did not pick him up to feed, provided the conviction that her approach was right. Reading books, that reinforced her approach to parenting, helped to increase her resilience to outside influences and with dogged determination she became less upset by casual remarks and through her own ‘identity work’ humoured the person who had criticised her.

‘Identity work’ which emphasised the ‘only me’ feeling created other relationship tensions. This was related specifically to the baby-centred nature of breastfeeding meaning little time to fulfil their identities as ‘partners’ within a loving relationship. They often felt torn between spending a long time feeding and little time with their partner. This made them question what their relationship with their partner was about and how their identities had changed.

> *It’s hard like giving up all of your independence, all of everything, all of your love that you have for your partner and putting the effort that you had for your partner into your baby and then trying to keep up with a relationship...* (Tracey12)

Those who felt well supported by their partners felt guilty that they were putting on too much pressure and tried to work out how they could lessen this. They felt indebted and yearned for the closeness that they once shared which resulted in feelings of sadness.

I spend all my time cuddling Lily and I feel like he spends so much time running around doing jobs…trying to go to work as well…and I feel like I can't ask for anything more from him, when actually it's really nice to, I suppose, to feel like someone, yeh not looking after me because I suppose he is…like giving me a cuddle…and that we have some time to talk… (Rosie2)

6.3.2 Identity work…Giving up something of self to serve another

'Identity work' involved toying with ideas about 'who they were' now as breastfeeding mothers sometimes expressing pride in their prior achievements. Very early within the data collection they started to share their plans for returning to work or college, most having a period of maternity leave. Apart from Sarah, who planned to take a full year away from paid employment, the early sharing of plans within their diaries appeared to trigger an inner struggle between their identity as breastfeeding mothers and how these plans would fit (or not) around their baby and breastfeeding. This identity work resulted in frequent and sometimes long ruminations as they deliberated over various options, sometimes 'yo-yoing' back and forth between their heart and their mind.

Thus, by the second week following birth, some mothers were trying to work out how they could fulfil this dual role of returning to work/college and fitting it in with breastfeeding. For some, this determination to resume 'work' was due to a financial pressure or to complete what they had already started. Sam wanted to go back to college, so she had already worked out that she could provide Zac with her *'valuable breastmilk'* (Sam3) by expressing and have her mother give it in a bottle (6.2.9). This flexibility fulfilled her moral identity of being a good mother by providing Zac's nutritional needs while she was engaged in her student role finishing her course. Thus, her focus in the very early days revolved around expressing and introducing bottles as much as it did about breastfeeding. Sharing her plans with her health visitor, was met with resistance when she felt chastised for introducing bottles too early. Sam's annoyance with this rigidity was evident as

it threatened one of her two identities, being a breastfeeding mother or being a student.

> *I was obviously considering going back to college but with Zac being so young I was really concerned about giving him a bottle and [pause] breast, and I don't want him to just stick to the bottle, so I was really concerned about that. Health Visitor had a bit of a go at us, because we've introduced the bottle too early apparently and you should introduce it at six weeks plus. Now, I just don't think this is very flexible thinking [for]…somebody like myself who wants to go back to college* (Sam2)

Sam determined to achieve both identities, 'worked it out' for herself (6.2.9), she bought essential paraphernalia to assist in the process. Working out how to fulfil her dual identity also caused her to search the internet to find out her rights as a full-time breastfeeding student. Finding this on the Maternity Alliance website was a revelation. She worked out that voluntary work necessary for her course could involve breastfeeding, providing her mother was available nearby to care for him. Nevertheless, the inner struggle between her dual identities as a breastfeeding mother and student became apparent when she shared her angst about leaving him despite having expressed copious quantities of breastmilk. The nutritional aspect of her maternal identity was catered for but perhaps not the nurturing side and leaving him was causing her to worry. Further tensions transpired between her dual identities when college commitments clashed with her baby's needs during the second postnatal week.

> *Fingers crossed, he's now in bed, it's quite late in the evening, I am knackered because I've sat up with a baby instead of doing my assignment which I was meant to be doing [frowning] for college…I've literally done nothing I was stuck on the sofa with Zac* (Sam2)

This identity work was evident in other mothers' diaries, for example Vicky felt nervous and seemed to be 'pushing away' the idea of going back to work, trying to work out other options. There was an inevitability that it was going to happen, but

a certain denial and a need to talk and to work it out very early and frequently in her diary entries. In her inner struggle she toyed with her breastfeeding identity and how this could possibly fit into her professional identity in her work environment. Thus much of her frequent ruminations involved working out how long she could afford to delay picking up her work identity again as well as the practicalities of how it could work.

'Identity work' for Rosie was frequent, long and reflective and appeared to involve 'offloading' (5.3.3). Her impromptu unsystematic diary entries demonstrated her inner struggle as she wrestled night and day for many weeks with her identity. She had no doubts that unless something extraordinary stopped her she would continue breastfeeding. She 'yo-yoed', however, between recognising her value as a breastfeeding mother…

> *It's easy to forget or discount that looking after Lily is a valuable job or work or thing to do in life and that it takes a LOT of time and effort [sitting rocking back and forth with Lily in sling, just finished folding laundry]* (Rosie4)

…and yearning for something more. Rosie also needed to be valued in society. The latter was set against her identity as a mother keeping her baby close by her for nurturing and breastfeeding (as evident in the videos). In Rosie's 'identity work' there was no need for expressing, but there was a need to work out how this dual identity could be realised so that both identities would be in harmony. Her discussions included 'offloading' (5.3.3) and 'working it out', but in two late evening diary entries, filmed in the dark, rocking her baby to sleep, she reflected on her life now and in the future. The dissonance between valuing her identity as a breastfeeding mother, where her baby was the centre of her being, and the need to have something more in life than just her baby, was at the crux of many deliberations. As she contemplated these ideas she worked out that she had to let go of her former identity to take on her new one.

[Sitting on bed rocking Lily] I have this feeling that she has to be the priority and the centre of what I'm doing, but that has to be in the context of doing something else, that I almost owe it to her, that she isn't the be all and end all of my world, there needs to be more in the world than Lily, because a world that is only Lily is, like what's the point of that for Lily? (Rosie5)

[Extracts taken from 31 minute recording at 22.42hrs in the dark, cuddling Lily-] .. to actually work with the horses…it takes a real ego-presence, and I think it's something you can't do with a baby strapped onto you…and that maybe in this still quite strange time after the baby being born you don't have that ego-presence… and in a way the experience of having a baby is about giving up something of your ego [long pause] yes giving up something of yourself to serve another, which is baby, and that's you little Lily…….And we were talking about when we will know when breastfeeding is established and in a way I need to know, is my life established? …there is no question that I am going to breastfeed…but there is a question of what is my life about and how does it work and therefore how does the breastfeeding fit into it?.....…There's a real feeling of who am I now and what is my life all about, and how is it going to work out and that's frustrating…frustrating because I can't make it into the known…I don't thrive on unknown. I like to be in control. (Rosie5)

There was a real inner drive to bring a sense of self-worth and self-esteem to mothers' evolving identities. The inner struggle appeared to be a battle between what mothers thought their identity was now and what they wanted it to be. Tracey's identity work came to an abrupt crisis during her twelfth week, when in a series of five diary entries, it became evident that despite her determination to continue breastfeeding in the face of adversity, she was on the brink of giving up. With a need for financial and social independence she had worked out a way of continuing to care for her baby and to earn money. The dilemma between continuing as a breastfeeding mother and becoming a wage earner was too difficult and breastfeeding lost, as she was driven to distraction trying to work out

the dual roles. The battle of emotions was evident as she offloaded her troubles onto the camcorder realising that she had 'had enough' of breastfeeding (6.2).

Despite this small sample, the 'identity work' that occurred for each breastfeeding mother was different. This was because despite all feeling a moral obligation to breastfeed, their different perspectives and priorities were shaped within their own unique socio-cultural context.

6.3.3 Getting back to 'normal'…Logistics

Craving freedom and finding the space for 'play' (6.2.6) was closely interlinked with getting back to 'normal'. All mothers yearned some of their former social life and sought to work out how this could be (partly) achieved. For some this meant going out with their baby, which inevitably meant working out the logistics of feeding in front of others. For others it meant working out how quickly they could create space away from their baby and continue to breastfeed. This was a priority for Sam as a student and all that that involved (6.3.2). Thus within a week of giving birth she had arranged to attend a New Year's gathering without her baby. With keen determination but nervous trepidation, and not knowing how much to express she left her baby with her mother and 4oz of expressed breastmilk in a bottle. She returned three hours later to a hungry baby, but that gave her the confidence to express regularly, referring to the quality product of '*my valuable breastmilk'*. Thus, expressing and someone else giving breastmilk in a bottle gave her some freedom and social life that she yearned for, at the same time as fulfilling her moral obligation to breastfeed. This also fitted with her feelings of humiliation when breastfeeding in front of others. Expressing breastmilk provided her with the flexibility to continue providing Zac with nutrition without feeling *'out of place'* (Sam1) in those awkward moments when she was out with him and he needed feeding (6.3.4).

'Identity work' was not the only deliberation that took place in relation to getting back to 'normal' and to work. Planning the logistics was equally important and this planning occurred early and on a frequent basis. Sam, for example, always

intending dual roles as breastfeeding mother and student, expressed her breastmilk frequently between breastfeeding, for her mother to give by bottle when she returned to college on the fourth week following birth. Resuming her social life and taking time out away from her baby within a week of giving birth triggered an early start to this experience and provided a 'trial and error' period to see how it worked before returning to college. By the time she concluded her diaries at eight weeks she was confidently using an electric pump regularly in the day and a hand pump at night, expressing copious amounts of milk in between breastfeeding to keep up with the demands of returning to college. She appeared to prefer this method, as for her, it provided flexibility. Valuing the nutritional qualities of her breastmilk and feeling proud of her achievement, prompted her to donate her excess breastmilk to the local hospital.

> *I've actually got some ridiculous amount of milk now that I've contacted … maternity hospital to see if I can donate some* (Sam7)

Some mothers valued the relational side of breastfeeding (5.2.3) which meant that they needed to work out the 'logistics' of breastfeeding being part of the process of getting back to 'normal'. This often involved discussions about setting routines and structure into the day (6.2.3/6.2.5). Thus, early musings involved working out the 'logistics' alongside their individual goals of continuing to breastfeed. This involved discussions about when to go back to work, to prolong breastfeeding, including thinking about expressing and storing breastmilk, and how that can be done in the workplace.

> *…it [book] says how important it is to feed for the first year, but I was thinking about going back to work, maybe in July, September or October [at 7-10 months]…and how does that work out? Will I just have to express enough for those two days? [thinking] Like obviously, I'll be able to do an early morning feed and an evening feed, so I'm a bit worried.* (Vicky6)

Valuing the embodied relational nature of breastfeeding meant for Rosie working out how to get back to 'normal', including meaningful work, not necessarily paid, at her workplace. Determined to feel a sense of value she also thought about the logistics as early as the second week.

> *How and when and what I can do? I'm a bit worried that it will be really difficult to go back to work and do meaningful work and I feel like I want Lily to be priority and there's no way I want to send her away and someone else looks after her, but at the same time, I know it's really important to me to be able to be outside and to be able to do gardening. And also I have to justify myself and make a living, so how is that going to work? [Kneeling in garden planting basil]* (Rosie2)

Rosie conveyed her inner thoughts to her diary verbalising what she thought was feasible and what was not. This culminated in a trial and error period, where she conducted a number of visits, planning them within diary entries, carrying them out and then reporting back after the event.

> *Yesterday I walked to the farm with Lily…it took an hour…I planned it that I would do a little bit of work in the garden…to kind of see what it felt like and how it worked…One thing I hadn't really appreciated before Lily was born was…you know if I'm gardening then my hands are like always dirty…to pick her up would mean leaving muddy fingerprints all over her blanket, let alone putting soil in her eye or getting her some terrible soil born disease or something…Another thing if I need to feed her…then it means going into the house, and that means taking off muddy boots, taking off overalls, unwrapping various layers of Lily's blankets…and by then she can be desperately screaming or apparently gone back to sleep and not need feeding after all.* (Rosie5)

This trial and error period helped her to work out that getting back to 'normal' with her baby was more problematic than she had imagined. This brought on another inner struggle as she tried to work out what that meant for her. She continued to

use her video diaries to deliberate repeatedly as she tried and tested the logistics of going to work with Lily, bending with a sling, doing manual work, breastfeeding in front of others and taking on some, but not all responsibilities of the job. When she was pleased with the results, she was upbeat and felt a sense of achievement but sometimes she appeared downhearted as she realised that life was different with a breastfeeding baby and she couldn't always achieve everything she hoped for.

> *Part of me thinks that's absolutely right … and it's important for life to go on and not to be entirely consumed by baby and part of me feels that's wrong and it should be absolutely that Lily's first and I shouldn't feel like I need to go back to work and I shouldn't be just doing what I want to do and we should be gently pottering about at home and that's enough…it's going to be a difficult line to tread. …I've perhaps got a ridiculous unrealistic picture in my head…of peasant communities and people living and working off the land and there's children everywhere…and you don't go on maternity leave because you are just living your life and I sort of want to feel like that…not that I am banished for six months and then expected to be a super hero afterwards.. I don't know what I'm meant to be doing …and don't know even what I want to do, well I kind of want everything and I can't have it and then I can't imagine how the future is. I really need to have a picture in my head about what does it look like for summer at least, like for this summer* (Rosie5)

6.3.4 Getting back to 'normal'…Going out

Finding the space for 'play' (6.2.6), often involved going out and that gave all mothers a sense of getting back to 'normal'. This included going out to see friends and family, shopping and attending groups. Going out sometimes meant juggling the outing around feeding times and when this worked out well mothers felt a sense of achievement. When this did not work, mothers felt that outings pressurised feeding times which resulted in further tension. For longer trips out,

however, it inevitably meant breastfeeding in front of others, which brought a whole new set of challenges as mothers tried to work out how comfortable they felt about this.

Each woman felt differently about feeding in front of others and for some this depended on the situation in which they found themselves and their own personal feelings about exposing their breasts. Indeed some mothers also felt that breastfeeding was socially unacceptable and that the general public did not expect or like to see it. Thus whilst some mothers were comfortable feeding in front of friends and family, three felt '*out of place'* and awkward feeding in a public place. All three ensured that the camcorder frame did not capture them breastfeeding during the filming of the video diaries.

Social media banning breastfeeding pictures on their network affected mothers' confidence to breastfeed in public. This impacted on Sarah so that she felt more reserved breastfeeding in front of strangers, believing it was considered socially unacceptable. With this sense of repression, she sometimes felt intimidated when she breastfed in public places full of strangers especially when she sensed that she was being watched or judged. She assessed each environment, developing techniques to manage this.

> *I was pretty discreet I had …a vest top on and a dress over the top, so I just put the vest top down and the other top up, so all that was exposed was a little bit of breast and then she could feed* (Sarah5)

Sam also felt 'out of place' feeding in public when she went shopping two days after her baby was born. She had not worked out where or how she would feel about breastfeeding in public, hence it was a shock. She felt intimidated by the 'outside world', not fully supported by her partner and lacked confidence feeding in public. Her description sounded like she had walked into a familiar world but now her position in society had changed. Because she breastfed in public, she felt judged and criticised. She felt an internal struggle between meeting her baby's needs and breastfeeding in front of others, or finding a more secluded

place which was unpleasant and unhygienic for feeding. She chose the former but then felt ashamed, needing to hide her baby under a blanket while feeding.

> *… when I actually needed to feed him, I didn't know where to gooo, I didn't know how to feel, I didn't know what other people would think, I was nervous about them making comments. I actually ended ...in the restaurant, sitting in the corner with a cover straight over the top of the baby's head breastfeeding. I felt so bad, completely out of place, it was a horrible experience. I don't think people think that it's a right thing to be doing in public… I just think that I felt very out of place and people stared...I just found that there just really wasn't anywhere I felt comfortable feeding the baby…I just didn't really want to feed my baby in the toilet, or in a changing room really, I wouldn't eat my food in there and I wouldn't expect him to either.* (Sam1)

Tracey also identified with the feeling of being watched and judged. She felt self-conscious of breastfeeding in front of anyone other than her partner, including family members. When she was compelled to feed in a public place while out one day she was intimidated, feeling that she was being unnaturally watched and this brought on distress which her partner could not understand.

> *I had to feed the baby in the car which I wasn't too pleased about because I don't like breastfeeding in public… in Tesco's car park, right?...and next door to us was a pervy old man that would not go away and I got quite upset about that because I feel like, I'm exposing my body, and Scott really doesn't get it, but I'm trying to stay calm*. (Tracey8)

When mothers were compelled to feed in front of strangers they no longer felt in control of their own privacy and dignity, and these awkward and uncomfortable experiences might have compounded their feelings, reducing confidence further. This resulted in mothers either avoiding going out for lengthy periods, or developing strategies for feeding in public. Tracey chose to avoid situations when she might be caught having to feed in public which considerably restricted her

movements and that resulted in feeling isolated at home. It also meant that opportunities for mixing with other mothers were curtailed, causing more profound feelings of isolation.

> *I'm very lonely and it's difficult because…I'm not quite there at going out yet* (Tracey8)

> *I still don't like breastfeeding in public and I think it comes down to like part of it, why I won't go down today [picnic in park with baby group] ….I am a bit sad that I am not going today and I was psyching myself up to feeding him in public um but yeh* (Tracey8)

Sam who was more determined to get back to 'normal' quickly, partly through necessity to go to college, worked out a way to overcome this by expressing and giving a bottle of breastmilk. Tracey feeling more intimidated, worked out this much later and only just before giving up breastfeeding altogether.

Part of being confident about feeding in front of others was about a woman knowing that she could attach her baby to her breast easily with minimal fuss and minimal exposure of her nipples. In the early days, when the mothers needed to expose their breast to ensure optimal attachment, they felt intimidated but as confidence grew and attachment became easier, they felt less fearful, because being discreet was easier.

> *And then with the mastitis, all you want to do is have your boobs out and checking he's latching on properly, and checking you can massage your boob at same time as feeding, while [he's] there, and trying to [be] slightly more modest, so it means I'm not able to do that really* (Vicky5)

> *Nipple shields in public are a nightmare, putting them on and off are an absolute nightmare, because you have to get your boob out, and then put your nipple shield on, then get your baby, so you've got an exposed breast with a nipple shield on*…(Sarah6)

When mothers had a supportive environment where breastfeeding was considered normal, it boosted their confidence. Rosie for example, felt uninhibited feeding in front of her working community. As the mothers' confidence grew, they became more relaxed and hence could feed anywhere. That enabled them to go out and about unrestricted and their social life was full as they met up with friends and joined various mother-baby groups. They had the conviction of their beliefs and they felt ready to be challenged by anyone.

6.3.5 Summing up

Being in a '*state of flux and getting back to 'normal''* involved mothers undertaking identity work, as they sought to work out who they were as breastfeeding mothers and how to get back to 'normal'. The real-time conversations within the safe confines of the diaries highlighted the internal struggle for some, as they realised what they had given up to become the mother that they were now. It involved them validating why they were breastfeeding in the first place and for some this helped them value themselves. Identity work also helped some to realise that they needed to go with the rhythm of breastfeeding whereas others continued to fight, finding the time consuming nature of breastfeeding an intrusion into their daily lives.

Getting back to work and going out were important for most mothers to feel that they were moving towards getting back to 'normal'. To achieve these aspects of 'normal life', they needed to work out the logistics of either leaving or taking their baby with them. These preparations and plans commenced very early in the breastfeeding trajectory and were frequent and detailed.

Being separated from their babies and working out how to express and leave breastmilk for a carer to give to their baby, added another layer of anxiety, and yet all but one craved independence and space that they could call their own. Going out with their baby for any length of time brought a different dimension, as they needed to consider whether they were comfortable to feed in front of others. If they felt uncomfortable, other strategies were worked out and employed, such as

taking a bottle of expressed milk or avoiding feeding times altogether. Nevertheless, the latter limited time spent going out, causing feelings of isolation and resentment that breastfeeding was curtailing ‘normal’ life. The other option was to face feeding in front of others causing an uncomfortable embarrassing experience. Three mothers believed that breastfeeding in front of strangers was not socially acceptable and reduced their confidence to breastfeed in public, and hence their breastfeeding experience. The other two mothers grew in confidence and thus felt more and more relaxed feeding in front of others making outings more flexible and less pressured, so that getting back to ‘normal’ was not so contrived but natural.

The next chapter explores ‘the support conundrum’ that each mother experienced along their breastfeeding trajectory.

7 ‘The Support Conundrum’

7.1 Introduction

The third theme, ‘The support conundrum’ demonstrated the daily challenges mothers faced because of the breastfeeding support they experienced from a multitude of sources; professional and lay supporters, social networks such as friends and family and the mass media including the internet, books and television. The approach and aim of the support were also important. Dykes et al. (2003) identified five approaches for breastfeeding support: emotional, esteem, instrumental, informational and network support. The findings from this study reinforce the complex nature of the support experienced by mothers in relation to its source, its approach and aim and how mothers perceived and dealt with it on a daily basis.

The first subtheme explores mothers’ perceptions of being ‘under surveillance’**.** This subtheme is derived from the categories, ‘*on the right track?’* when mothers valued the encouragement from healthcare team with regular check-ups and support. This was in distinct contrast to feeling ‘*scrutinised, judged and sabotaged’* when mothers felt their breastfeeding was constantly being examined, criticised and threatened. Mothers felt *‘abandoned and alone’* when they found it difficult to access healthcare support when they most needed it or avoided it to circumvent further scrutiny.

The second subtheme ‘Managing support from family and friends’ is derived from categories relating to support provided by mothers’ own social networks both from friends and family. The discerned categories were *‘nurturing the nurturer’* where mothers felt sensitively but actively supported to nurture their baby and breastfeed, *‘finding a new equilibrium’* when compromises were proposed to ensure a more even balance between breastfeeding and daily life and ‘*interfering*

opinion' when mothers recognised that breastfeeding was threatened when fixed views were expressed.

The third subtheme 'The gap and filling it' is derived from two categories, '*looking it up'* where mothers proactively sought specific information to 'fill the gap' to answer their own questions and overcome daily breastfeeding challenges. *'Reading more'* occurred when mothers enjoyed using a wide range of sources to deepen their knowledge and find out new things about breastfeeding.

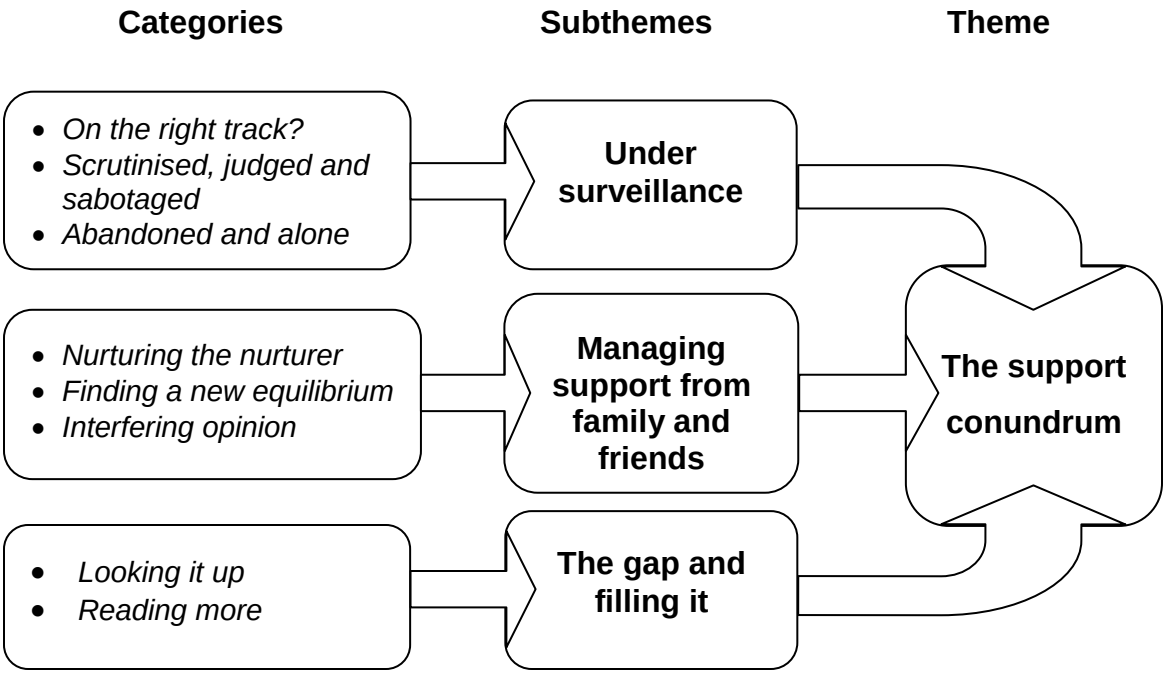


Chart 5 Categories, subthemes & theme: 'The Support Conundrum'

7.2 Under surveillance

Mothers expressed their experience of the health service, feeling that they were under surveillance where mothering skills, breastfeeding and development of their baby was under continual review by healthcare team members including midwives, health visitors, support workers and peer supporters. Mothers became keen critics, discussing individual members of the 'surveillance team', evaluating their practice in a measured way. Some mothers found being 'under surveillance' reassuring and helpful, feeling that the healthcare workers were ensuring that they were '*on the right track'* in a nurturing way, giving advice and support when needed. These moments often involved their baby's weight gain which was discussed frequently but briefly. At the other end of the spectrum, mothers felt breastfeeding was *'scrutinised judged and sabotaged'* leading to frequent and lengthy emotional offloading on camcorder by 'scrutinising the scrutineer', condemning the surveillance programme and the team members involved. The final category describes when mothers did not access or did not receive the support they needed from the healthcare team causing them to feel '*abandoned and alone'*.

7.2.1 On the right track?

When mothers experienced the opportunity to build relationships and trust with healthcare workers, they felt reassured and encouraged so that a feeling of being able to ask whether they were '*on the right track?*' was regarded as nurturing and affirming. This was felt particularly when their baby progressed well. For mothers to reveal their concerns in such a way they needed to feel at ease with the healthcare worker and for some that meant a more equal footing. A reciprocal relationship which involved trust enabled them to ask questions and share their concerns without the fear of being scrutinised and judged for what they said or did.

> *We had…a midwife who isn't actually a midwife, a midwife support worker or something like that, and that was really nice actually because I had the feeling like…sometimes I don't want to say anything to the midwife…in case they say oooooh terrible, oh dear, and make me do something, and it somehow felt it's not quite so bad to say something to her because she isn't an official midwife* (Rosie1).

> *[The health visitor] likes [my baby] because he sticks out his tongue to her …and she gets very excited when she sees that…. And I feel like I've got a good bond with her and I can talk to her about anything* (Tracey5)

Healthcare workers, who listened and understood what was happening, were considered especially nurturing as all mothers were initially in a quandary and doubted their capabilities to breastfeed successfully. Even the most well informed mothers, who had prepared by extensive reading, needed positive affirmation and reassurance that breastfeeding was 'working'.

> *Quite nice that she was there to watch in real-time, and also that she had time to see… she wasn't in a rush. Mostly she was reassuring…basically said it's right and the baby is obviously getting something out of me and pretty much, just carry on. And it's a good feeling to know it's right, because I guess that part of the difficulty with it, is that never having done it before, it's not obvious what is right and what is not, and you can be in fear or doubt as to whether it's working, whether I am doing it right or doing something stupid* (Rosie1)

When mothers experienced difficulties they did not appear to be finding reasons to stop breastfeeding but instead demonstrated determination to work through them. This required frequent and regular validation that breastfeeding was going well, not just at the beginning of their journey but also later on. Mothers sought this through routine check-ups with health professionals where their baby was weighed and checked. Indeed, for all mothers, weight gain was the single most important validation of breastfeeding. Thus validation revolved around a

biomedical reassurance that their baby was growing, emphasising the nutritional importance of breastfeeding rather than the relational side including seeing and believing that breastfeeding was making a difference. Mothers demonstrated the importance of this by squeezing in extra appointments for weighing just to be sure their baby was '*on the right track'*. These frequent but brief descriptions of validation revolved around numerical values rather than words of positive affirmation expressed from the healthcare team.

> *… she's now 8lbs and she was 7lb 11 …that has given me a real boost knowing that although I'm sore, although I might be a bit miserable about it, the very fact that Sophie is putting on weight means that she's taking milk and it's doing its job and that I'm actually feeding her and doing it OK [screwing up nose], well enough to feed her anyway!* (Sarah1)

> *... I just feel it is more reassurance when I get him weighed every week* (Sam4)

Healthcare workers who were sensitive to the needs of mothers who wanted to know that they were '*on the right track'* chose the right time to provide useful information that would encourage breastfeeding. Being forewarned was being forearmed so that mothers were not fazed by some of the breastfeeding challenges and were less likely to be alarmed, discouraged or give up.

> *The health visitor confirmed what I have been thinking, it's still such early days and completely normal that it's [feeding pattern] all a bit random and all over the place, and she said, 'don't expect it to settle down into any kind of routine for until like the first six or eight weeks', which is even longer than I had thought.* (Rosie3)

> *She said it's good to alternate [positions], like across and then rugby ball because it empties different parts of your breast…I didn't know* (Vicky4)

7.2.2 Scrutinised, judged and sabotaged

For some, if not most of the time, mothers experienced an overwhelming feeling that health professionals were not checking that they were *'on the right trac*k' in a positive nurturing way. Instead they felt their parenting skills, including breastfeeding, were being scrutinised and judged. Feeling 'scrutinised' made mothers wary that the resulting advice or action by health professionals could sabotage breastfeeding. Rosie felt that she was more likely to be judged by a midwife than a support worker (7.2.1). Despite having a homebirth, with midwives in attendance, her feelings of being submissive and under scrutiny meant that she could not openly discuss her problems with midwives for fear of potential sabotage. Mothers felt that they needed to be constantly on guard just in case there was an unexpected visit by a health professional. Such scheduled visits resulted in a flurry of activity to prepare for this.

> *You almost don't want to admit to any midwives or any kind of health professionals in case they then say 'right we're going to whisk you off to hospital' or 'we'll have to take your baby away because you're not doing it properly or something', which is a stupid fear to have, but I suppose it's a shame it exists…that I should potentially feel like that, they should manage to make that not happen* (Rosie1)

> *…so I better make sure the house is smart, I better make sure I'm looking presentable…like I don't want to be caught out somehow…they could come at any moment and I want to keep them happy and…potentially they have some sort of power over me.* (Rosie2)

As mothers shared their experiences of initiating breastfeeding in hospital, their feelings of being scrutinised, judged and rendered powerless were even stronger as support was often rushed, overpowering, controlling or 'hands on'. The powerlessness felt by three mothers receiving 'hands on support', where midwives held their breast and pushed the baby on, or felt scrutinised by being constantly 'watched and criticised' whilst breastfeeding, was particularly evident.

> *The student midwife was actually trying to teach me how to do it with kind of, a hands off approach, and just talking me through it, maybe try this, maybe try that…and an old school midwife came in and said, 'this is how you do it' and just plonked Sophie onto my boob…the poor student midwife looked a little bit shocked* (Sarah1)

> *I really wish over the last week someone had taken a little more time and not just plonked her on the boob and say that's how you feed baby, crack on with it, because then we might not have all this soreness and miserableness*. (Sarah2)

Apparently without consultation, Vicky also experienced a 'hands on' approach at birth, despite wanting to try 'biological nurturing' which she hoped would encouraged her baby to self-attach (Colson 2012).

> *So when the midwife helped me, when I'd just given birth, unfortunately she did then just put him on rather than [pause], we couldn't experiment with biological nurturing because she sort of latched him on for me* (Vicky3)

Tracey was distressed by the baby's incessant feeding and the controlling attitudes of the midwives in hospital who appeared obsessed by breastfeeding and not her overall wellbeing. The instructive approach was demoralising and she felt degraded being forced to expose her breasts for the staff to watch her feeding. Her powerlessness turned to anger, as she ranted on video with her partner about her experience of feeling singled out, scrutinised and judged as a bad mother by the staff who kept telling her that her baby was hungry. As previously discussed (6.2.1), no-one had explained that it was normal for babies to feed very frequently in the first few days, so her expectations were at odds with her reality. That resulted in her feeling intimidated and hopeless.

Fed him all the way through the night, continually, was not allowed to take him off…was instructed to lie down and show this midwife everything which I wasn't very happy about, because I feel very conscious of my chest area…Got told that I was to continue feeding my baby…because of all this I just felt I'd failed my baby (Tracey1)

[Scott said] they didn't want to know how you felt apart from that, or anything about your pain levels or anything they could get you to make you more comfortable. I know they are midwives and not just nurses, but all they were interested in was breastfeeding, and show us you are doing it right, the baby is hungry, the baby is hungry, the baby is hungry (Tracey1)

Once home, mothers felt that healthcare workers were frequently towing the 'party line' when giving advice instead of providing individualised care and information. They feared the scrutiny would continue and they felt it had the potential to threaten breastfeeding. They were afraid they might be seen as not coping which caused them to work out strategies to minimise any negative judgement made about them. One strategy was to conceal real issues and to keep up appearances. Another strategy was to appear to agree with health professional's advice to create a good impression but then actually ignore it. While they revealed their 'deviance' on their videos, they were careful not to reveal it to the healthcare workers. This clandestine feel to the diaries (5.2.2), was like a disguise, telling one story to keep the healthcare workers at bay but acting differently in order to follow their instincts or what other mothers had advised.

…so she said, well done, carry on as you're doing. Brilliant! Exhausting! Last week she told me not to feed for more than 20 minutes on each side, didn't tell her I wasn't doing this. (Vicky4)

I've made a conscious decision that if my health visitor asks me to put formula in his feeds this week, I'm not going to do it because it's happened quite a lot with my friends and they've said not to do it because it encourages them to have more of the bottle…and I'm going to listen to my

instincts and take it from there, and just agree with the health visitors, because he's very healthy and very happy little thing (Tracey7)

Another strategy used to halt the scrutiny and further aggravation, was to deny their own opinions by conforming to health professionals' advice, in order to satisfy them. Mothers followed advice to prove that they were capable and compliant. Sometimes this meant going above and beyond what they wanted to do to try to meet their healthcare workers' expectations. Mothers analysed the situation, preferring a route of least resistance to gain inner peace and privacy.

The health visitor has been going on and on about baby massage to me and I thought, you know, Zac will hate it because he hates being naked, and he just screams but I thought, you know, to shut them up I'm just going to go. (Sam6)

Booked the osteopath for yesterday, so done everything the health visitor had asked me to do basically (Tracey5)

While the majority of mothers were reassured by healthcare workers when they were '*on the right track*' because it validated breastfeeding, some encounters with staff contradicted that experience. This was because attitudes displayed by staff were judgemental and discouraging. When Tracey's baby was deemed not to be gaining adequate weight she felt her breastfeeding was scrutinised and even sabotaged. Sam experienced a similar attitude when she asked about introducing bottles ready for her return to college (6.2.9).

The authoritarian approach of healthcare workers which Tracey described caused her to display a multitude of emotions on camcorder, ranging from confusion, anxiety, low self-worth to anger. This study demonstrated the lasting and damaging effects of healthcare workers' attitudes when they did not show dignity and respect for mothers. Tracey originally recounted her experience almost straight after the event and then repeatedly for weeks. This strength and duration of emotion would not have been captured by a single interview. After one

of the incidents, where Tracey felt particularly judged, humiliated and demoralised as a mother, she turned on the camcorder five times in one day to retell her experience. She was keen to show the effect of the cold and hostile environment of the clinic on her baby. Two days later she repeated her story four times more, expressing angrily her anguish over and over again.

> *I've just been to the clinic. Over the last three days I have been finding it really hard because he's only been on [the breast] five or ten minutes at a time [baby starts crying in background] and there's a reason why I'm leaving my baby to cry at the moment because I want to show you EXACTLY what this clinic is doing to my baby* (Tracey5)

> *The previous week she [healthcare worker] hadn't been very nice to him and said 'oh can't you behave yourself, you need to be quiet when I'm weighing you', like proper Godzilla like seriously. And this week she went, 'look at the centile…it's dropping', the previous week, she told me… if I didn't feed him, he'd look scrawny looking, and this week, it was 'look at the centile, oh that's not good, you need to bring it back up, are you feeding your baby' …Then with this other woman…she weighs [her] baby… and she says, 'ah perfect, on the centile, you are such a good boy, do you breast or bottle feed him?' The lady goes 'bottle' and she says, 'you are such a good mum'. And I thought…you already made me feel like shit, you've exposed private data in front of this other mother…and I'm proper disorientated. My health visitor, who's VERY nice…came over and went to show me the chart and the first thing I said was, 'don't show me that, it makes me feel crap', because it does. I'm really worried about my baby now.* (Tracey5)

Feeling in the depths of despair with low self-esteem, these events were retold in several video diaries over several weeks, and the description did not change. In particular the word 'scrawny' used by a healthcare worker was threatening and created such a negative impression that it was not forgotten, continually being

referred to over and over again. The mixed messages, from witnessing positive encouragement for formula feeding and behaviour threatening for breastfeeding were disconcerting and made Tracey feel she was failing as a mother and failing her baby, which resulted in torment, further anguish and her confidence plummeted.

> *This woman has really knocked my confidence by saying that my baby's scrawny and this is week 10 now, and I've been breastfeeding for 10 weeks. I never thought I would be able to do that. It's very draining, I'm very tired, I don't feel good, but to have somebody knock your confidence is just awful.* (Tracey11)

The constant judgemental scrutiny that Tracey endured, the implication that breastfeeding was not as good as bottle feeding, the lack of privacy and confidentiality, resulted in constant emotional turmoil. The antipathy shown by healthcare workers towards breastfeeding was disempowering, demoralising and Tracey felt under direct sabotage, causing a tortuous dilemma between wanting to give up because breastfeeding wasn't valued by healthcare staff and wanting to carry on for the good of her baby. This was extremely stressful and she seemed constantly tense.

> *I just feel very on edge, and panicky about everything, and it's starting to affect like, when I go to feed him, I don't actually want to do it anymore, because so many people, like that I've seen, are being praised for bottle feeding their baby and it's very disheartening and I don't really know how to get over this…I feel like two out of the five weeks, we haven't been successful at breastfeeding and that he hadn't put on the weight that he needed to put on, which isn't good because I've never really failed at anything in my life and this is such an important thing…Like I know that breastfeeding helps their bones their teeth all of these things. What if he ends up with no teeth?* (Tracey5)

The mixed emotions displayed daily on camcorder that were related to feeling 'scrutinised' were part of the rollercoaster of emotions expressed when they were offloading. Sometimes mothers felt anxious and defeated and at other moments when they appeared defiant, wanting to fight back. When Tracey felt defeated she recognised how her self-esteem and confidence in breastfeeding had been blown. Indeed during these low times when she felt crushed, she felt she could not face the onslaught that might ensue at the next 'weigh-in' on her own and needed moral support to cope. At other times (5.3.2.), she was so outraged, she vented her anger during diary recordings as if talking to the very person who had upset her. Venting in this way appeared to bring a cathartic release which seemingly made her more determined to continue breastfeeding.

> *The lady I met today…her son was… was on centile number 2, and good on her for carrying on breastfeeding because lady, you must have…nerves of steel, they've already broken me in my eyes and I thought I was a strong girl. I think what will happen next, I'll get my partner to come with me when Theo gets weighed next, because I just cannot handle this by myself anymore.* (Tracey6)

> *The emotional damage that you have caused! The amount of tension you have put in my relationship in regards to breastfeeding yeh? And the worry that I'm not being a good enough mum to my son is NOT ok…you need to get up with the times yeh? You made people 25 years ago feel like this, you haven't moved forward, and you need to change it. You need to change your attitudes. You're not doing your job properly and I quite agree with that report that came out the other day, women DO NOT FEEL supported after they've had a baby, OK? And you're NOT going to get to me anymore. I've made a decision…I don't care what you have to say, my baby is putting on weight, he will do it in his own time…..My baby comes first and what my baby tells me to do, I will do…I don't care about it anymore, I'm going to relax, you are NOT going to make my milk dry out and I'm NOT buying formula, that is the end of it.* (Tracey6)

This study demonstrated the effect of conflicting advice and opinions on most participants as they verbalised their confusion and tried to work out which route to follow over several diary entries. While this was sometimes because of differing opinions between friends, healthcare workers, literature and the internet it was particularly damaging when health workers disagreed with each other. Conflicting opinions combined with scrutiny, caused mothers to become confused, anxious and vulnerable, which then affected their breastfeeding experience and their closeness with their baby. It was noticed both in hospital and continued once home.

> *[Scott said]…in a hospital where you are in a professional environment, there should be one way that's taught and one way only because it's quite unsettling and bewildering when you think, 'oh. I'm doing what that midwife said to do' and then ten minutes later someone else comes in and says, 'no you do it like this, you do it like that' and you just think, well give me a break. And if you're getting flustered and uptight, the baby does.* (Tracey1)

Conflicting advice caused mothers to become defensive and healthcare workers lost credibility, which meant that mothers sometimes ignored advice and continued with their own plans. Indeed, for Tracey, conflicting information was further compounded by confusion over which infant growth charts to use for a breastfeeding baby. When members of the 'surveillance programme' could not agree, this caused even further anguish, anger and further feelings of being sabotaged. This caused mistrust of all members of the healthcare team and a reliance on '*looking up'* information in other places to fill the information gap (7.4.1).

> *…she did make me feel supported but I just got a phone call… to say that this chart is not correct and that the one in my red book is, well a couple of hours ago, she said the one in my red book isn't the correct one and that there is one for breastfeeding babies…I'm really pissed off with them. I feel really let down, I thought these people were supposed to help you, not patronise you or not bloody get the information right… [reading child-health record] 'reassurance regarding range of weight gain for full term healthy breastfed baby, 0-17 weeks equals 5-7oz per week'. It changes with everybody that you speak to, so I think that is a load of rubbish, and on the internet it says 3-7 oz. per week*…(Tracey6)

All mothers felt compelled to seek out urgent support when unexpected problems arose such as engorgement, sore nipples, mastitis and a constantly feeding and /or crying baby. They often searched through books or sought solutions online first before seeking help from others. These problems were triggers to call their midwife or health visitor or to attend peer support groups or an emergency department at the hospital to get their issues resolved quickly. Painful feeding often put mothers in a vulnerable position, because they felt compelled to accept advice to address their problems, despite recognising that breastfeeding could be sabotaged.

> *I spoke to the doctor in the emergency clinic and she said, 'express your if you want to, feed her with a bottle with the expressed milk, and let your boobs heal', which I didn't feel very comfortable with feeding her from a bottle, but I thought there is no way I can feed her from the breast anymore, they are too much of a mess.* (Sarah2)

The fear of being scrutinised and judged, also spilled over into fear and intimidation when attending peer support groups, because most mothers for one reason or another, felt awkward and uncomfortable. The potential for support and help from other mothers was seemingly marred by the idea that someone could be judgemental and advice could be unhelpful or disparaging. Indeed these fears

were realised in some cases and when some mothers were forced to expose their breasts they felt insecure, intimidated, anxious and humiliated.

> *It was pretty horrible when I first walked in. It was my first session, the first time anybody seen me, professional obviously, seen me feeding Zac and I was so nervous. It was horrible. I was worried that she would have a go at me because I was doing it wrong. I was worried that she would have an opinion on me. I only went once. I found it quite daunting.* (Sam8)

> *Also I told her that I was conscious of that area and that I feed by myself, I don't even let my mum see me breastfeed or anything like that, so she insisted on being in the room whilst I breastfed which made me cry as soon as I left* (Tracey6)

For these mothers, their experiences were not empowering or encouraging and thus to prevent themselves feeling judged further, they avoided attending again.

7.2.3 Abandoned and alone

Mothers felt abandoned when they did not receive adequate support or they did not access it for fear of further scrutiny. Some mothers found healthcare workers had not checked enough to see if they were '*on the right track'*. They felt that this should have occurred initially in hospital, where they should have been shown how to breastfeed, so that they knew what they were doing once home, rather than having no help at all, as in Sam's case, or the 'hands on' support that Sarah received (7.2.2).

> *In hospital, I wasn't actually shown how to breastfeed, or offered any assistance…I got a shock when I came home the same day…it was quite painful at first, I didn't think I had done it properly, because I was a bit unsure…I struggled in the night, I found he wasn't latching on, he was restless…I wasn't warned at any time that I would need the support for the breastfeeding.* (Sam1)

> *I'm finding that he isn't latching properly still…he's really trying to search, really frustrated and then I get upset…I speak to the health visitor about it and she says, 'make sure he's latched on properly', which doesn't really help, because in actual fact how do I know he's latched on properly when I've not had a baby before, no-one's checked that I knew or didn't know* (Sam2)

For Sarah, a breast examination would form part of surveillance along with a neonatal examination. She resented the lack of surveillance because no-one had examined her breasts and her baby's tongue tie had not been diagnosed in the early days. This led to moments of feeling alone and abandoned with self-doubt and despair. In retrospect, she blamed this poor assessment for all her breastfeeding problems and the extreme pain and misery that ensued, believing that early diagnosis and treatment would have given her a better breastfeeding experience.

> *Am I anatomically ever going to be comfortable…is it actually viable to feed comfortably ever from this breast…no one has ever checked my breasts…before I had her to see if I had inverted nipples or any breast problems* (Sarah7)

> *I will always feel disappointed and always feel let down by the system really...when the doctors are doing their… post birth baby checks… that quick look under the tongue and a quick snip will actually do an awful lot for mothers because I really did get very down and struggle with the whole breastfeeding and I wasn't able to enjoy my baby for the first couple of weeks…and I don't think that's fair…I mean the pain was incredible when I was sore, it was pain that curled my toes and wished my baby wouldn't wake up so I didn't have to feed her again* (Sarah9)

Feeling 'scrutinised' caused mothers to experience anxiety and nervous tension especially when they thought that they would be judged for not following advice or reaching the necessary milestones for the 'surveillance programme'. In these

situations, mothers did not know where to seek support without further scrutiny and judgement. To circumvent judgemental opinions, especially from healthcare workers or breastfeeding mothers, they purposefully avoided contact by not always attending groups or clinics and not arranging appointments. Avoiding the 'officially available' support resulted in mothers continuing to feel alone and abandoned.

> *I was naughty really, I should have gone along …I actually think I am not going because I am still a little bit embarrassed that she's having some bottles… I've got this fear of what if I'm feeding and feeding and feeding her while I'm there and she's not satisfied and I have to get the bottle in a breastfeeding group, and I don't want to go and that be a problem.* (Sarah7)

> *…and I've already said to her [health visitor] I'm not going to that clinic again…she advised me to see the specialist as well, and named the lady who came round my house and was a pile of rubbish and I said to her, 'I'm not being funny…but I don't like her, I've seen her before'* (Tracey5)

Not wanting to ask again for support for fear of further judgement and potential sabotage meant that mothers were left in a quandary as to what to do next so that feelings of being abandoned were exacerbated. Indeed, purposefully avoiding asking for further support from the health service caused mothers to feel lonely and helpless with what sometimes seemed insurmountable problems. They needed someone to listen to them with time, respect, support and positive affirmation to help them work out their issues and to move on.

> *I'm lonely as well, I wish there was somebody I could talk to really, [pause] and trust, that isn't patronising, that talks nicely to you …..so I'm just really agitated …and I'm just getting really fed up, in a couple of days if this doesn't resolve itself then I think I'm going to have to go to bottle feeding, because when you are trying so hard and not getting anywhere* (Tracey3)

Feeling abandoned also resulted from not being able to access the health visiting service when required. There were desperate moments for mothers when they did not know where or how to access appropriate support. Turning to close family was sometimes their only option despite having reservations about causing relatives anxiety and being at potential risk of being judged by them.

> *I did try ringing the health visitor I couldn't get hold of anybody, no-one's there, I don't have an emergency number for anyone, so really it was fend for yourself, it being a Friday.* (Sam2)

> *I just hope this resolves itself…I think it's important for people to understand the pressure that it puts onto family as well. Like I don't know about anyone else's family, but if I tell my mum… she's going to start worrying … But I'm just going to have to do it because I've got no-one else to speak to* (Tracey3)

These feelings became prominent features of Tracey's diary entries. Indeed, feeling anxious, abandoned and alone with nobody she could rely on for non-judgemental advice precipitated a desperate visit to the accident and emergency (A&E) department.

> *I had to take him to A&E …because he wasn't feeding a lot and he was screaming and he was tired and I just felt he was really sick around the eyes…I was worried he was dehydrated…but this is the consequences, I feel, of the medical profession* [not] *supporting me at the moment …because if I understood what was going on…when I ask questions it's, 'oh it's because of this'…not really supportive and it's the way people do it as well which is frustrating…I can't stop worrying, because I'm his mum* (Tracey 5)

7.2.4 Summing up

This subtheme demonstrated how mothers felt about feeling 'under surveillance'**.** When healthcare workers confirmed that mothers and babies were '*on the right*

track' with frequent 'check- ups' and 'weigh- ins' that validated breastfeeding, mothers were reassured and their confidence increased. Conversely, mothers experienced doubt and lacked confidence when they felt '*scrutinised, judged and sabotaged'* by healthcare workers. These feelings were exacerbated when dignity and respect were not afforded and healthcare workers adopted an authoritarian critical approach, instead of a kind, nurturing manner which encouraged self-worth. Then the 'surveillance programme' became destabilising so that mothers doubted themselves and found coping with breastfeeding more difficult. The resulting anguish and stress caused mothers to circumvent further scrutiny by avoiding support from healthcare professionals altogether causing them to feel '*abandoned and alone'.* The feelings of being '*abandoned and alone'* were further exacerbated when support was not available in a timely manner.

7.3 Managing support from family and friends

This subtheme demonstrates how mothers went about 'managing support from family and friends' on a daily basis. Partners, family members and friends were often concerned with the health and wellbeing of mother and baby. The type of support they offered depended on their own previous experience of infant feeding and the value they placed on breastfeeding themselves. In managing support, mothers needed to decide whether to seek it, accept it, ignore it, reject it or compare and combine it with support offered or received from other sources of support. In the decision making, mothers analysed what that support would mean for them in terms of breastfeeding and how it fitted with their own values and goals. This subtheme has been derived from three categories: *'nurturing the nurturer', 'finding a new equilibrium'* and *'interfering opinion'.*

7.3.1 Nurturing the nurturer

When mothers felt nurtured by a partner, close family or friends, it encouraged them to nurture their babies more confidently. Indeed having someone close by in the house in the early days was a vital source of support for all mothers, and

helped to increase confidence in breastfeeding and combat feelings of isolation (7.2.3). The physical presence of a partner or close family member had a greater positive impact when this was coupled with a listening ear, a calm approach, practical support and positive encouragement with breastfeeding, and it was readily accepted.

> *… day eight, so that will give you an idea of like how well the breastfeeding was going because of a lot of perseverance and support from Daddy…I think because Daddy is a bit more relaxed, it helps me to relax, so when I'm feeding him he's [baby's] more relaxed* (Tracey3)

> *[Jason is] very supportive with this breastfeeding thing…telling me I'm doing well and that it's ok to ask for help and things, being really supportive and making sure I'm comfortable and things…* (Sarah1)

'Nurturing the nurturer' involved practical support which came in various guises, with partners and family members helping with household chores and baby care. Practical support helped mothers feel cared for and loved and it enabled them to focus on their baby's needs more confidently. It also involved team work with all the fathers helping with night-time parenting in the early days. Mothers frequently mused in their diaries about how they would cope without the father's support.

> *Peter did the washing up last night, which is amazing, he doesn't DO washing up at all, so that really meant a lot to me. He's being a real support, really lovely, encouraging words, saying that I'm a really good mum and I'm doing the best for our baby. That means a lot to me because words mean a lot to me* (Vicky4)

> *It felt really luxurious because Tom was there and I got up and Lily was still asleep so Tom got back in bed with Lily [smiling broadly] and I could have a shower and get dressed and walk around the house a bit without needing to be worried about Lily* (Rosie4)

Mothers talked about and filmed fathers supporting them when their babies needed comforting, and nappies changing which included video clips of fathers having skin-to-skin contact with their babies. This provided visual cues of how fathers nurtured their partners by relieving them for personal time, at the same time as nurturing their babies, demonstrating their shared responsibility for parenting. Indeed, when mothers felt nurtured they talked about working as a team, and the indulgence of having time for themselves to do the ordinary everyday activities in life that had been taken for granted.

> *I have just been feeding, and my husband is just winding her and changing her and he's actually going to have some skin-to-skin contact now himself and give her a little cuddle, keep her nice and warm on his chest while I go and have a shower* (Sarah1)

> *And I was really pleased that Peter was here and he had Benjamin for a bit and I could just walk away from the crying. Like how do you cope when you are a single mum and you've got to cope with that, surely I would have gone crazy last night, like if it was just me? So just lost the plot* (Vicky4)

As time progressed and partners returned to work, being nurtured and working as a team took some negotiation and shared responsibility appeared to be more limited. Just having someone who would listen at the end of a long day, however, was valued.

> *Had a proper conversation …and everything is all sorted which is great. He's going to help me over the next couple of weeks until I get myself up and ready and then I take over everything then (*Tracey4).

> *And I try talking about it, and he is so grouchy at the moment, 'cos he like drives over 300 miles a day with his job, then comes home and like probably has to listen to me moan about these health visitors and things like that* (Tracey5)

All mothers accepted practical support from their own mothers, with two who lived away visiting for several days, and three living nearby. For those mothers who would normally prioritise cleaning the house over anything else, help in the home was a vital nurturing element of support. This was because when the house was not meeting their normal standards they felt distracted, frustrated and helpless and when it was clean and tidy, they felt in control and able to focus on breastfeeding. Some mothers received practical support from well-established friends and social networks. Vicky, for example, felt nurtured and cared for by her church who sent in cooked meals on a daily basis for two weeks, which freed her to nurture her baby and focus on breastfeeding. Rosie was visited by work colleagues who were all experienced breastfeeding mothers providing empathic breastfeeding support alongside practical help.

> *I've done a spring clean which makes me feel a lot better...When you've got a new infant you just don't have time to sort out these things… and my mum was very good and she came over and helped me. And I feel I am back on my feet a lot more… So I feel like I'm able to care for my baby a lot more…I feel a lot more confident like looking after him* (Tracey5)

> *Thankfully when my church was doing us meals and my mum was here, we put different things in the freezer so I'm still not having to cook properly* (Vicky4)

Nurturing was sought and received by mothers in different ways. Some mothers welcomed experienced breastfeeding advice from close family as nurturing and helpful but for others it caused anxiety and emotional turmoil. This may have been because they felt defensive in case they were criticised or were embarrassed about talking about breasts and breastfeeding. Tracey never felt comfortable feeding in front of others and found it difficult to discuss breastfeeding with people she knew well. Conversely, speaking in her video diary, to an audience she could not see, did not appear to cause any inhibitions.

> *People should be aware of these things, about how lonely it can be, I know I've always got people there, like my mum and like Scott's mum and everything else like that, but you don't want to be talking about, you know, (whispering) breastfeeding to them, it's still quite a taboo subject*. (Tracey3)

Mothers became daunted about being left alone when the nurturing presence of someone at home was no longer available. This was particularly evident when close family members returned to their 'normal' lives and they felt 'trapped' in their new role as breastfeeding mother. They fretted in their video diaries about juggling caring for the baby, breastfeeding, caring for themselves and managing the household.

> *I was really nervous about having him on my own. I know it sounds really silly because I'm his mum, and he depends completely on me, but I depend on Ryan* (Sam2)

> *…apprehensive about being on my own in the evening, like just being trapped feeding, needing some water or the door going or being lonely. So I don't know whether to invite someone round to stay or bite the bullet and get on with it.* (Vicky5)

When mothers were nurtured with practical support they appeared more confident with breastfeeding but when it diminished they were more likely to be seen on camcorder as tired, daunted and isolated. This was demonstrated visually by their demeanour as much as by what they described. These feelings occurred when their partners returned to work and they all took on the night-time parenting alone. This may also have been compounded by reduced practical support during the day. Indeed, the feeling of lone parenting and being tied to the baby because of incessant feeding became more of a reality to them once their partners fully returned to work.

> *I don't wake [husband] in the night so he is sleeping through, but he also has to go to work, and I'm a bit worried about putting too much demand on him and also maybe [pausing] like the sense of freedom has gone, like you know you have to feed…and that he's [baby] dependent on you…Yeh obviously a big change becoming a parent, but I don't think you ever really know. Like suddenly you have real live person and you've got to take care of them [pausing while thinking] and it's wonderful and it's lovely but it's also tiring and a bit like scary, this is forever*…(Vicky5)

'Nurturing the nurturer' involved spending time together. Mothers craved quality time together with their partner or as a family needing to feel nurtured and secure within their relationships which had become constrained by baby care and feeding (6.3.1). Mothers who had nurturing encounters in this way appeared calm and content whereas mothers who did not experience this remained more tense and anxious.

'*Nurturing the nurturer'* included positive encouragement and support with breastfeeding itself. For partners this was helped with an acquired knowledge of how breastfeeding works so that the support encouraged effective breastfeeding and did not disturb the rhythm. Vicky recognised nurturing in her partner's proactive breastfeeding support as he 'watched out' for her in a protective way.

> *I was really lucky that Peter bothered to read the books, and those early nights, when I was doing my night feeds in the first week, he did get up and he did say 'No, you're not doing it right, this is how it goes,' or 'No, it's not quite nose to nipple, take him off, do it again.' And I don't think I would have bothered because I was really tired and you just think, 'oh they're getting something, it's the middle of the night', but that might cause nipple trauma and then I might have given up, and certainly he's very encouraging…* (Vicky7)

When Tracey spoke about Scott's ambivalence about breastfeeding, anxiety was evident in her demeanour and she doubted her ability to breastfeed.

[Scott said] It's working well. How long you will continue to do it? [throwing his hands up in air] Don't know, doesn't matter at the moment, just keep doing it while it's still working I think (Tracey1)

Still have to work on Daddy because he's a little bit sarcastic towards Mummy about feeding and stuff like that (Tracey6)

Nurturing by female friends and family was especially valued when they had personal experience of breastfeeding. It was considered nurturing when empathy and understanding about the challenges mothers were facing were shown and suggestions made to keep breastfeeding going. Mothers were influenced more by those with previous breastfeeding experience than healthcare workers, particularly when they shared similar experiences or challenges with breastfeeding. Nurturing was thus enhanced through shared camaraderie. Rosie, who found herself surrounded by mothers with experience of breastfeeding, recognised the nurturing value of normalising breastfeeding.

I think that's quite a critical point…it's really different to have a conversation with or advice from the professional, like the midwife or the health visitor, compared to my mum or friend, who even though they aren't breastfeeding now, I'm kind of meeting them in the role of a formerly breastfeeding mother…(Rosie2)

...and everyone around being supportive and encouraging and not supportive in the sense of like 'oooh well done you are doing something amazing and unusual but just assuming that is what I would do and …expected (Rosie4)

And she had sore nipples…She said eventually after a couple of weeks she did get used to breastfeeding and she said if I can persevere…the soreness will go. It doesn't always feel like it will go but it will. And she was breastfeeding her little boy while I was breastfeeding Sophie today in the

lounge with our husbands and that was quite nice because it was kind of a womanly bond thing (Sarah1)

Nurturing support for mothers did not always have to be physical presence. Just being available, as a contact, all hours of the day and night, by messaging or text, was reassuring. Mothers frequently reported texting friends for breastfeeding advice late evening, which prevented loneliness setting in and helped them to keep going with breastfeeding.

Had a really hard night last night, Benjamin fed from 4 'til 5pm, then again from 6 'til half past seven, then again from eight 'til pretty much midnight at which point I texted some friends and got some advice…(Vicky4)

'Nurturing the nurturer' was offered in many different ways and mothers accepted this support because they felt cared for so that in turn they felt confident in nurturing their own baby, including focused time on getting breastfeeding right.

7.3.2 Finding a new equilibrium

'Finding a new equilibrium' was derived from codes that demonstrated well-meaning support from friends and family who suggested trying to get some balance back into the mothers' everyday lives from the chaos that was arising from life with a breastfeeding baby. Suggestions offered stemmed from a feeling of care and compassion for the mother. This type of support may have been needed because of the unrealistic expectations of the new parents and a craving to return to their former life. In an effort to try and find a life balance, support was intended to be encouraging rather than a rigid opinion that should be adhered to. Sometimes, however, this approach backfired when it upset the mother or disturbed the rhythm of breastfeeding.

> *Tom was saying, well she's a week old and we need to get a grip and not stay in bed until one o'clock and then eat lunch at three o'clock and let's have a bit of a schedule. Yeah sort of pull ourselves together really and he was only meaning in the sense of [pause] it will be helpful to have a little bit of structure in the day and make sure that I sleep in the day and don't get too tired...and I think he quite likes doing the household jobs…but it made me feel, 'oh no, I'm completely useless, I don't manage to do anything, just spend my whole life trying to sleep and doing breastfeeding and flopping about'* (Rosie2)

'*Finding a new equilibrium'* for some parents involved shared responsibility, not just '*nurturing the nurturer*', as described in 7.3.1 enabling the mother to focus on breastfeeding her baby, but also sharing the responsibility of feeding. Seemingly, some fathers did not feel valued if they did not share this element of baby care. Added to this was a perceived reality that 'freedom' to do other things could be realised if the father could do just one feed. This highlighted the daily dilemma mothers faced as they tried to work out the practicalities which included how to express and when to introduce a bottle (6.2.9) Conflicting opinions between the 'expert' health professional and the 'experienced' breastfeeding mother increased the dilemma so that Vicky became fixated by this idea, believing that she needed to do it before it was too late, in case Benjamin rejected the bottle altogether. With the added pressure from Peter to feed seemingly to enhance his self-worth as a father, Vicky made it her mission to express enough breastmilk in order to film the first bottle feed as a milestone in Benjamin's development at five weeks. Similarly, although Sarah was upset when she felt forced to introduce a bottle because of nipple pain in the early days, craving freedom away from the baby was a reason for continuing to give some bottles. *'Finding a new equilibrium'* for Sam meant returning to college 21 days following birth and introducing a bottle after one week to facilitate her social life.

Vicky: You had been wanting to do that [using a bottle and feeding] for a couple of days and your wife had stopped you, how did that make you feel? Cross? Grumpy?
Peter: Something along those lines… No it was nice to be able to do something.
Vicky: You do a lot of things already
Peter: [smiles and shakes his head] (Vicky5)

I'm tempted to keep one expressed milk in a day because although the breastfeeding is nice, being able to say to Jason, here you are take her, I'm going to get in the shower, and not have to worry whether she's fed…It's just the convenience of saying to someone else. Here you go, you take her I'm just going to do this…Otherwise you feel very much attached to her, which is fine but sometimes you just want a little time to yourself to do something or just be free…and it's nice for the partner to be involved as well (Sarah4)

The pressures of breastfeeding caused three partners to suggest formula feeding. This was not about '*nurturing the nurturer'* to continue breastfeeding, but about *'finding a new equilibrium'* when there were challenging moments for the mother. It was about providing support to enhance the balance between breastfeeding and what they considered was achievable at the moment. In this study initial suggestions about using a bottle were firmly rejected by all mothers, but the seeds of doubt may have been sewn. Before Sarah's nipples became too sore to feed, Jason had suggested using a bottle. Persevering to get back to exclusive breastfeeding after giving formula feeds took huge commitment from Sarah and an emotional rollercoaster ensued. Thus, 'finding a new equilibrium*'* did not mean the use of formula as this turned into an inconvenience but, as suggested in her quote above, the use of expressed breastmilk in bottles became part of the answer for a while.

> *Yesterday, had a little bit of a blip and again my nipples ended up really sore and I was starting to despair and my husband even mentioned the 'B' word as in bottle overnight last night, because I was getting so sore and just feeling so frustrated by the whole thing, but I said, no I'm not bottle feeding her, I'm not! As long as I can bear it I will do it.* (Sarah2)

> *I just wish I could get her off this bottle. It's inconvenient, it's so much hassle. Sterilising everything! I've only got three bottles and I don't want to buy anymore bottles, because I don't want to be using them. (*Sarah4)

'Finding a new equilibrium', for partners, was sometimes about not having to face the challenges of breastfeeding and making life easier. Suggesting formula supplements was met with resistance from all mothers and sometimes caused tension within a relationship. Seemingly this caused more stress with life balance, probably because mothers' confidence in their ability to effectively breastfeed had been questioned.

> *… he actually bought like a tin of formula home the other day with him… that caused friction between us literally the whole night on Wednesday we were arguing about breastfeeding. 'Cos he sees me struggle like in the middle of the night and stuff like that, if I'm really full and how uncomfortable I am and I know that he loves me and I know that he loves the baby but I think he's worried about how much he should have and everything* (Tracey5)

For some *'finding a new equilibrium'* included accepting the offer of a babysitter enabling mothers and their partners some time away from their babies. Although, mothers' parents appeared to be the favoured trusted babysitters, the mothers still demonstrated mixed emotions about going out and leaving their babies. On one hand, they appeared to yearn their former social life but, on the other they felt nervous and scared. Babysitting meant that mothers needed to work out the dilemma of expressing and how to cope with not feeding while away from the baby. As highlighted earlier in this subtheme, Sam started expressing and leaving

Zac with his grandparents within a week of giving birth and then continued to leave him with her own mother on a regular basis.

> *Zac went to Nana's house for the night. I was really nervous and really scared obviously because it's the first time I've left Zac overnight without me…he had breastmilk in a bottle but apparently he had drunk 12 oz between six and eight o'clock. Went down at eight o'clock and only woke up three times in the night, which was amazing because he doesn't even do that for us yet.* (Sam5)

> *…my mum's coming round to babysit for two hours so that's nice. Wouldn't want to leave him with anyone else…I've caught myself a couple of times today thinking…I don't want to leave him, I would rather stay in but I think it's healthy for both of us…and to enjoy Scott a little more because he was speaking to me last night about how he feels a bit left out (*Tracey4)

When mothers were considering how to '*find a new equilibrium'* their ideas came from a range of sources. Some debated whether to introduce routine and feeding schedules, or a bottle of formula at night. These suggestions had been offered by other mothers who had used similar strategies to '*find a new equilibrium'* in their own lives (6.2.5). These ideas, however, had the potential to produce seeds of doubt, making mothers wonder whether they were capable of exclusive breastfeeding. Mothers had to decide what advice to follow and what to ignore, which caused debate on camcorder. Vicky and Rosie were given books by friends or family, to add authority and reinforce the advice they had already given. These books, however, were sometimes contentious so that when mothers perceived that the material challenged their own beliefs about breastfeeding and parenting, they felt an added pressure and felt nervous about reading it. This meant that sometimes mothers had the dilemma of deciding to read the information without delay or putting it off to a later date.

Getting lots of people with different opinions…I've got a friend…who did routine feeding every three hours and then did formula feed at 10 o'clock at night to try and get her son through the night and then by 8 weeks he was sleeping through, I've got this book to read which still daunts me, still not read about routine….just in a quandary about what to do about routine (Vicky3)

Support offered by family and friends so that breastfeeding mothers could '*try to find a life balance'* was usually well-meaning although it sometimes compromised breastfeeding. However, that was not always the case, sometimes family and friends who had experience in bottle feeding as well as breastfeeding, were determined to provide their own '*interfering opinion'.*

7.3.3 Interfering opinion

'*Interfering opinion'* occurred on only a few occasions when support offered undermined the mother intentionally and had the potential to sabotage breastfeeding. It involved strong views and attitudes that made the mother feel uncomfortable about how she was parenting or breastfeeding. Sometimes mothers were shocked and managed these interventions with an irritated silence or responded in a way to keep the peace. Sometimes they ridiculed them on camcorder laughing it off as absurd.

[Her] advice about breastfeeding is to cut out the night feeds [laughing] and just leave them (Vicky3)

She said 'come over…after you've finished feeding, then we can put him in the pram', trauma trauma [mocking], 'because you don't want to hold him in case you spoil him'. Poor Benjamin, he doesn't cry because he wants to manipulate you, he cries because he's either hungry, got a dirty nappy, got wind or is lonely (Vicky5)

And I was still getting used to him feeding quite frequently. That was really hard because, even though he wasn't feeding for very long…she said, 'ooh

dun't he look hungry' and you just think aaaagh! That really irritates me! (Tracey3)

Mothers felt unnerved in the presence of family or friends who were known to have '*interfering opinions'* on how they should parent or breastfeed (6.3.1). These opinions produced mixed feelings so that they felt a strong protective instinct over their babies at the same time as feeling guilty about their own mothering strategies. Arguably, these feelings had the potential to affect breastfeeding as mothers became tense in these situations which in turn might have caused the baby to become more restless. Relationships within families became strained as mothers agonised over how to manage the situations and became angry on camcorder.

…but I've found that I've changed how I feel…I used to be really really relaxed…but now I have the feeling that she wants me to feed by routine, she said a few things like leaving him to cry if we are eating, so like my needs come first, about putting him down not holding him all the time…and she has a way of saying things that are quite blunt…..All he wants to do is feed, have a little break, feed, have a little break, and I just felt I couldn't do that there, because I was being disapproved of for feeding all the time…and I want to go and pick him up, but you feel like you can't, but I do anyway but then just feel bad (Vicky5)

…so when someone tells me my baby is screaming … I'm not just going to leave my child to scream the house down…really really hacked off (Tracey3)

The interfering opinions were discussed and analysed on camcorder which enabled strategies to be considered and evaluated. Vicky realised that attitudes were based on the person's out-dated experience, perhaps from decades ago. This provided opportunities for renewed strength and self-confidence including preparation to prevent further undermining influences by family members, with partner support when necessary.

Either I need to be more assertive about picking him up when he's crying and feeding him when I just want to, or I actually need to just say something [pulling shocked face], or ask her, 'perhaps I should video you and your ideas of breastfeeding' [pause] but I don't know whether I'm brave enough to do that. Maybe not yet. Maybe not on my own. Maybe I need Peter to do that. (Vicky5)

Yesterday I went over…and actually it was much better then Sunday, I felt more in control and more assertive about feeding when he cried, even had a chat with her about feeding and routines and what she did…and I was explaining to her all about cluster feeding (Vicky5)

So boundaries are going to be put in place, weekends are going to be our own. They can come round…during the evening on a weekday…and they have to call before…so that's been taken care of. (Tracey6)

Interfering opinions continued throughout diary recording for some. Indeed one family member brought an unwanted tin of formula to Tracey's home at 12 weeks which caused further tension.

She had dropped round some…[formula milk] the week before [week 12] which I FELT was wrong, my partner had told her to butt out and to stop doing it and she basically didn't listen at all (Tracey20)

7.3.4 Summing up

This subtheme 'managing support from family and friends' reveals how support was offered from differing viewpoints. The nature of support depended on who was providing the support and their previous knowledge and experience of breastfeeding. This meant that people who had knowledge and experience grounded in successful breastfeeding were more likely to be facilitative and encouraging whereas people who had knowledge and experience of some formula feeding were often either ambivalent or interfering about breastfeeding. Some support '*nurtured'* mothers, and that in turn helped them to '*nurture*' and

breastfeed their own baby. Other support focused on '*finding a new equilibrium'* with a newborn baby which was not always helpful to breastfeeding. A small amount of the 'support' was *'interfering opinion'* and was aimed at influencing or even changing parenting styles. Mothers managed the support they received from family and friends in varying ways including accepting, ignoring and combining it with other sources of support. The support conundrum was not solved, however, without mothers searching out information for themselves, which is the subject of the final sub-theme, 'the gap and filling it'.

7.4 The gap and filling it

All mothers had sought information from a variety of sources such as antenatal classes, family and friends, books and leaflets to help them prepare and cope with breastfeeding. Mothers, however, spoke about the initial pressure to breastfeed, that was strongly advised in pregnancy by health professionals. This included information about the health benefits but very little about the realities of breastfeeding and how challenging it could be. Compounding this, mothers found support following birth was either insufficient or confusing which left them with unanswered questions or in a quandary.

> *[Scott said] It seems they are so pro breastfeeding, it's almost as if they kind of skirt around these other issues, and if it's done in a way to try and sort of give you confidence and make you feel it's more achievable, it's not working, because it doesn't come across like that*.(Tracey3)

> *So like, when you're pregnant you hear like all the good benefits like do this for the health of your baby and the health of you, but they don't actually say, look, this is how breastfeeding is, you have to sit down and just, you know be like a cow, graze and feed and don't try and do much. And people do find it tough.* (Vicky7)

This subtheme is derived from the categories '*looking it up'* where mothers purposefully searched out information to cope with daily challenges and '*reading*

more' when they enjoyed finding out new things about breastfeeding.

7.4.1 Looking it up

The first category in this subtheme is '*looking it up'* where mothers actively searched out information and support to 'fill the gap' between information they had already obtained and that needed to meet the daily challenges of breastfeeding.

All mothers used the internet to 'look up' information when issues or problems arose, when they had unanswered questions or needed to validate or reassure themselves. Using the internet meant that they could look up information instantaneously by using search engines, such as Google, as a self-help method to answer questions before seeking advice from health professionals.

> *Again my nipple is severely sore…not quite sure what to do next. I have been looking online for things to do. I have seen something called nipple soothers. So I'm going to look in the shops for those. See if I can repair it rather than having to give up feeding* (Sam2)

Using the internet to look up specific problems was sometimes daunting when there was an overwhelming number of results and not the right answer. This was frustrating and caused further isolation, anxiety and self-doubt. Mothers needed instant answers and needed to connect with someone else who could provide information, guidance and positive affirmation.

> *I've tried to express…and it's not really going very well, I only managed to get that little bit out and that was it. I really wish that there was like a website or something that I could just have a look at to show me how to do these things or for somebody to be there so they could answer my questions, like about breastfeeding*. (Tracey5)

Searching the internet inevitably meant that mothers found information from a diverse range of websites including those sponsored by the commercial companies such as manufacturers of bottles and teats. Tracey, who spent a great

deal of time searching for information about expressing, recognised this commodification and was disappointed. She was not looking for the best buy but interested in learning about the process. Maybe she had the insight to realise the potential bias of the commercial information or maybe the information did not answer her questions but its lack fuelled her frustration.

> *I was looking on the internet the other day…because I wanted to know about expressing…and there really wasn't anything out there except for the manufacturers' [websites for pumps]…* (Tracey6)

Perhaps not recognising the conflict of interests on websites supported by the commercial industry, some mothers reported their findings with conviction, believing that what they had read was from a trustworthy source which had the health and wellbeing of the breastfeeding mother and baby as the focus of the information.

> *I'm worried about putting it [breastmilk] into a bottle because…you can get this thing called nipple confusion…all this stuff I'm learning, it's brilliant…I've been looking at the website Medela.com and they've made a new breast teat which means they [babies] have to do the same sort of feeding as when you are breastfeeding* (Vicky4)

The internet was not the only place where the information mothers received was supported by commerce. Promotional material in 'Bounty Packs' also influenced their decision making. It appeared that although Sarah could think rationally about the use of nutritional supplements, the information provided was enough to undermine her confidence in her ability to produce the quality and quantity of breastmilk she felt she needed. Perhaps breastfeeding mothers were an easy target for such advertising because they were already feeling vulnerable in their 'state of flux' (6.3) and would do anything to enhance their breastfeeding experience.

> *…there was a leaflet…[shows brand name to camcorder] it's for supplements that you can take for breastfeeding, and it says it's supposed to help with your milk and make it really nutritious, I'm not sure I believe that…surely if you are having a balanced diet… which hopefully I am, your milk should be nutritious anyway…that said I'm still tempted to buy them…I'm just trying to make my milk as good as possible and as much as possible* (Sarah3)

Mothers used other sources of information including books and shared the latest revelations in their daily diaries. Sometimes this was because they had gained surprising insights when looking for other information. At other times, it was because they had proactively looked up information for an issue needing to fill an information gap. New knowledge about breastfeeding sometimes caused more information gaps than originally needed filling, and then mothers felt disconcerted or their confidence levels dropped. Conversely, when they discovered something empowering, it gave them the impetus to keep going.

> *This engorgement of my breasts is pretty miserable but I've read in that book that it only lasts 2-5 days, hopefully, so if that's as long as it lasts, I can cope with it.* (Sarah1)

> *I've found out from Ina May's book that I'm not supposed to be using the same pump as somebody else? You are supposed to get different collection kits but I don't know why? What's the matter if you wash and sterilise it? What are you going to do to harm your baby? [Big sigh] So that is a slightly stressful thing* (Vicky11)

> *I looked online…it was on the Maternity Action website, and in October 2010, it said when the Equality Act came into force, it meant that breastfeeding mothers could feed anywhere and people cannot ask you not to, we found this website useful as we didn't know any of our rights, and we were able to find out my rights as a full-time student too* (Sam2)

Most mothers felt they had not been given enough information about breastfeeding while they were pregnant. Sometimes they sought information and support because they wanted to clarify something that a health professional had said, but most of the time it was because they had numerous unanswered questions. This suggested that they had huge uncertainty about what they were doing or planning to do, which caused angst and stress. At these times, mothers looked further information from a range of sources including the internet which provided an instant response, comparing and contrasting ideas from health professionals and experienced friends and family, so that they could come up with a decision of their own.

7.4.2 Reading more

Mothers enjoyed reading more about parenting and breastfeeding not always because they had a question or challenge to address but they wished to do a good job as mothers and this included learning more breastfeeding. Rosie and Vicky proactively 'read more', using a number of books which helped them to pre-empt most breastfeeding challenges. Whilst both read avidly, they used contrasting approaches when applying the literature to their breastfeeding experiences, with Rosie not wishing to follow any book to the letter and Vicky reading and trying out each new technique one at a time.

> *I really like her style and approach … she says don't look after babies by a book, look after baby by the baby, really acknowledging that you can't just read it in a book and then do it and expect your baby to conform like some text book baby.* (Rosie3)

> *I'd just like to show you my new position that I'm trying, the laid back position, seems to be working quite well, although his nose seems to be stuck in my boob…but he is swallowing…apparently gravity helps it, this is what I'm reading at the moment. So read it, try it out! Brilliant!* (Vicky5)

As discussed in 7.4.2, mothers were recommended books to read by family and

friends aimed at '*finding a new equilibrium*'. Knowing her parenting philosophy early in her breastfeeding journey helped Rosie select reading material that affirmed her beliefs. For other mothers, who weren't aware of the diverse spectrum of breastfeeding practices, it was like walking through a minefield as they learnt about one breastfeeding practice after another. Tips and tactics were often inconsistent, causing mothers to feel baffled over the conflicting messages, which in turn undermined their confidence in breastfeeding. As discussed in 7.3.2 Vicky was engrossed by the information given by friends aimed at '*finding a new equilibrium'* including debates on 'routine versus baby led feeding', 'night-time parenting' and 'introducing a bottle before it is too late'. This stimulated further reading as she battled on a daily basis with the arguments raised, sharing the latest information she had read and how she felt about it on camcorder.

> *I've been sent a book called, 'The Sensational Baby Sleep Plan' which talks about feeding at certain times…which is slightly daunting and makes me feel maybe I've not been doing it right already, but then if he's hungry then surely he should feed. Controversial! Everyone has different plans.* (Vicky3)

> *It's very good, it talks about the first forty days being really important about setting rhythms and not interfering with the baby by having routines or bottles or anything like that* (Vicky5)

As mothers sought to 'read more', the information appeared to influence their thoughts and feelings about breastfeeding. Indeed, as time progressed, some became analytic consumers of information, questioning what they had been told or read, agreeing or not agreeing with the philosophy of breastfeeding approaches proposed, or realising that information was outdated, irrelevant, or unhelpful. Seemingly, sharing the information on camcorder provided additional opportunities for mothers to discuss what they had learnt, enabling them to reflect on the positives and negatives and hence draw conclusions. Sometimes information was affirming so that they knew they were '*on the right track'*, but

sometimes it was undermining, and their confidence levels dropped as they questioned themselves. This undermining influence of literature was particularly poignant in one of Vicky's final diary entries at 20 weeks. Initially she demonstrated anger towards the author about the promotion of routines and formula feeding thus demonstrating her knowledge and passion for breastfeeding, but by the end of the diary entry she questioned herself, indicating the powerful and undermining influence that such literature can have on mothers' confidence levels.

> *..She's against demand feeding because it's not practical…it says…you should take control right from when it's a baby'. You can tell I'm cross. Then it says … 'formula gives longer and more lasting satisfaction to a baby'. What? How can you say that? Doesn't give longer satisfaction it stays in the stomach longer…So; do women formula feed because they get to sleep through the night? Is he not sleeping through the night because I don't expect him to sleep through the night? Is he not sleeping through the night because he's still in our room? Is he not sleeping through the night because I stir at every opportunity and then feed him? Have I done something drastically wrong to him and therefore he can't train himself to fall back asleep? Am I doing something wrong, I just don't know* (Vicky20)

7.4.3 Summing up

This subtheme, 'The gap and filling it' demonstrates how mothers needed to fill a knowledge gap by searching out information and support on a daily basis. '*Looking it up'* and '*reading more'* directed them to a multitude of sources often resulting in conflicting messages, sending mothers into a whirl of confusion. They might have felt the need to search for information so frequently because of a lack of confidence in their ability to breastfeed and the need for affirmation, a yearning to be successful, or a recommendation by family or friends. The need to fill a knowledge gap might have arisen because of a lack of information offered by the

health service or perhaps a reluctance to ask for advice for fear of being judged.

7.5 Conclusion

The complex nature of 'the support conundrum' demonstrates the daily challenges mothers faced in relation to breastfeeding support.

The first subtheme explored how mothers perceived and dealt with being 'under surveillance'. When they experienced healthcare workers checking and confirming that they were '*on the right track* in a sensitive nurturing way, they felt breastfeeding was validated and worthwhile. However, when mothers felt '*scrutinised, judged and sabotaged'* they became stressed and anxious and demonstrated feelings of poor self-worth. When mothers were too nervous to access support in case of further scrutiny or were unable to access support in a timely way they felt '*abandoned and alone'.*

The second subtheme discussed how mothers went about 'managing support from family and friends'. When they were 'nurtured' they were enabled to nurture and breastfeed their own baby. Well-meaning support offered by family and friends often involved compromises aimed at *'finding a new equilibrium'* in the mothers' chaotic life with a breastfeeding baby. *'Interfering opinion'* from family and friends necessitated mothers developing coping strategies to combat the harmful effects on breastfeeding.

The third subtheme 'the gap and filling it' demonstrated how mothers needed to answer questions and challenges by '*looking it up'* for themselves on the internet or in books and how they were keen to '*read more'* in their quest to do a good job as mothers. 'The gap and filling it' was a conundrum in itself because mothers needed to become analytical consumers of information so that they could recognise what would potentially enhance or undermine their breastfeeding.

8 Discussion

8.1 Introduction

The video diaries recorded by five first-time breastfeeding mothers in the first few weeks following birth, provided an abundance of rich audio-visual data providing multiple insights into the socio-cultural context of infant feeding. When I initially started analysing the data, hundreds of codes were discerned, which were merged to form categories, subthemes and finally three themes, as presented in the findings chapters. The analysis of the data often caused much deliberation about where codes and categories sat in the wider socio-cultural nature of breastfeeding and hence how the themes were discerned. This process enabled me to recognise that the three themes or even the subthemes are not distinct entities but that there were many meaningful interconnections between them, as indicated in the thematic map (Chapter 4 – chart 2). The analytical process identified five important areas for discussion which drew on the main themes and the interconnections between subthemes and categories as detailed below. This chapter links, these key areas to the up-to-date international research literature.

In the first area for discussion (8.2) I explore the *'therapeutic use of the camcorder'* as mothers '*offloaded*' their thoughts and feelings about breastfeeding. In 8.3, '*A state of flux and getting back to normal: identity work',* I discuss how the video diary method illuminated valuable insights into the evolving identity of mothers and how they repositioned themselves within their own socio-cultural context of time and place. In 8.4, *'Breastfeeding consumerism: essential paraphernalia',* I discuss the impact that commercialisation and commodification of breastfeeding had on mothers' experiences of breastfeeding. '*The biomedical approach: it's not working'* (8.5) discusses the impact that the medicalised approach to infant feeding had on mothers and their families and considers new approaches to improve support. Finally 8.6, '*The video diary method: strengths and limitations'* addresses key methodological issues around

my participatory research using the camcorder as a data collection tool highlighting the strengths and limitations of the study.

8.2 Offloading: Therapeutic use of the camcorder

The therapeutic benefits of using video diaries has been reported in the academic literature (Brown et al. 2010; Buchwald et al. 2009; Holliday 2007; Noyes 2004). These studies have reported how the camera has been used as a confidante (Buchwald et al. 2009; Noyes 2004), a counsellor (Noyes 2004) in a confessional manner (Holliday 2007; Noyes 2004) and as extended friendship (Sutherland and Young 2013). This section discusses how the diaries offered the potential for therapeutic effect.

8.2.1 Offloading: Talking to someone

Research studies have consistently highlighted that the qualitative research process can in itself have a therapeutic effect on participants, particularly when sequential interviews are involved (Birch and Miller 2000; Dickson-Swift et al. 2006; Ortiz 2001; Rossetto 2014). An unexpected outcome for Ortiz (2001, p. 199), for example, who interviewed 48 wives of professional athletes in a longitudinal study, was the therapeutic effect reported by some participants when they were provided with the opportunity “to cathartically release unpleasant or pent up feelings” in the context of their everyday lives. Finding himself an “accidental therapist”, Ortiz (2001, p. 196) proposed that emotional self-revelations were shared because, over time, he developed an attentive, trusting, non-judgemental relationship with participants, which in turn helped relieve their stress. Birch and Miller, using the term “expressive culture” (2000, p. 193), suggested that the very nature of qualitative interviews provides participants with the freedom to reveal intimate details of their personal experience, releasing emotions that have built up. Dickson-Swift and colleagues (2006) recognised the similarities between the qualitative interviewer and a psychotherapist, arguing that the former has the potential to provide more time for

active listening and gentle probing. Active listening does not just involve hearing the words that participants have to say but involves attempting to understand the meaning which includes interpretation of vocal intonation, body language, emotions and the socio-cultural context of each individual (Nelson-Jones 2005).

In this study, I was not in the room as an interviewer, therefore unable to use non-verbal behaviour to demonstrate active listening and an empathetic approach or to gently probe with questions to encourage the participants to share further information (Dickson-Swift et al. 2006). Instead of the physical presence of the interviewer, mothers used the camcorder as the eyes and ears of the active listener or whoever they thought they were talking to, to reveal their feelings and share their experiences. They only had a guide sheet to trigger discussion. Dowmunt (2001, p. 10) highlighted the value of the video camcorder as "something to talk to that would never answer back". Perhaps because the camcorder was neutral and unable to respond or interrupt, mothers were able to share candid accounts of what was happening and to agonise over how they were feeling and what they were thinking, without fear of retribution or judgement. Mothers, however, appeared to personify the camcorder, usually having someone in mind as they shared their experiences (5.3.2). Dinsmore (1996, p. 41), critiquing the television series 'Video Diaries,' proposed that the term 'diary' suggested an "intimate personal encounter with the maker of the programme". As a PhD researcher I experienced this personal touch by the way mothers addressed their video diary with '*Hi Alison'* (Rosie1) and purposefully demonstrated actions to the camcorder (5.3.2). This was also comparable with Brett's (1987, p. x) interpretation of a writing diarist, in which he believed that

> "very few [diarists] seem to be completely unselfconscious, all have the thought of a reader at the back of their minds".

Indeed as Bates (2013) suggested the mere offer of showing something to the camcorder acknowledged the existence of an audience who would watch at a later date. In the minds of most study participants, it appeared that the principal

audience was me as the researcher and main contact for collecting the video recordings.

Although '*nervous to start with'* (Vicky12) about filming themselves (5.3.1), within a week, mothers became visibly and audibly relaxed as they opened up, talking without interruption about their breastfeeding experiences as well as what was happening in the context of their daily lives. Despite knowing the purpose of the research and its eventual intended wide dissemination, participants used the camcorder as a confidante, a trustworthy friend that they could share their secrets with, and after doing so they admitted feeling a release of tension that had been building up. Usually this realisation was retrospective but sometimes they recorded deliberately for this cathartic purpose and the recordings were lengthy (5.3.3). Confessional in nature, mothers revealed thoughts and feelings about breastfeeding within the socio-cultural context of their lives as new mothers which they perceived to be chaotic. The clandestine feel of the video diaries (5.3.3) was also reported in a different area of social study by Holliday (2007) who noticed that participants shared more intimate sexual details when alone than in the company of others. Renov (1996) suggested that a virtual companion through digital technology is far more effective at encouraging emotional outpouring than the physical presence of a conversation partner. In my study, participants were positively buoyant when sharing conversation with family and friends but displayed unguarded emotional turbulence when alone. This suggested the need for mothers to offload to someone other than family and friends.

Catharsis is considered to be "the process of emotional discharge which brings relief to emotional tension" (Scheff 2001, p. 45). In this research mothers were able to offload their anxieties, feelings and emotions whenever they felt they needed to and, therefore, were not reliant on a person that they could trust to listen to them at a specific time and place. This meant that when they were facing particular difficulties, they disclosed what was happening in real-time or almost immediately after the event. This provided instantaneous responses as well as spontaneous emotions, and may have prevented emotional turmoil building up.

The literature emphasises the importance of ‘letting go’ of thoughts and feelings because suppressing them can be harder work, cause short term physiological changes in the body, long-term ill health and interfere with one’s ability to think clearly (Gross and Levenson 1997; Pennebaker 1990; Scheff 2001). Scheff (2001) also proposes that repressed emotion can interfere with one’s ability to build strong relationships with others which in turn fosters isolation exacerbating the situation. If discharge of emotions is enabled, these consequences are reduced, tension is relieved and thought processes regain clarity (Gross and Levenson 1997; Pennebaker 1990; Scheff 2001).

This therapeutic effect has recently been noted in a longitudinal study which explored the breastfeeding experiences of first-time mothers using audio-diaries and interviews (Williamson et al. 2015). Findings from the audio-diaries recorded by participants each day for the first week and then again from 21-25 days for a further week, proposed that participants valued the opportunity to “vent their feelings and frustrations, especially when experiencing difficulties” (Williamson et al. 2015, p. 24). Scheff (2001) suggests that the cathartic process which relieves the emotional tension of grieving is the reflex that triggers crying. Mothers, having relieved their stress by crying during their video diaries, expressed their relief afterwards, and yet also apologised for crying in the first place (5.3.3, Figure 20). This apology might have indicated a learned reaction that crying should be controlled (Scheff 2001). Nevertheless, as Sheff (2001) describes, mothers increased their clarity of thought following each display of emotional distress, and with pressure taken off there was usually a resolve to continue breastfeeding.

Non-directive counselling, also known as ‘listening visits’ have been found to be an effective intervention for mothers with mild to moderate postnatal depression (Cooper et al. 2003; Holden et al. 1989; Morrell et al. 2009; Slade et al. 2010). One study explored how the experiences of listening visits undertaken by research health visitors who were previously unknown to them affected women diagnosed with postnatal depression (PND) (Turner et al. 2010). Participants valued having the opportunity to ‘offload’ their feelings about anything that was

worrying them because they had not spoken to anyone else before for fear of "being judged as a poor mother" or "not coping" by family and friends or known health professionals (Turner et al. 2010, p. 236). This included issues around personal expectations as new mothers, feelings towards their baby, changing relationships with partner and financial difficulties. This finding is strikingly similar to findings from my study, with the same word '*offload*' being used by participants in relation to releasing their feelings to 'someone' they could trust who would not be judgemental. In my study, mothers were not diagnosed with postnatal depression and yet they still felt they needed to talk to 'someone'. The difference however, was that the non-directive counselling of the research with health visitors was underpinned by Rogers' theory (1957), whereby the listener not only provided an hour of uninterrupted space for the mother to offload, but then helped her to work out for herself why she was feeling the way she was including strategies to help her cope (Hanley 2015); this is discussed further in 8.2.3. This person-centred approach is the same theory used for Breastfeeding Network (BfN) counselling which requires the counsellor to be

> "genuine or congruent, to offer unconditional positive regard and acceptance, and to feel and communicate a deep empathetic understanding" (Hall Moran et al. 2006, p. 2)

Brett (1987) argued, however, that omissions in written diaries are significant because writing about emotional turmoil can sometimes cause further anxiety. In my study, omitting to record for a few days also seemed important for some mothers. This was sometimes because the 'period of flux' was more chaotic than usual. Sarah, for example, did not record over the few days that she had been expressing and introducing a bottle because it was too painful to breastfeed, but on return, she apologised, explaining her absence. Mothers, however, were not limited to a time frame for 'offloading' by a minimum or maximum number of visits. This meant that they turned the camcorder on 24/7 and as many as eight times in one 24 hour period. Researchers exploring the therapeutic effects of 'listening visits' noted that over half of the 22 participants did not feel the scheduled eight visits were enough to treat their PND with some expressing anger because they

were “left hanging” when the visits suddenly stopped (Turner et al. 2010, p. 237). In my research study, mothers continued to record their diaries until they felt their infant feeding method was established, which continued beyond the expectations of the research proposal. The motivation for continuing to film each day and for length of diary entries may have been linked to the therapeutic benefits that they were experiencing and thus a gradual weaning over the last few weeks of data collection occurred.

Despite the small number of participants, the length of time for which the mothers breastfed, compared to national statistics, was noteworthy. Four out of five mothers were exclusively breastfeeding at six weeks with one breastfeeding alongside formula feeding, thus all were doing some breastfeeding. The last UK Infant Feeding Survey identified that 55% of mothers were doing some breastfeeding at six weeks, with 23% exclusively breastfeeding (McAndrew et al. 2012) (2.3). Sam stopped recording at eight weeks and was continuing to breastfeed, expressing breastmilk regularly to give by bottle. Vicky and Rosie who kept in touch with me, were still both exclusively breastfeeding at six months. Tracey abruptly stopped at 12 weeks following a visit to the clinic where she was advised to give formula due to inadequate infant weight gain. Despite mixed feeding because of early breastfeeding problems from 11 days, Sarah persevered with breastfeeding until she had increased her milk supply enough to be fully breastfeeding by 12 weeks. A Hawthorne effect might have been the reason for the mothers to have continued breastfeeding (4.5.4) but it could also be argued that they were already motivated to breastfeed for a lengthy period and that is why they consented to take part in the research.

8.2.2 Offloading: Letting off steam or fuelling the fire?

Two mothers offloaded their frustrations, appearing to ‘let off steam’ with impulsive bouts of outrage when they faced difficulties, speaking as if they were directly venting their complaints at the known person or group whom they were annoyed with (5.3.2). I was unprepared for the strength of feeling displayed,

particularly as at first viewing the anger appeared to be directed at me as the person watching the video. Dinsmore (1996, p. 44) suggested that the diarist might create an “imagined reader” and Renov (1996, p. 88) concurred proposing that interaction with the video camcorder, especially of a confessional nature, did not always need to be with the researcher but with an “absent imaginary other”. Using a reflexive approach helped me to understand that the mother could replace me as the imagined listener with people who had caused irritation and anger (5.3.2). I was not the only researcher to have experienced this. Ortiz (2001, p. 206) experienced similar angry responses during interviews, feeling under attack like a “substitute husband” when athlete’s wives ventilated pent up rage towards their own husbands. He noticed, however, that self-disclosure accompanied by angry discharge assisted rationalised thinking, self-revelations and problem solving. Catharsis, thus fits with Breuer and Freud’s theory (1974), which argued that openly expressing personal anger rather than holding feelings in, prevents long-term resentment and hostility.

The therapeutic effect of offloading to someone via the camcorder resulted in Tracey believing that she might have ‘*gone a bit potty without it’* (Tracey11). These findings, however, need to be treated with caution, because according to Zech and Rimé (2005), a perceived catharsis does not necessarily mean an actual recovery. Exploring whether talking about an emotional episode aids recovery, Zech and Rimé found that participants who talked about their emotions were less likely to recover than those who kept to factual descriptions of the event alone. Thus a “repetitive uncontrolled process through sharing or thinking” can impede recovery, whereas a “more constructive, insightful and controlled process” leads to more positive outcomes (Zech and Rimé 2005, p. 285). In this study, Tracey’s diary entries were often turbulent with feelings of anger expressed repetitively about the lack of support she received from the health professional who called her baby *‘scrawny*’ (Tracey5). Kennedy-Moore and Watson (1999) argued that self-regulation of emotions is important for wellbeing so that excessive expression or non-expression of emotions can be detrimental.

Wilkins et al. (2009), exploring emotional processing in childbirth suggested that when someone is having difficulty regulating their emotions they may show "repeated or intrusive memories of a stressful event, a reliving of the orginal emotions" (p. 155). For Tracey, the repetitive discussion might have reinforced the word '*scrawny*', 'fuelling the fire', making her angrier every time she spoke about it (7.2.2). Capturing the rollercoaster of emotions, expressed on camcorder in real-time, demonstrated how mothers fluctuated between all-consuming despair, when their inner strength appeared depleted, and anger when blaming the healthcare team for why breastfeeding was not going as they expected, which in turn provided strength and determination to keep going.

8.2.3 My Video Diary: Tool for the evolving mother

The way the mothers set up their camcorders by turning the screen around, meant that they could see their own image in the camcorder's frame and could talk to themselves. This eye contact with themselves was not unlike the mutual gaze that occurs in a natural conversation. Mutual gaze, when people are looking at each other, is an important part of communication as it helps to regulate and manage a conversation (Kendon 1967). This is particularly noteworthy as participants mostly talked to their diaries on their own and thus did not need to restrict their conversation to fit in with another, and yet they still made eye contact with the camcorder. The average length of mutual gaze during normal conversation is 1.18 seconds for English people (Argyle 1990), although Devito (2014) argues that women use eye contact more often and for longer periods than men. Whilst not measuring every single glance, it was evident in this research that most mothers followed a similar pattern when glancing at the camcorder. There is, of course the risk of over analysing this, a very practical issue for mothers turning the screen round was to ensure that the picture was properly framed and her face was not (half) cut out of the picture.

Adams and Kleck (2003) suggested that fear and sadness are associated with mutual gaze aversion, whereas anger and joy are associated with protracted eye

contact. Rayudu (2010) agreed proposing that when people avoid mutual gaze during social interaction they might be embarrassed or distressed. In this study, as mothers built up a relationship with the camcorder, this link with emotional state also appeared apparent. Generally, when mothers were feeling sad and tearful, especially when breastfeeding was not going well, they barely looked at the camcorder, looking all around the room but when they were angry or joyful they looked directly at the camcorder.

Looking at themselves in the camcorder frame also appeared to assist mothers to define their identity, in a way that research exploring women's experiences of breastfeeding has not exposed before. The camcorders were used like mirrors as participants reflected on what they could see in the monitor, and yet for me as the researcher, it was like looking through the viewfinder as I could also witness what they were seeing. All commented at times within their diaries about their 'rough' or 'relaxed' appearance, apologising as if standards had dropped since becoming a breastfeeding mother (5.3.1).

For some, seeing their own image appeared to trigger a deeper reflection resulting in an identity crisis, *'this isn't who I am'* (Tracey12). While this method of reflecting has not been highlighted in research exploring breastfeeding before, Holliday (2004b) suggested that the mirror image, facilitated through the camcorder monitor provided a 'narcissistic' function enabling the participant to speak candidly to themselves as an imagined viewer.

Thus the diaries offered a safe place to talk to themselves and for deep personal reflection as they tried to work out how to survive the early days as breastfeeding mothers and how to 'get back to 'normal'' from their new 'state of flux' (5.3). Indeed when using the camcorder as a sounding board, mothers appeared to be thinking out loud, sometimes talking for a very long time, day or night.
Self-reflection is a deliberate process whereby people focus on experiences that have affected them with a specific aim to understand what has arisen including self-examining thoughts, feelings and actions (Wood 2013). Educational theory

suggests that reflection is triggered particularly when a dissonance occurs between what people experience and their expectations or beliefs about an experience, creating the potential for transformation (Jarvis 2006). In my study the dissonance was due to many unexpected realities that they were trying to 'work out', including how breastfeeding fitted in to their life now and in the future and this triggered the deep reflective discourses within the video diaries.

Research using video diaries has found that participants who spent recording time trying to interpret their experiences by talking out loud became self-aware, gaining valuable insights about themselves (Brown et al. 2010; Holliday 2004a). Brown (2010, p. p428) suggested that this self-awareness brings about a "cognizance" with potential for transformation. Theory underpinning 'listening visits' for women with postnatal depression (8.2.1) advocates uninterrupted listening followed by prompting to help women develop their own strategies to manage challenges (Hanley 2015). Mothers in my study did not have a listener to prompt questions but they asked themselves questions before ruminating over them and 'working out' their identities, their current and future situation and how best to deal with it. Like Kindon's (2003) research using video diaries with Maori in New Zealand, mothers in my study appeared to use their own reflections for 'analysis [of] their own realities' as breastfeeding mothers. This provided "holistic transformative potential" (Kindon 2003, p. 148) empowering them to work out for themselves how to negotiate breastfeeding within the context of their daily lives.

8.3 A state of flux and getting back to 'normal': Identity work

'Working it out' and being able to 'offload' to someone via the camcorder meant that mothers were provided with the time and space to verbalise their 'identity work', reflecting and reappraising who they were, in their state of flux following the birth of their baby and how breastfeeding fitted into their everyday socio-cultural context. The literature review highlighted how mothers negotiated their new identities as breastfeeding mothers and re-negotiated them to meet the realities of their breastfeeding experience (3.5.3) (Sheehan et al. 2010). Findings from this

study supported this, however, because data were recorded on most days over a number of weeks and mothers valued the space to 'offload' their thoughts and feelings, a number of valuable insights about the evolving identity of mothers and how they repositioned themselves within their own socio-cultural context were identified.

8.3.1 Identity work: Thinking ahead

Findings demonstrated that plans to '*get back to 'normal''* included "identity work" (Faircloth 2013, p. 53), where a reappraisal of their new identities began very early within the data collection period. Mothers exposed an inner struggle as they deliberated over who they were before the baby was born, who they were now with a breastfeeding baby, and the type of woman and mother they wanted or did not want to become (5.3.1/5.3.2). Feeling a moral obligation to breastfeed in order to be considered a 'good mother' (3.5.1) (Brown et al. 2011; Johnson et al. 2013; Miller et al. 2007; Payne and Nicholls 2010; Ryan et al. 2010; Schmied and Lupton 2001; Sheehan et al. 2013) and to fulfil health promotion recommendations to exclusively breastfeed for the first six months (Department of Health 2003; Kramer and Kakuma 2002), most mothers in my study perceived a dilemma when thinking about maintaining or finding new positions within employment and/or education. The value of breastfeeding has been questioned because of its potential to disrupt women's capacity to return to work (McCarter-Spaulding 2008; Stewart-Knox et al. 2003), and the challenges of both working and breastfeeding have often been cited as the trigger for giving up breastfeeding altogether (Galtry 1997; Gatrell 2007; Skafida 2012). This was the outcome for one of the five mothers (Tracey) who gave up breastfeeding at 12 weeks because it was too demanding to try to meet the nutritional needs of her baby and to fulfil her financial imperatives (6.3.2).

With the option of paid maternity leave in the UK, entitling mothers to a full year off work, with 39 weeks of Statutory Maternity Pay (Smith 2010), and equal rights for college students (Equality and Human Rights Commission 2010b), four mothers

discussed their plans, within a few days of giving birth, of going back to work or college. The literature review highlighted how women, juggling the demands of breastfeeding within contemporary life, including work, went to extreme lengths to maintain their identity as ‘good mothers’ (Marshall et al. 2007). Payne and Nicholls (2010, p. 1812) proposed that this was due to imposed dual responsibilities, the moral imperative to be “the good worker” as well as the “good mother”. Dykes (2006) expressed her shock at mothers’ early attempts to manage breastfeeding during their hospital stay in order to initiate the transition of getting back to ‘normal’ life, including paid employment. Supporting these findings, my study demonstrated the early start of such planning, but also demonstrated the depth and frequency of this deliberation that occurred throughout the breastfeeding trajectory. The need to regain control of what mothers perceived was the ‘time-consuming, unpredictable nature of breastfeeding’ within the early days preoccupied all diary entries so that establishing some structure or a routine was high on mothers’ agenda (6.2.5).

A national UK survey found that over three quarters of mothers with babies returned to work, with a third taking less than the statutory number of weeks of maternity pay (Chanfreau et al. 2011). Among the multiple responses for their return were end of maternity leave (43%), end of maternity pay (35%), financial need (59%), self-motivation (25%), fear that a longer break could harm their career (8%), independence (11%) found suitable childcare (9%) and because they missed the companionship of work colleagues (12%). It was unclear whether mothers in my study knew that current English law does not require an employer to provide facilities or paid breaks for mothers to breastfeed or express their breastmilk (ACAS 2014) but discussions included frequent and long ruminations as they speculated what returning to their workplace would be like in the context of being a breastfeeding mother. The crucial planning also involved trialling the logistics, with immediate feedback to the video diary (6.3.3).

Biomedical promotion of breastfeeding has brought about a distinction between mothers who value the nutritional ‘product’ of breastmilk and those who

appreciate the embodied ‘process’ of their relationship with their baby as well as the ‘product’ (McCarter-Spaulding 2008, p. 208). Described as a mechanical approach in the literature, the product ‘disembodies’ women as it is not reliant on the mother’s presence during feeding times as expressed breastmilk can be given by someone else (Buckley 2009; Burns et al. 2012; Dykes 2005b; McCarter-Spaulding 2008; Ryan et al. 2011), whereas the process of breastfeeding needs mother and baby in close proximity, so that a responsive relationship occurs (Blum 1999; Hausman 2003). While my study demonstrated how participants worked in different ways to maintain their identities as breastfeeding mothers within their own socio-cultural context, it also illuminated how their identities evolved as they grappled with these ideals in an attempt to take on multiple identities to get back to ‘normal’ and back into the workplace. The intense need to plan ahead appeared to consume their thoughts, so that some of them began to ask themselves existential questions, wondering what value they brought to society now they were a breastfeeding mother. The socio-cultural environment within the Western world which values work in the paid employment sense rather than a mother’s work with their babies (Dykes 2009) dominated their thoughts and feelings throughout the course of data collection. This was also reported by Lupton and Schmied (2002), who explored decision-making by 25 first-time mothers about returning to work in Australia. They found that mothers’ identities were more strongly interrelated with their paid work than motherhood which was not always felt to represent the “real me” (Lupton and Schmied 2002, p. 106).

Ryan and colleagues (2010, p. 951) applying Foucault’s theories relating to the ethical relationship that one has to self, explored the moral identities that mothers constructed in their breastfeeding narratives. Qualitative interviews revealed the moral work that mothers do by repositioning themselves in different situations, by “reinventing themselves as rational beings of moral integrity” (p. 951) in an effort to maintain self-esteem and fulfilment. Applying these principles of “moral work” to participants in my study it was noticed that mothers’ ‘identity work’ involved

multiple representations (Ryan et al. 2010). Tracey, for example, demonstrated "biographical preservation", (p. 954) because she preserved her identity as a breastfeeding mother by persevering with breastfeeding despite seemingly fighting a never ending battle with relentless feeding and authoritarian scrutiny from health professionals. Although she finally gave up breastfeeding on her thirteenth week, she did not record this critical decision but returned some weeks later at around 20 weeks to conclude her video diary. Perhaps her 'identity work' took time while she undertook "biographical repair", so that when she re-presented herself, she was able to reframe her decisions in the light of becoming a self-employed worker, providing income for herself and her family, alongside having a thriving baby who, under the scrutiny of the healthcare team, had put on weight with formula feeding (Ryan et al. 2010, p. 954). Indeed each of the mothers demonstrated multiple representations of their moral work within the video diaries and for all but one of them these involved detailed plans to get back to work or college.

8.3.2 Determination and Resilience: Reaching for a Goal

This study revealed the strength of character and determination to breastfeed not retrospectively, but displayed on a daily basis as all mothers sought to work out their challenges as well as their identities. Determination to succeed and persistence despite difficult challenges have also been highlighted in the literature (Berridge et al. 2005; Hauck and Irurita 2003; Hauck et al. 2002; Hegney et al. 2008; Maclean 1990; Manhire et al. 2007; Schmied et al. 2001; Scott and Mostyn 2003). A study that involved interviews with 33 women who had exclusively breastfed for six months provided an insightful overview of the strength of character and determination that mothers showed as they faced the challenges in pursuit of their goal and esteemed identity as breastfeeding mothers (Brown and Lee 2011).

Dixley (2014) argued that mothers sabotage their own intentions to breastfeed by a host of excuses including insufficient milk supply. Mothers in my study did not

appear to be looking for excuses to discontinue breastfeeding but showed determination to work through and learn from their varied experiences of breastfeeding. Sarah's testimony, for example, demonstrated her commitment and sheer determination so that she '*got there in the end'* (Sarah13) (7.2.8). Applying the concept of 'moral work' discussed by Ryan and colleagues (2010, pp. 953–5), it was clear that Sarah was unwilling to accept permanent "biographical repair" in her identity as a 'formula feeding' mother, and therefore only accepted it temporarily until her baby's tongue tie was cut. Arguably, she remained in the "biographical repair" mode, re-orientating her position to mixed feeding and "altruism" bearing much pain in order for Sophie to benefit from breastfeeding. Through determination and resilience, she was able to adapt positively to this adversity, boosting her milk supply, so that her identity evolved and she was able to regain the "biographical representation" she yearned as a fully breastfeeding mother by her thirteenth week.

Schmied and colleagues (2001) identified resilience as a quality in a longitudinal study exploring motherhood in Australian first-time mothers. Women's fanatical determination and resilience were highlighted as worrying emotional outcomes of the pressure they put themselves under to succeed at breastfeeding, which in turn disrupted the development of close relationships with their babies (Schmied et al. 2001). This was thought to be in response to the public health agenda which provoked in them a strong moral imperative to breastfeed. However, Wilson and colleagues (2012, p. 157) explaining the term 'resilience', when an individual "adapts and/or perseveres despite difficult circumstances", found this personal attribute to be positive in the 17 women who were interviewed in a qualitative study exploring how mothers overcame breastfeeding challenges. Hunter and Warren (2014) applied 'resilience' to midwives who developed strategies to cope with adversity in the workplace and suggested that it required a strong sense of self-awareness in relation to identity and autonomy. My study enabled mothers to become more self-aware as they reflected on their experiences, working out positive coping strategies and developing confidence to face the challenges of

breastfeeding. Sam felt that breastfeeding '*was not all that it is cracked up to be*' but with a strong sense of moral duty (6.2.6), found ways to preserve her "biography" (Ryan et al. 2010, p. 953) as a breastfeeding mother and student by expressing her '*valuable breastmilk'* for Zac. She also demonstrated "altruism" (Ryan et al. 2010, p. 955) by donating her excess breastmilk to the local hospital (6.3.3). While the concept of resilience cannot be applied to all participants in this study, the findings suggested that this was an important quality of those who regained or maintained their identity as 'breastfeeding mothers' beyond data collection.

8.3.3 Evolving identities: witnessed in the embodied experience

This study agrees with Schmied and colleagues (2001, p. 52) who advocated that mothers need time and space to "articulate the sensed and perceived experience" of breastfeeding, which was created within mothers' diaries and acknowledged and validated when they trusted in me as the researcher to watch the videos. Studies have revealed two extremes of the embodied nature of breastfeeding, so that "connected" or "disconnected" experiences impacted on women's identities as breastfeeding mothers (Ryan et al. 2010; Schmied and Barclay 1999; Schmied and Lupton 2001, p. 239–240). Consistent with their findings, my study provided evidence of diverse experiences of the embodied nature of breastfeeding when mothers spoke about how they felt. Unique to my study was how these two extremes were captured on camcorder in the way mothers behaved whilst breastfeeding their babies; these permeated through to me as the ethnographic observer. For some mothers, the visceral nature of breastfeeding involved a reciprocal relationship with their baby because they looked relaxed as they touched and chatted to the baby lovingly during feeding, whereas other mothers looked tense and exhausted, sometimes wincing at the physical pain. The combination of the emotional conversations about their breastfeeding experiences which included candid accounts of how they were feeling and what they were thinking alongside the visual representations of the

embodied (connected or disconnected) experiences of breastfeeding evoked a strong sense that I was there with the mothers.

UNICEF UK Baby Friendly Initiative (2012b) suggest in their updated standards, that when breastfeeding is going well, a reciprocal relationship occurs between mother and baby because of the connection, intimacy and enjoyment. Indeed the public health message that mothers cannot “spoil” a baby by breastfeeding is to encourage them to develop close and loving relationships with their babies without the fear of overfeeding through breastfeeding (Entwistle 2013, p. 75). Mothers in my study perceived breastfeeding to be relentless in the early weeks and they all talked about the demanding nature of being tied to their babies and the ensuing feeling of exhaustion. It felt like the baby and breastfeeding was an intrusion into their daily routines of ‘normal’ life. This is not a new finding, with many studies already highlighting the unexpected and unpredictable reality of frequent feeding (Burns et al. 2010; Miller et al. 2007). However, during each mothers’ breastfeeding trajectory it was possible to witness how each came to terms or coped with these unexpected challenges and how that appeared to influence their embodied experience of breastfeeding.

Cooke and colleagues (2007) in a large longitudinal study using questionnaires found that women who strongly believed that breastfeeding was their maternal role were more likely to continue breastfeeding despite problems, compared to women who did not associate breastfeeding with their identity. O’Brien and colleagues (2009) used focus groups to interview mothers and breastfeeding practitioners to identify what psychological factors influenced breastfeeding duration. These researchers found that the overriding factors were a mother’s confidence in her own ability to mother her baby together with a “loving focus” to prioritise her baby above anything else, a strong belief in the benefits of breastfeeding, the ability to relax when stressed and a trust in her own capacity to breastfeed (O’Brien et al. 2009, p. 60). Trust in breastfeeding has also been highlighted by Brown and colleagues (2011), who found that mothers who exclusively breastfed until six months had a strong belief that their bodies were

designed to breastfeed, believing it to be normal and natural. It was clear that some mothers in my study enjoyed the sensual, intimate relationship that developed with their growing confidence. What was especially apparent was that those mothers who portrayed a 'giving' approach to mothering and breastfeeding, came to terms with the relentless feeding, accepted it as a 'new normal' and stopped 'fighting the battle'. By going with the rhythm, for example, they realised that they needed to '*relax…[because] in the evenings I sit and feed, that's what I do'* (Vicky5) (6.2.2). Indeed, the mothers who decided to *' give up something to serve another '* (Rosie5) and trusted that they had the capacity to breastfeed, were noticeably more relaxed and appeared to benefit from a reciprocal relationship that was developing with their babies through breastfeeding (6.3.2).

Conversely, some mothers became more ambivalent about the relational, child-centred, embodied aspects of breastfeeding during the course of their trajectory, and never moved beyond finding it 'incessant, time consuming, intruding, painful, exhausting, draining and emotional' (6.2.2). It seemed that these mothers were trying to get back to how they were before and could not accept a 'new normal', being unprepared for the huge change with a new baby in their lives. Tracey, for example, said no one had prepared her for the relentless feeding in the early days. Subsequently, she used powerful metaphors involving a '*milk fiend'* and '*being infested'* to describe her desperate feelings. The images did not represent 'giving' or a picture of a reciprocal relationship, but rather conjured up images of being a victim of consumption, invasion and robbery. Her facial expressions also portrayed pain, stress and exhaustion. These strong feelings have been described in studies before, with a "disembodied" experience of breastfeeding being labelled by mothers as a "battle ground", "a fight", "an intrusion", being "suck(ed) dry", "devourment', and their baby perceived as a "rotten sucking little leech" and an "uncivilised creature" (Schmied and Barclay 1999, p. 331). The strong feelings described by Tracey about "*losing my mind*" and feeling "*proper disorientated*" have also been identified in a longitudinal study by Maclean (1989, p. 364–5) exploring the psychosocial factors of 100

participants who were interviewed 12 times between birth and six months. My study highlighted that, despite a plethora of studies over the past quarter-century, mothers still feel like victims, with something being taken (robbed) from them.

8.3.4 Damned if you do and damned if you don't

Earle (2002, p. 212) reported that some mothers who chose to formula feed had already considered their identity and defended the decision not to breastfeed with an overwhelming feeling of wanting to restore "their identities as non-mothers". This was because they believed that breastfeeding was 'out of place' within contemporary culture due to the stigma which surrounds it (Earle 2002; Sheeshka et al. 2001). Stewart-Knox and colleagues (2003) using focus groups to explore pregnant women's perceptions of infant feeding agreed, but provided a more complex array of socio-cultural factors influencing women's choices including perceived restrictions to freedom and independence, social isolation, inadequate support and embarrassment to feed in front of others. Since I conducted the literature review for my research, I have noticed growing tensions portrayed in the UK media with increased exposure of women's breasts as sexual objects (Dykes 2007; Hawkins and Heard 2001; Mahon-Daly and Andrews 2002; Palmer 2009), and increased marginalisation of women breastfeeding in public, fuelling mothers' anxieties further (BBC 2014; Carter 2015; Simpson 2014). Sarah voiced her concerns about the marginalisation of breastfeeding mothers seen on Facebook, and concluded that most people find breastfeeding in public taboo.

Legislation in England states that anyone treating a woman unfavourably because she is breastfeeding in a public place can be charged with sex discrimination (Equality and Human Rights Commission 2010b). Yet, "there is no statutory right for workers to take time off to breastfeed" (Equality and Human Rights Commission 2010a) and mothers are still banned from breastfeeding in the Chamber of the House of Commons or in Committee sessions (Sear and Miller 2003). With these mixed messages, it is not surprising that mothers in this study also felt embarrassed and *'out of place'* (Sam1) when breastfeeding in front

of others, for part, if not all of the time. As in previous studies, these intense sensations did not stop them breastfeeding, but it did cause them all to re-evaluate how to 'manage' breastfeeding within different socio-cultural contexts, with some choosing to express and use a bottle, (also reported by Johnson et al. 2009; Ryan et al. 2010) and others working out how to be discreet to protect their own modesty or to save others from being embarrassed (also reported by Sheeshka et al. 2001; Stearns 1999). This 'management' of breastfeeding was discussed regularly within diary entries, demonstrating the frequent appraisal and re-appraisal of their individual 'public and private' identities and how they perceived they might be judged by others within each socio-cultural context. Douglas (2010) also found that mothers felt damned if they didn't breastfeed, as it didn't fit into the 'good mother' ideology, but damned if they showed their breasts 'in public' because they were seen as deviant. Sam, for example, preferred to be seen feeding her baby in public with a bottle rather than feeling the humiliation of exposing her breasts, while Sarah did not like to use a bottle of expressed breastmilk in the peer support group for fear of being judged for not breastfeeding. Tracey felt confined to a private space, mostly home, causing extreme feelings of isolation and loneliness, and Vicky, Rosie and Sarah became practiced at how and who they could share their breastfeeding experience with, gaining confidence at being discreet over time.

8.4 Breastfeeding consumerism

Findings suggested that as mothers 'worked out' how to negotiate and manage breastfeeding they searched out information and equipment that would assist them in their '*state of flux'* (6.2.9/7.4). This study demonstrated the extent of the use of paraphernalia offering important insights into how mothers were affected by the commercialisation and commodification of breastfeeding. This was demonstrated not just by the explicit data when mothers recorded themselves talking about books and websites, and demonstrating gadgets and clothes they had bought but also by what I observed when viewing the videos, such as the

frequency with which equipment was used. This provided an added dimension to the data that would not have been evident using written or audio-diaries.

8.4.1 Using the internet

Findings from this study suggest that the unforeseen relentless feeding made mothers vulnerable to outside influences as they sought to find instant solutions or to make sense of their unnerving experience on the internet and in books, rather than waiting to see members of the healthcare team who they felt had already been judgemental about their questions (6.2.9). It is important to remember that mothers in my study are of a generation that has grown with instant access to a smart phone, digital tablet or computer, so internet access was easy for all of the mothers. Studies have revealed that women take advantage of the immediate accessibility of health information using search engines on the internet, such as Google, during pregnancy (Larsson 2009) particularly when there is a lack of information provided by health services (Lagan et al. 2010; Lima-Pereira et al. 2012). In one study, 97% of 613 pregnant women from 24 countries over 12 weeks were found to have used search engines to access information about pregnancy, find support groups and shop online (Lagan et al. 2010). Hoddinott et al. (2010a) found that the internet answered a wider variety of parents' questions than the health service which was too prescriptive in its approach.

The internet is an unregulated source of information and there is no guarantee that people have the skills required to evaluate whether what they are reading is authentic, trustworthy, correct, valid or appropriate: this can result in erroneous decisions and poor outcomes (Lagan et al. 2010; Weber et al. 2010). The mothers in my study found information from a diverse range of websites including those sponsored by the industry. Only one mother (Tracey) suggested she was aware of the potential bias of the information she was viewing, which meant the rest might have been influenced to purchase products that were erroneously claiming to make breastfeeding easier. Shaikh and Scott (2005) evaluated 40

websites on breastfeeding in America and found that consumers most frequently used websites sponsored by commercial enterprises with a propensity to include advertisements on educational material, breastfeeding supplies and other items. Lima-Pereira (2012) found that almost 70% of the 135 participants trusted the information that they viewed even though they were more likely to use commercially sponsored websites than non-commercial. While one study deemed most of the content on the websites correct and conforming to the International Code of Marketing of Breast Milk Substitutes (Lima-Pereira et al. 2012), another study found that very few had all the information accurately presented (Shaikh and Scott 2005). Furthermore, there is little published evidence about the influence that marketing practices on commercial websites have on mothers' infant feeding choices and practice.

8.4.2 Commercialisation and commodification

This study demonstrated through visual and audio data the importance that mothers placed on expressing breastmilk using a pump and the early introduction of a bottle to the baby. Some mothers had already had their ideas about this rejected by the healthcare team, and so searched the internet to gain some understanding of the rationale and to find the right equipment to pursue their goal. Thomson and Dykes (2011) reported on health professionals' reluctance to share information about bottles, teats and nipple shields in an evaluation of the implementation of the UNICEF UK BFI standards in the community, despite mothers maintaining that these items were essential for breastfeeding. As a result these researchers warned that, when healthcare workers limit information, it can lead to misunderstanding and the potential misuse of equipment resulting in complete cessation of breastfeeding.

Corroborating other studies, introducing a bottle of expressed milk was seen as a way of managing the problems that occurred in the early days, such as painful nipples, mastitis and boosting a perceived inadequate milk supply but mainly to fulfil the craving for some freedom and independence (Buckley 2009; Johnson et

al. 2013; Win et al. 2006). This partly revolved around the need to work out the logistics in relation to returning to work or college (Payne and Nicholls 2010) and partly an altruistic drive to involve the father who also wanted to experience bonding through feeding his baby (Johnson et al. 2012; Ryan et al. 2010). These findings supported the growing discourse in the literature highlighting the dissonance between the 'reciprocal, instinctive, embodied' nature of breastfeeding and the mothers' imperative to control and manage the process to create some sort of 'routine' and 'freedom' in daily life (Avishai 2007; Dykes 2007; Johnson et al. 2012, 2013; Ryan et al. 2013). This is thought to have been fuelled by the medical model of infant feeding which started at the turn of the 20th century promoting strict schedules, feeding measurements and regular inspection of infant growth and development, the influence of which is still strong today (Apple 1987; Dykes 2002; Fisher 1985; Palmer 2009). This medicalised approach, apart from promoting formula milk, has objectified breastfeeding, focusing more on the benefits of breastmilk as a product than the process of breastfeeding (Burns et al. 2012; Dykes 2002) and breast pumps have been identified as commodities endorsing that approach (Van Esterik 1996).

Kirkham (2015) reminds us that commodities are marketed for financial gain in order that reinvestment of return can generate more commodities to feed into a constantly widening market. The market for commodities, however, is dependent on new 'needs' being identified (Kirkham 2015, p. 211). The medical model of infant feeding has provoked a technological approach to breastfeeding which has created the 'need' for commercial companies to produce, for example, the 'perfect' double pump which enables a mother to do virtually anything else but breastfeed her baby while expressing. In addition, the internet has provided mothers instant access for online shopping to purchase the commodity including next day delivery when required. Researchers have questioned the motives for the growing marketing in breast pumps by both manufacturers and agents of breast pump hire, realising the possibility of a hidden agenda behind their practice (Buckley 2009; Ryan et al. 2013). In America, it seems that the breast pump is

considered an essential piece of baby equipment that is bought along with the car seat and is included on antenatal checklists because of an assumption that every mother will use bottles (Buckley 2009). Pumping breastmilk is also becoming increasingly fashionable in the UK (Ryan et al. 2013). It is not surprising then that mothers in my study were enticed into the commercial world of breastfeeding when they went on the internet or spoke to friends. With catch phrases shared in their diaries from the equipment they had bought such as '*closer to nature'* (Sam8), and demonstrations in front of the camcorder promoting their chosen products and brands, they appeared convinced that they had found the best product and that it was essential for them for them.

Sheehan (2014) using a social semiotic approach examined adverts from leading brands of breast-pumps to identify marketing ploys and revealed implicit and explicit ideological issues targeted with each advert. Analysing the representational, interactional, compositional features of each advert, these authors suggested that women are lured into believing that breastfeeding itself is not necessary to give breastmilk, pumping can be more enjoyable than breastfeeding, offer time to relax, and that science and technology knows what is best for babies. Blum (1999, p. 53) demonstrated the power of advertising which promoted "disembodied mothering" in America, with ploys to encourage the breastfeeding mother back into the workplace. To gain a feeling for the experiences of the mothers in my study, I searched the internet, using the phrase '*expressing by pump"* in a search engine, which generated 14,300,000 results in 44 seconds. Images of the slim, well organised woman, using her 'hands free' pumping kit while engaged on a computer related to the "disembodied motherhood" that Blum (1999) proposed (7.3.2), but perhaps are very appealing to contemporary mothers who take on dual roles of "good mother" and "good worker" (Payne and Nicholls 2010, p. 1812) as in my study.

Douglas (2010, p. 123,128), in a theoretical discussion about women's rite of passage as breastfeeding mothers, argued that they are currently caught between the 'medicalisation of infant feeding' (2.5) and 'yummy mummy'

syndrome. The former results in women being hindered by biomedical surveillance as described above, triggering a mistrust of their own body's ability to breastfeed. The 'yummy mummy' syndrome is part of post-modernity which encourages mothers to become empowered and take control of the physical 'transfiguration' of their bodies, so that they become fit, healthy and 'gorgeous' with anything less considered a failure. Remarkably similar to Douglas' (2010) icon of the postmodern 'milkmother', Blum (1999, p. 58) warned that the breastfeeding 'Supermom' syndrome in America was the product of medicalisation combined with commercialisation of breastfeeding so that mothers expect to work and meet the standards of the 'yummy mummy'. The commodities on the internet promoting an 'easier' breastfeeding experience appealed to mothers in this study who required a balance of 'work, rest and play' (6.2.6). This included, for some, aspirations for 'supermum' status, multi-tasking, resuming social life and dressing up to go out (6.2.6) at the same time as trying to reduce the anxiety engendered by health service surveillance which leaves them feeling scrutinised and judged (7.2.2).

8.4.3 Creating a dilemma: Searching for a physiological alternative

Once expressing was underway, mothers needed to "train" their babies to take breastmilk from the bottle as well as from the breast (Payne and Nicholls 2010, p. 1815). This caused tensions between introducing a bottle before it was too late because of a fear that rejection later would stifle independence and freedom, and a fear of nipple/teat confusion (Neifert et al. 1995). The conflicting opinions about nipple/teat confusion and giving breastmilk in a bottle have caused much debate in the literature (Hargreaves and Harris 2009) although it is one of the main rationales underpinning step 9 of UNICEF Baby Friendly Hospital Initiative (WHO 1998) which prohibits the use of teats or dummies for breastfed infants. Seemingly, commercial companies have used the apparent 'need' (Kirkham 2015) to create an array of teats specially designed for the breastfeeding baby which according to Hilton (2011) have been developed as a result of research using ultrasonography to view babies' suckling at the breast. The conflicting

opinions to which mothers were exposed, including vicarious experience from friends and family, scientific evidence from health professionals or books, and commercial advertising on the internet caused much debate in the video diaries. When mothers were searching for the 'perfect' solution to prevent nipple/teat confusion, the commercial websites apparently reassured them that they had the answer and mothers enjoyed showing the camcorder the latest technology in design of bottles and teats (6.2.9).

8.4.4 At whose expense?

Applying Kirkham's (2015) description of commodification further, it became apparent from the video diaries that commercial companies have sought to use breastfeeding and some of its perceived challenges for their commercial gain. Leaving breast pumps and bottles aside, mothers presented a wide range of different commodities that were considered indispensable to their breastfeeding experience (6.2.9)**.** This array of specialised equipment has also been highlighted in an American study interviewing 25 first-time mothers from privileged backgrounds who were thought to have a greater chance of continuing breastfeeding (Avishai 2011). Indeed, likening it to a "project", Avishai (2011, p. 27) highlighted the expensive obsession women had for buying the latest gadget. My study did not involve parents on very high incomes and yet the trend for buying breastfeeding related paraphernalia was evident. Kirkham (2015) highlighted the exploits of commercial companies to lure, through advertising, new mothers who can least afford to buy their commodities, because of the apparent 'need' for the new baby to fit into contemporary lifestyle choices. Consequently these companies, by clever marketing that suggests that everything can be fixed at a price, have monopolised the way contemporary mothers think of themselves, create new identities and manage their breastfeeding experiences. Selecting four examples from the findings of this study, ('breastfeeding in public', 'breast support', 'leaking breastmilk', 'relentless feeding and the unsettled baby'), I will discuss how commodification impacted on

mothers' experiences without them realising it, including the potential issues that could undermine their confidence in breastfeeding.

Breastfeeding in public was one of the challenges that some mothers faced in this study as they were embarrassed and felt '*out of place'* (Sam1). This need has resulted in commercial companies marketing specially designed bras and clothes like the top Rosie bought designed for the "conscious…with a wraparound front and practical inner top to make nursing easier" (H&M 2015). Of all the five mothers Rosie was the least concerned about breastfeeding in public, but nevertheless bought one of these. In addition, breastfeeding covers, called "udder covers*"*, originating in America and have been designed to help mothers feel "chic and stylish" by "enjoy[ing] nursing their baby in public and in fashion" (Udder Covers 2015). This terminology from a website selling a cover for similar reasons to that demonstrated by Sarah, may be considered a form of black humour by some but emphasises the paradox faced by breastfeeding mothers. There is a moral imperative to breastfeed, but alongside a pressure to maintain a 'yummy mummy' appearance to conceal the 'animalistic' natural function of their maternal body.

Buying bras was also found to be complex and confusing in my study because, once the baby was born, shopping was more difficult and the internet overwhelming with too much choice. With humour, Rosie disregarded the models that she saw online that didn't '*remotely look like nursing mothers'* (Rosie1). I would argue that advertising very cleverly reinforces the 'modern' discourse moulding mothers' desires to become 'yummy mummy' models and offering solutions for unrealistic and uncomfortable aspirations which seriously undermine mothers' confidence. This has the potential to fuel guilt and failure when mothers are not conforming to what they think are the standards set by society.

Leaking breastmilk is another breastfeeding 'problem' that companies have used to create a commercial 'need'. Concurring with previous research, mothers in my study found leaking breastmilk annoying, embarrassing, awkward or

uncomfortable (Britton 1998; Maclean 1989; Schmied and Barclay 1999) especially when it was prolific. Hence various commodities were shown / discussed on video to manage the problem. Whilst my study highlighted the uncontrollable, neuro-hormonal, humorous and private nature of the let-down reflex, with 'spraying' and 'leaking' of breastmilk witnessed on camcorder, it also highlighted the embarrassment mothers felt, and hence trying hard to hide the evidence from the gaze of others. Mothers promoted different brands not just for comfort, but as Battersby (2007) suggested to conceal leaking milk so that they were not embarrassed or judged as dirty or offensive.

Relentless breastfeeding and an unsettled baby were interlinked. In addition to breast pumps and special bottles and teats, commercial companies have developed an array of commodities that mothers are lured into thinking they will not be able to cope without. This study illuminated the way mothers bought and used some of the commodities aimed at settling their baby, providing valuable insights into their differing parenting styles and how this affected their breastfeeding experience. Some mothers for example, took pride in filming their babies asleep in rocking or vibrating chairs, which are promoted on the internet as "…ideal for snooze time…gentle vibration function to sooth and relax" (Mamas and Papas 2015). Mothers who were exhausted invested in these commodities to gain some 'space' from their baby. It could be argued that if the 'promise' was fulfilled, their babies would have slept for longer and feeding cues might have been missed, potentially undermining the natural physiology of lactation which is dependent on responding to baby's early feeding cues and frequent feeding. In contrast, commercial companies have also recognised that 'baby wearing' for the "*busy mum"* is becoming a popular method to "keep your baby close and nurture him…in an instinctive, natural way" (Natural Mothering 2015). Following an "attachment mothering approach" (Sears and Sears 2001), Rosie mostly recorded herself either feeding or 'baby wearing' at the same time as multitasking, and could not understand why slings were not recommended for all mothers. Evidence suggests that breastfed babies carried in slings are less likely

to cry and more likely to gain weight (Hunziker and Barr 1986). Arguably, using a sling embraced the 'supermum' syndrome but keeping baby close enhanced the neuro-hormonal response and the maintenance of lactation. However, the use of slings is contentious; the Department of Health's (2011) 'Off to the Best Start Leaflet' still shows a picture of the way Rosie used her sling initially despite no longer being recommended because of serious health risks (Infant Sleep Information Source 2015).

Another commodity that has been developed to address mothers' 'need' to cope with 'relentless breastfeeding and their unsettled baby' is parenting manuals. My study demonstrated both the enhancing and damaging effect that parenting manuals had on mothers' self-confidence and faith in breastfeeding. Avishai (2011) highlighted a similar issue when pregnant women sought expert opinion by reading numerous books in readiness for breastfeeding which made them anxious when they became breastfeeding mothers. In the UK, parenting manuals have become well known, on the one hand, for their support of breastfeeding by encouraging a responsive approach to parenting thereby enhancing the physiology of lactation (Wiessinger et al. 2010) and, on the other hand, prescribing a regimented style of structure and scheduled feeding (Ford 2006) with the potential to undermine physiology (Ogbuehi and Powell 2015). Schmied and colleagues (2001) also highlighted this conflicting advice for mothers; to recognise the need to be continually with their baby for breastfeeding and yet to gain space away so that motherhood is not all consuming. Like the internet there is no regulation of the information presented in books. While many parents are aware by reading the foreword what stance the authors take, and thus can avoid or put off reading a book, this study showed that when mothers became exhausted and desperate they searched for alternative solutions to their problems. Like Thomson and Dykes' evaluation (2011), mothers sought to make sense of their experiences from a range of sources, and when there was inconsistency between them it was unnerving.

8.5 The biomedical approach to support: It's not working

Mothers in this study were caught up in the medicalisation of infant feeding by surveillance that at best reassured them that they were on the 'right track', but at worst sabotaged breastfeeding by being disrespectful, judgemental, and authoritarian. Schmied and colleagues (2011) undertaking a metasynthesis, analysed 31 studies mainly from the UK and USA, to examine mothers' perceptions and experiences of professional and peer support for breastfeeding. These researchers proposed that:

> "support for breastfeeding occurs along a continuum from authentic presence at one end, perceived as effective support, to disconnected encounters at the other, perceived as ineffective and counterproductive" (Schmied et al. 2011, p. 51)

The findings from my study concurred with this metasynthesis. Although all mothers felt they were under surveillance, there was a wide spectrum of support experienced. Some mothers talked about valuing healthcare workers who had provided support in real-time, someone whom they could trust and who could provide time and space to listen and empathise with their concerns and answer their questions in non-judgemental and meaningful ways (Hoddinott and Pill 2000). Rosie, in her first week after a home birth gave an example of this when a 'midwifery support worker' provided one-to-one support by observing a feed and providing positive affirmation. Hoddinott and colleagues (2012, p. 8), undertaking a longitudinal qualitative study in Scotland, with four weekly interviews over the first six months, found that all participants believed that the most important moment for face-to-face support was following birth and were helped most by a professional "sitting through a feed" providing reassurance.

All mothers, however, talked about feeling scrutinised by members of the healthcare team at some point in their breastfeeding trajectory, with one mother feeling particularly victimised by authoritarian, didactic, disrespectful approaches that threatened to sabotage her breastfeeding. Furthermore, although mothers talked about the "authentic presence" and "facilitative style", there was more

emotional offloading as a result of the “disconnected encounters” and “reductionist approach” (Schmied et al. 2011, pp. 51–57). The findings from this study add important insights into how mothers’ feelings of being judged or scrutinised impacted on their own communication with healthcare workers. These findings also offer an important contribution to existing research about the impact that effective and ineffective support has on mothers on a day-to-day basis over the first few weeks.

8.5.1 Off track: disconnected relationships

Mothers became keen critics, discussing individual members of the ‘surveillance team’, evaluating their practice in a measured way. It was noticeable that although mothers talked about valuing the opportunities for reciprocal relationships built on trust (7.2.1), there were relatively few examples of how and when this occurred. Indeed, although they spoke frequently about being reassured that their baby was ‘*on the right track’* because of weight gain, these were brief encounters and related more to the biomedical approach of support that is frequently described in the literature (Burns et al. 2010; Dykes 2002; Ryan and Grace 2001; Sachs et al. 2006). It appeared that mothers were fixated by numerical values in relation to weight, rather than seeing and believing that their baby was thriving through the relational side of breastfeeding as well. This has been reported in previous research, with health professionals and mothers considering weight plotted on growth centile charts to be an important indicator of wellbeing and development (Sachs et al. 2006).

Schmied and colleagues (2011, pp. 51–53) discussed the importance of providing “an authentic presence” and using a “facilitative style” to support breastfeeding mothers effectively. To use these approaches, members of the healthcare team embrace a two-way relationship, taking time to find out what is important to mothers and to observe a feed, helping them feel relaxed, providing positive and sensitive affirmation and encouragement, sharing personal experience, including realistic information and practical support. Schmied and

colleagues (2008, p. 101) in an action research study to improve care on the postnatal ward, highlighted how midwives, reviewing the evidence themselves, recognised the importance of “building a trusting relationship with the woman and focusing on their individual needs” involving active listening. Putting this into practice, with dedicated “one-to-one time” for 20-30 minutes, was difficult to achieve (Schmied et al. 2009, p. 1858). With most mothers receiving less than ten minutes, midwife/woman interaction was not enhanced, and there were no significant improvements in breastfeeding outcomes. Marshall and Godfrey (2011) observed health professionals in the community setting using different communication strategies in a concerted effort to find out mothers’ concerns about breastfeeding and to offer individualised information that would be meaningful to them. Hunter (2006), exploring how community midwives manage emotion in their work using an ethnographic approach, observed the development of the midwife-woman relationship from a different perspective. She recognised that the quality of relationship was not necessarily attributed to midwives’ personal characteristics but rather to whether there was reciprocity between woman and midwife, with an even balance of “give and take” within their communication (Hunter 2006, p. 315).

Mothers in my study felt scrutinised and surveyed and were in fear of being judged by health professionals. They developed strategies to minimise the prospect of this occurring. Feeling afraid and being constantly on guard meant that mothers deliberately gave the impression that they were coping and did not share their worries or concerns. According to Hunter (2006), not sharing in this way could have produced imbalanced exchanges between mother and midwife, reducing reciprocity, so that the health professional was not able to support the mother effectively. Another strategy was to agree to follow advice to create a good impression but then to ignore it, following significant others’ advice instead. Similar behaviour has been reported elsewhere (Andrews and Knaak 2013; Hoddinott et al. 2012). Spencer at al. (2015, p. 1082) exploring 22 mothers’ experiences of breastfeeding, using interviews, also found that mothers created

“illusions of compliance”. Indeed agreeing with Spencer et al. (2015), my study found mothers choosing not to take health professionals’ advice to suit their own practical needs, creating an illusion of confidence and competence in breastfeeding, creating impressions of being ‘supermum’ and not asking for support when they needed it for fear of judgment or criticism. From the health professionals’ perspective, a reciprocal relationship might have been difficult to achieve if mothers were not prepared to “give and take” with open and honest communication (Hunter 2008). Spencer (2015) and Hunter (2006) both agree that working in partnership with women is necessary to provide individualised care, but Hunter (2006) recognised this as a complex issue. The findings from my study concur, and suggest that complex communication issues arising from a fear of being judged by health professionals have been in existence in the UK for over a century (Carter 1995).

8.5.2 Scrutiny and sabotage: Authority, control and disrespect

The breastfeeding-centred rather than person-centred approach to care characterised the medicalised scrutiny that mothers experienced in hospital. Barclay and colleagues (2012), examining support for breastfeeding women in Australia, recognised that mothers have come to believe that breastfeeding is so technical that it cannot be achieved without professional support. While Sam said that nobody had seen her feed her baby in hospital or offered any support for breastfeeding, Tracey was particularly incensed by the controlling attitudes of staff and the obsession with breastfeeding rather than with her overall wellbeing.

The medical model of care within midwifery has become an established approach that “prevents, manages and controls risk or risky situations” to avoid untoward incidences and litigation (MacKenzie Bryers and van Teijlingen 2010, p. 488). Application of this medical model in hospital, ‘allowed’ the healthcare team to control and manage breastfeeding using excessive monitoring to ensure safety and minimise risk of morbidity by intervening early with ‘hands on’ support. The medicalised approach where women’s breasts were treated as parts of a

machine was noticed by Burns and colleagues (2013) observing midwife/woman interactions in hospital and at home in the first postnatal week. Women's quiet compliance to the 'hands on' approach was in direct contrast to the surprise regarding lack of consent and dislike of this corporal invasion expressed later at interview. This medicalised approach ignores evidence that supports infant self-attachment which promotes wellbeing in both mother and baby (Bergman 2013; Smillie 2013) including self-efficacy in the mother (Glover and Wiessinger 2013; Thomson and Dykes 2011; Weimers et al. 2006). Health professionals' attitudes have been widely reported as impacting on mothers' experiences of breastfeeding (Bernaix 2000; Ekström et al. 2005; Gilmour et al. 2009; Palmér et al. 2012, 2015). When mothers felt they were forced to endure 'hands on support' in hospital, as in the case of Sarah, they felt unable to refuse because they were already feeling vulnerable thinking they were incompetent, or their baby incapable of feeding or both. In addition, feelings of humiliation, intimidation and insecurity were particularly triggered when mothers felt forced to expose their breasts for healthcare workers or peer supporters to watch feeding. Palmér and colleagues (2012) interviewed eight mothers with severe breastfeeding difficulties and reported very similar feelings.

The risk averse medicalised approach to breastfeeding support which was found in my study to be prescriptive, contradictory, authoritarian, and disrespectful both in and out of hospital was consistent with international research studies analysed in two meta-syntheses (Beake et al. 2012; Burns et al. 2010) and additional evidence published since (Hoddinott et al. 2012; Palmér et al. 2012; Spencer et al. 2015). Applying the same medical model in the community setting meant that many encounters with the healthcare team revolved around attending clinics, weighing babies, and plotting measurements on graphs. This was not a reassuring process if a baby did not meet the expected norm and one mother in this study felt she had faced humiliation and degradation in public that showed a lack of dignity, respect and empathy. Parallels can be drawn between the Francis Report (2010), where communication and attitudes of nursing staff were

described by witnesses as ‘sharp’, ‘surly,’ ‘unsympathetic’, ‘dismissive and rude’, and the authoritarian attitude of healthcare workers and the poor communication that Tracey described. The Department of Health (DOH) review of the ‘Dignity in Care Campaign’ (2009, p.6) defined dignity stating that:

> *“Dignity in care...means the kind of care, in any setting, which supports and promotes, and does not undermine, a person’s self-respect regardless of any difference.”*

Indeed, as part of the response to the Francis Report the “Compassion in Practice” campaign was launched promoting compassionate care that shows “empathy, respect and dignity” interpreted as “intelligent kindness” (DOH and NHS Commissioning Board 2012, p. 13).

This study, however, adds a further dimension to the growing body of evidence which suggests the biomedical approach has not been working, by offering valuable insights into the damaging and lasting effects of healthcare workers’ attitudes when they showed a lack of dignity and respect for mothers. The DOH review (2009) suggests that while it can be problematic to clearly define dignity, people are fully aware when they have not been treated with dignity and respect. In my study, when mothers felt they had been disrespected or they had received an inadequate standard of care, it impacted on them negatively, so that they turned the camcorder on many times, displaying a rollercoaster of emotions (7.2.2). The depth of emotion Tracey experienced wasn’t captured just once immediately after an event, but repeatedly on many days over a period of weeks and sometimes multiple times in one day. Discussing the use of anger when mothers were experiencing breastfeeding difficulties, Palmér et al. (2015) suggested that it depended how the mothers used their anger as to whether they continued breastfeeding. They suggested that when mothers were able to transfer the responsibility for their difficulties to others they were able to continue breastfeeding but if they blamed themselves they were more likely to give up. Hinsliff-Smith and colleagues (2014), using a combination of written diaries and interviews with 22 first-time mothers, highlighted the ongoing emotional

rollercoaster endured in the first six weeks following birth. While identifying discontent with health professionals' support, however, they did not attribute the emotional disturbance to them specifically, but to the mothers feeling ill prepared for frequent feeding, the unexpected realities of exhaustion and the guilt experienced when giving up. My study added to these findings with audio-visual evidence of how emotions expressed directly to or about the healthcare team fluctuated in strength over hours and days, either keeping their motivation going to breastfeed or teetering on the edge of losing '*the will to live'* (Tracey12), particularly when exposed to feelings of persistent scrutiny (7.2.2).

That conflicting information is given to mothers about breastfeeding has been widely reported (Fox et al. 2015; Graffy et al. 2005; Leeming et al. 2015; McInnes and Chambers 2008; Schmied et al. 2011). This study demonstrated the effect of conflicting advice and opinions on most participants as they verbalised their confusion and anxiety over several diary entries and tried to work out which 'route' to follow. Mixed messages demonstrating a leaning towards formula milk feeding rather than breastfeeding, and conflicting information about the use of growth charts, was particularly undermining. Tappin and colleagues (2006) using 3294 child health records in Glasgow to examine the influence of 146 health visitors on breastfeeding, found that mothers were twice as likely to give up breastfeeding if they had been supported by a health visitor who had not undertaken breastfeeding training in the previous two years. The WHO/UNICEF Ten Steps to Successful Breastfeeding (World Health Organization 1998) and the new UNICEF UK Baby Friendly Initiative Standards (2012b, p. 2) state that all staff must be educated "according to their role and the service provided". In my study parents needed consistent information. Scott, for example, emphasised the need in hospital for '*one way that's taught and one way only'*. Providing consistency, however, did not mean a prescriptive authoritarian approach. Mothers expressed their need to offload their concerns and be listened to with time, respect, support and positive affirmation to help them work out their issues and to move on (7.2.1). The current medicalised approach to infant feeding

support was not able to provide that, as demonstrated by some health care workers that mothers encountered in my study. The evidence from Thomson and Dykes' (2011) study, which is consistent with this research, has also been used to underpin the updated UNICEF UK BFI standards (Entwistle 2013, p. 79) which require supporters of breastfeeding to adopt "relation-based support" discussed previously. I would argue that this cannot occur through the training of a healthcare team alone but needs a radical approach that destabilises the medicalised, risk averse, time-pressured focus on care.

8.5.3 An alternative to the biomedical approach: Family & friends?

Support offered by family and friends was another predicament because there were also conflicting opinions to deal with and their advice did not always correspond with the information provided by the health service. Not unlike other studies, family and friends, including partners, were mostly concerned with the health and wellbeing of mother and baby (Hoddinott et al. 2012), however, the way they offered support depended very much on the value they themselves placed on breastfeeding. This meant that when significant others had faith in breastfeeding, mothers were more likely to feel nurtured themselves and that increased confidence, whereas when significant others were ambivalent about breastfeeding, mothers received less constructive support, felt lonelier, lost confidence in themselves and doubted whether breastfeeding was 'working'.

Mothers discussed changes in their relationships with family members, especially when support given did not match their expectations and understanding of breastfeeding. In fact family members and friends sometimes adhered to the medical model themselves. The dilemmas of working out how to deal with these tensions were 'secretly' shared within their diaries. Lavender and colleagues (2006, p. 153), using a multi-method approach with women and their families, found that family members appeared to "overtly or covertly" undermine breastfeeding despite having said they were supportive of it. Reid and colleagues (2010), interviewing 11 grandmothers, highlighted that despite them being an

important part of the mothers' social network, they felt tensions when offering breastfeeding support because ideals were different. Fox and colleagues (2015), undertaking a qualitative study using focus groups and interviews involving 51 mothers and 18 with babies over six months old, found that even supportive family members became less enthusiastic and encouraging as time progressed, particularly at vulnerable points in the breastfeeding trajectory. While none of the mothers in my study collected data beyond 20 weeks, the findings strongly support the argument that the healthcare team needs to work much more closely with families, especially partners and significant others to discuss practical approaches to support and instilling confidence in mothers. Strategies could include couples spending quality time together that embraces breastfeeding, and how fathers engaging without the need to give a bottle, such as skin-to-skin time. Indeed my study concurs with other studies suggesting that health service support should offer opportunities for conversations with significant others about all aspects of infant feeding including the relational side and coping strategies.

The findings from my study suggested that breastfeeding support from close family members lasted for a short while before everyone else returned to their 'normal' lives. Mothers became particularly vulnerable at these points and sought company from previous friendships. These have been called pivotal points by other researchers, being recognised as times when mothers need additional support (Fox et al. 2015; Hoddinott et al. 2012). Those who had friends with experience of breastfeeding gained most helpful support, being able to text them both day and night. Applying findings from this study, I would argue that supporters from the health service need to work with mothers to develop their social networks to include experienced breastfeeding mothers to prevent feelings of isolation and to provide empathetic understanding and support. This could include peer support groups which have been found helpful in other studies (Alexander et al. 2002; Fox et al. 2015; Hoddinott et al. 2006). In my study, however, mothers only accessed them when they were having problems and were very apprehensive and afraid of being judged by experienced mothers that

they did not know, and they did not return. Mothers need to establish friendships or be able to meet breastfeeding mothers within these groups during pregnancy so that they can see breastfeeding happening in a positive light (Hoddinott et al. 2006) rather than waiting for ‘pivotal points’ afterwards.

Mothers were influenced more by women with previous breastfeeding experience than healthcare workers, particularly when they shared similar experiences or challenges and when their values about breastfeeding matched their own goals. This has been highlighted in previous research which found empathetic breastfeeding support from experienced family members or friends was particularly valuable when mothers are surrounded by bottle feeding images (Hoddinott et al. 2010a; Scott and Mostyn 2003). Brown and Lee (2011) recognised that mothers who exclusively breastfed beyond six months surrounded themselves with like-minded people to stave off criticism and to maintain their position as breastfeeding mothers. This study agreed that mothers were less likely to be swerved off track, by well-meaning relatives who were trying to encourage ‘balance’ back into daily life or the opinions of family members apparently determined to sabotage breastfeeding, when they did not feel isolated and had social contacts who supported their goals. These social contacts were not necessarily always face-to-face but included social networking like Facebook, texting and email. This suggests that further research needs to focus on evaluating how mothers can build social networks to include online chat rooms and Facebook groups.

8.6 The Video Diary Method: Strengths and limitations

This chapter started with discussions about how the camcorder was used by mothers to bring about therapeutic relief as they shared their experiences within their video diaries. This section looks at the strengths and weaknesses of video diaries from my perspective as a researcher.

8.6.1 Ethnographic stance: capturing the spontaneity of experience

That mothers were able to find the time to record on a daily basis within the mayhem of new motherhood renders the data unusual and particularly valuable. They did not seem constrained by the guidelines for keeping the video diary. Instead, as suggested by previous research, mothers controlled the extent of their involvement, selecting how and what to include in and out of the frame, and what they discussed and chose to leave out. Using Larkin & Jorgensen's words (2014, p. 373), mothers became "central agents of the data collection process'' using a range of approaches and styles to create their diaries. Sam, who recorded the least often, always prepared some notes before filming. Most of them managed to film each day including in their 'hour of need' to share something that was important to them and for some this was several times a day (4.5.4). This could have been because it was much easier to capture the full extent of what was occurring as it was happening rather than waiting for a quiet time to make a retrospective record which may not have happened until days later. For all other mothers, the spontaneity provided evidence of the impulsive nature of recording without any sense of planning or forethought. Dinsmore (1996) suggested that this was a particular strength of video diaries compared to written diaries, as it is virtually impossible to write when caught up in action. Thus written diaries are retrospective, relying on memory which could possibly be altered or sanitised by changing circumstances, whereas video diaries captured action as it was happening in the mothers' individual socio-cultural context and were more likely to be complete.

Similarly, Dowmunt (2001) suggested that teenage girls who recorded video diaries for Channel 4, also enjoyed recording spontaneously without being concerned with how they appeared on screen. This is congruent with findings in my study because mothers' appearances, in the way they dressed and presented themselves, often seemed to reflect the timing, changing priorities and spontaneity of filming (5.2.2). The video data therefore provided contextual detail that would not be evident from other diary methods, for example, Rosie grappling

with clothes as she breastfeeds. Telling us about it in an audio or written diary is one thing but witnessing on video, with her chin holding her layers up, as she peers over the bunched up clothes to latch her baby on, provided additional insights and depth into her ongoing problem. In contrast to written diaries, therefore, the video diaries provided concurrent visual data offering further insights into the ongoing nature of breastfeeding that have not been captured before.

8.6.2 Ethnographic stance: personifying the camcorder

Using an ethnographic stance and handing over the camcorder to mothers to record their daily experiences of breastfeeding enabled me to gain insights by a 'unique presence of being there' with women in each of their breastfeeding contexts. It was not like 'being there' as a 'fly on the wall' where I was an uninvited bystander or surveillance camera eaves dropping into the conversation, but more like 'being there' as a guest, invited to observe and to hear about some of the most embodied, intimate, emotional, troubled moments during their first few weeks of motherhood.

This 'invitation' was felt because mothers nearly always '*personified the camcorder'* having an audience in mind. Critics of video diaries have argued incongruity when they are produced for public viewing, believing that the true definition of a 'diary' is personal (Dinsmore 1996). As discussed previously, most of the time the mothers' perceived audience was me and I was named several times in their salutations (5.3.2/8.2). Their perceived 'imaginary' audience may also have included my research supervisors, named on the participant information leaflet, or an array of others as they had signed the 'future use of video diaries' form. When one mother directed rants to health professionals who had annoyed her, they were abruptly inserted between the usual conversations with me her diary entry. Noyes (2004) discussed the dichotomous public/private understanding of the camcorder where children in his research either considered the camera as a confidante, when they shared their innermost feelings and

emotions, or as an opportunity for performance where they could become famous to a much wider audience. In my study, the different ways that mothers built up a relationship with the camcorder suggested that they too shared this understanding. This added strength to this research because mothers could talk to 'imagined others' in a way that they might not do face-to-face. Thus, while there seems little doubt that mothers did initially record for the sole purpose of the research, the majority also made far longer and more frequent recordings than had been expected and continued recording well beyond the eight weeks at which the research proposal expected their feeding method to be established, probably highlighting the therapeutic benefit of recording and how they eventually weaned themselves away from the diary recordings as they developed confidence in their infant feeding method (8.2).

8.6.3 Ethnographic stance: Performances of the everyday

Today's generation are generally very familiar with the media culture of reality TV and the self-confessional element of programmes such as 'Big Brother' or 'I'm a celebrity, get me out of here' (Muir 2008). In these programmes a camcorder is set up in a secluded place for the programme's participants to speak privately and candidly about feelings, emotions and to reveal game strategies. Programme editors manipulate the footage to create an exciting programme full of revelations. As both Kindon (2003) and Bates (2013) found in their research, using technology in the form of a camcorder did not appear to deter mothers from talking within their diaries at great length.

Initially the word 'performance' used by many researchers using video diaries (Brown et al. 2010; Holliday 2007; Kindon 2003; Noyes 2004; Pini and Walkerdine 2011; Rees 2010) made me deliberate about the words and actions presented by mothers in my study. Were mothers putting on a 'façade' that I could not see beyond or were they so comfortable with the camcorder that they felt relaxed enough 'to be themselves'? Questioning the data in this way formed part of the analysis and helped me understand, as highlighted previously, that

mothers nearly always '*personified the camcorder'.* Some researchers have argued that whenever there is a perceived audience there is a performance (Gibson 2005; Pini and Walkerdine 2011; Rees 2010). Mothers in this research shared their experiences using their own unique styles or 'performances' within their diaries (5.3.1).

Applying the ethnographic stance that Bates (2013, p. 30) used, mothers took up a unique double role, as creators of their own video diaries and as participants within them, "both in front and behind the camcorder" producing representations of themselves as breastfeeding mothers within their own socio-cultural context. It was not expected that these diaries would record reality but rather capture mothers' multiple perspectives and performances of socio-cultural life with a breastfeeding baby. Pink (2003, p. 55) argued that research videos do not provide "realist representations of the everyday lives" of participants but "representations of themselves" as performed in front of a camcorder. In my study, handing over the camcorder and giving mothers control to self-direct their own video diaries empowered them to record, at the time, what they considered most important to share with me as the researcher or whoever else they felt they needed to talk to (8.2). The camcorder was not meant to be a surveillance camera capturing every move that the mothers made, but a tool which the mothers could deliberately use to create and share their experiences of breastfeeding. Pini and Walkerdine (2011) critiquing video diaries suggested that they are subjective performances that cannot be trusted to be authentic, providing an example of a family member putting on a 'posh' voice when she realised she was being filmed. While I did not experience this type of example, I would argue that capturing these snapshots of people's reactions to being filmed provided unique examples of the socio-cultural context of peoples' lives.

The range of styles of mothers' 'performances' in front of the camcorder was varied with chatty informal dialogue and occasional demonstrations, short planned 'reports', long reflective discourses, ranting shouts for help and tearful bouts of emotion (5.3.1). This was not dissimilar to what was found in a study by

Bates (2013) who used video diaries to explore the body, health and illness of people with long term physical or mental illness. It was, thus, important for me to reflexively consider if there were any consequences of mothers putting on a 'performance' for the camcorder. While Pink (2003) found that participants put on an act for the camera in her study where limited time was given to 40 participants to represent themselves in a video tour of their own home, in my study most mothers used the camcorder daily for some weeks and relaxed into using it as part of their daily life. Thus, whilst mothers had control over how to portray themselves and might have adopted a performance style for the camcorder as described above, they each appeared more relaxed after the first few days and began to 'let go' of their inhibitions (5.3.3/8.2). This meant that their 'performance' became less awkward and more natural, providing enhanced insights into how breastfeeding was experienced as part of their everyday social life. As discussed in 5.3.2/8.2, '*building a relationship with the camcorder'* was evident, and as mothers took ownership of their diary entries, they began to 'pour out their hearts' in unanticipated and spontaneous ways. Noyes (2004) also experienced normalising of the participant-camera relationship over time which meant that diary entries more closely reflected the participant's usual behaviour.

Family members included in conversations within diary entries provided valuable insights because distinct differences were noted between the mothers' 'performance' with someone present when they were buoyant and their 'performance' when they were on their own which was sometimes more reflective less positive, downhearted, angry or emotional. A similar finding has been noted in other research using video diaries where participants appeared to perform in an upbeat way in the company of others but once alone they adopted a more confessional approach sharing intimate information (Holliday 2007). Seemingly the influence of another's presence prevented the mothers opening up to the camcorder and thus perhaps the self-portrayal in front of a known 'other person' over-rode their capacity to be frank, providing additional evidence of the clandestine nature of the diary entries (5.3.2, 8.2.1).

Without any words from mothers, the performance and self-portrayal of breastfeeding in and out of the camcorder's shot provided valuable insights into their culture and beliefs about what is acceptable and not acceptable in front of the gaze of others, including the potential audience of the video diaries. Sometimes this was spontaneous because the baby was hungry during the course of filming but at other times breastfeeding was purposefully staged for the diary entry or perhaps they were simply fitting in filming when they were sitting down and feeding. Like research undertaken by Bates (2013), the control of how much body to expose was with the participant rather than the researcher and this was an important choice for them to make (8.6.1). Not all mothers allowed the camcorder to witness breastfeeding.

8.6.4 Ethnographic stance: The researcher's influence & perspective

Handing over control of the camcorder enabled mothers to make choices about how much to reveal about themselves, not just what experiences and emotions they were willing to divulge but also about their corporal image and their identities. The choices made consciously or subconsciously about what to reveal might have been informed by what they thought 'their audience' needed to hear or see but, as previously discussed (5.3.2/8.2/8.6.2), for some mothers their perceived audience changed within diary entries. Pini and Walkerdine (2011, p. 143), analysed a longitudinal study following British girls from four years old, using video diaries as a research method until they became young women. They argued strongly that the video diary process did not empower the participants to share an 'authentic…less mediated' representation of themselves because they always had an audience in mind. The authors alluded to possible reasons for this, perhaps because the underpinning aim of the project was for TV broadcasting and participants had become disenchanted about being watched intensely again at the age of 16 or 21 years. The influence of the "absent researcher" in the creation of video diaries has been discussed by Gibson (2005,p4) who recognised that participants focused their conversations around the researcher's interest. Gibson (2005) proposed that the actual process of providing a

camcorder for participants to film, meant that the researcher had an influence in 'co-producing' the diary. Mothers in this research study knew that I was a midwife and PhD student with a particular interest in researching mothers' experiences of breastfeeding.

It has been suggested in the literature that research methods which involve self-reporting are more susceptible to social desirability bias (Wasylkiw 2007). This can be provoked further if the researcher is a nurse which stirs up in the participants difficult memories of a previous experience, so that participants react in a way that creates a good impression in order to please (Collins et al. 2005). In addition, as identified in many studies, mothers taking part initially felt a 'moral obligation' to breastfeed. Collins and colleagues (2005) suggested that because the researcher sets the agenda for the study with aims and objectives, and because participants divulge intimate details about their lives with little reciprocity, a power imbalance remains evident. This was true in my study. I am a midwife, I set the aim of the study and there was minimal reciprocity as I was not present in the room when mothers recorded their diaries, only meeting them to collect data memory cards. Handing over the camcorder, however, appeared to reduce the power imbalance between researcher and participant, breaking down the hierarchical barriers that can sometimes exist when the researcher controls the research process, by asking specific questions and recording specific details. While this has also been highlighted by other researchers using participatory video (Brown et al. 2010; Pink 2001), it is important to recognise that all mothers received suggestions of what they might like to include (Appendix 7). Brown and colleagues (2010) noticed that once participants took control and ownership of their diary entries they used the research guidance less and increasingly valued the freedom to speak about issues that were important in their lives. Although only Sarah was seen to use this guidance to trigger her conversation, this collaborative video approach did encourage them to reveal their everyday realities of life with a breastfeeding baby (5.3.1), and once confident, all mothers relaxed into recording whatever was important to them. Thus providing the crib

list and video camcorder, I too have influenced the production of the video diaries, and in one sense co-created them with the mothers. It was important to recognise this influence and reflexively consider how my influence impacted on them when they turned on the camcorder, who they thought they were addressing, how they portrayed themselves and what they wanted to talk about to fulfil their needs and that of the research.

Mothers were shown how to use the camcorder to edit video recordings, so that film clips that they were unhappy about could be edited and removed. Several of participants involved in the 'Girls on Film' study erased all the data before handing the tape back, claiming they did not enjoy the video diary process and portraying a sense of defiance by the adolescent participants (Pini and Walkerdine 2011). In my study, all mothers chose not to edit their footage at all, believing that what they had recorded was a real-time record of their experiences. This lack of editing demonstrated confidence in their own 'performance' as it was, rather than a collection of data that had been recorded and reworked to meet their own expectations as a breastfeeding mother or for the expectations of me as the researcher. Providing data to be analysed for research, which had not been reworked, assured me that the mothers thought their diary entries recorded at the time, in their rawest form, to be essential.

Reliability was enhanced with good quality recording equipment (Creswell 2013), which enabled frequent viewing during the analysis process. Furthermore, I was able to view video footage with my research supervisors at each stage of the research process who asked questions about my methods, analysis and interpretations of the data (Creswell 2013) and checked the themes carefully to confirm that I had not over-represented some aspects of my data (Holloway and Wheeler 2002). Having three supervisors to review the research process enabled them to probe from different perspectives and ensure inter-subjectivity was involved, enhancing the research process.

8.6.5 Limitations

It is important to recognise the limitations of this study which presents interpretations of the data recorded in video diaries by five mothers in the South of England. These data may not be generalisable to the rest of the UK but my findings have been corroborated by and added depth to many international studies that have previously been undertaken using many different qualitative research methods. Additionally, my findings presented at international and local conferences have resonated with many delegates.

The sampling strategy that I used to invite women to participate using a letter distributed by community midwives, meant that I was reliant on them as 'gatekeepers' to protect potentially vulnerable women from volunteering without the capability of making informed consent. However, Sharkey and Aggergaard (2005) point out that gatekeepers are not neutral in the process as they can limit access to research participants and can be seen as an associate of the researcher. To limit this impact, I met with the community midwives to explain the research carefully and to ensure they understood my inclusion criteria and how to introduce the research to women with the letter. Recruitment was slow initially and hence I visited two parent education classes to briefly introduce the research personally to women. Once invited to participate in this study, recruitment was reliant on self-selection. All mothers that self-selected, apart from those that did not fit the inclusion criteria, were included. This sampling strategy therefore could mean that this sample of mothers may not have been typical of the population of new first time mothers and that I recruited only mothers who had a real determination to breastfeed. Additionally the Hawthorne effect (Rees 2011) from involvement in the study might have been the reason for the mothers to have continued breastfeeding for longer than might have been expected. There is evidence that most mothers in the UK give up breastfeeding before they intend to (McAndrew et al. 2012) and this was not the case for these mothers. These limitations mean that the findings may not be transferable to a wider population of new mothers. While all the mothers, however, expressed their own rationales for

breastfeeding and showed determination to continue, this did not mean that they breastfed trouble free and did not think about giving up breastfeeding during their breastfeeding trajectory. This study therefore adds to the growing body of evidence demonstrating the challenges mothers face on a daily basis.

Although the socio-economic groups were varied, all women were white British. This limitation partly reflected the population of the area in which the study took place, and was partly due to the sampling strategy which prevented the recruitment of non-English speaking participants because there were no resources to employ a translator. This is regretted and limits the transferability of findings to non-English speaking cultures and backgrounds.

The sampling strategy also limited recruitment to first time mothers since previous experience of breastfeeding could have influenced their subsequent perceptions and experiences of breastfeeding (Dennis 1999). This limits transferability of the findings to all breastfeeding mothers but does focus attention on those who have not breastfed before.

The ethnographic stance enabled me to gain insights into the socio-cultural context of breastfeeding from the mothers' perspectives. This, however, meant that I was totally reliant on them to produce data for me to analyse (Muir 2008), and they all used different approaches to create their diaries (Gibson 2005). While this could have been a limitation, the different approaches and different personalities, in fact, added an extra dimension and strength to the findings by providing wider perspectives on breastfeeding.

Selecting this single method of data collection meant that I had no formal way to immediately probe or question mothers further as I might have done in interviews. This was particularly relevant to non-verbal behaviour that was sometimes difficult to interpret (Buchwald et al. 2009). Viewing the data in-between data collection visits did, however, provide me with the opportunity to ask related questions if I was uncertain about my interpretations of the diary entries.

The video diaries produced a huge amount of multi-media data and researchers have warned of the time consuming nature (Cotton et al. 2010; Rich et al. 2000b) and potential of loss of a layer of data through transcription (Markle et al. 2011). Therefore, the entire dataset was analysed using NVivo, with selected transcriptions made for the purpose of illuminating the rich descriptions (Brown et al. 2010). One of the limitations with this approach is that any future secondary analysis will need to rely on NVivo as full transcriptions are not available. I have produced rich, thick descriptions, data quotations and still images to illustrate my analysis within the findings chapters. However, I agree with Holliday (2004a, p. 1607) that "intertextuality" is one of the limitations of this method of data collection and it is extremely difficult to capture the full richness of the video diaries in text within the word allowance of a thesis.

8.6.6 Reflexivity

My positioning as a researcher and any bias that I might bring to the research has already been highlighted (4.3). As suggested by Pink (2007), I used a reflexive approach throughout the whole research process which included being aware that although I wasn't present during mothers' video recordings, I was still implicit in the research study (Brown et al. 2010).

When viewing the video diaries, there was not just the 'performance' to watch, but the socio-cultural environment to absorb with colour, lighting, sounds, movement and ambience which in turn triggered other senses like touch, smells, feelings and emotions. Bates (2015, p. 10) suggested that the video method is best considered as:

> "a sensory method, not simply because it blends what we see with what we hear, but because it evokes a sense of feeling…"

Thus when coding, analysing and interpreting the data I was mindful that my interpretations added my 'voice over theirs' (Pocock et al. 2009, p. 411), which was influenced by my own personal and academic background. As a midwife and mother I could empathise with the sights, sound, smells and textures that were

presented and evoked. Mothers appearing exhausted in the darkness of the night or in bright daylight, yawning deep wide yawns caused me to yawn too. A mother fumbling while changing a soiled eco-friendly nappy or milk spraying as a baby suddenly loses attachment off the breast during a letdown of milk, evoked senses of smell and touch that I too have experienced. Babies screaming, mothers using constant movement by rocking and jiggling their babies to try and settle them aroused feelings of empathy within me. When mothers cried, I cried too, as I shared their anguish and pain. Indeed, sometimes the angry rants, though not directed at me personally, felt invasive. I could almost feel the spit on my face as it was unintentionally sprayed out with fury, and then I needed to walk away and gather my thoughts before watching the diary entry again. Thus, my experience as a mother and midwife enhanced the analysis process, because it meant that a multitude of senses were stimulated, tapping into a tacit knowledge, assisting in a corporeal, embodied interpretation of everyday life with a breastfeeding baby.

As mothers ‘poured out their hearts’, I sometimes felt ashamed and let down by my fellow health professionals and at other times I felt I wanted to rush in and help by providing advice as a midwife. When mothers recorded breastfeeding, it afforded me the opportunity of occasionally witnessing an inconsistency so that what I saw did not always match what the mother was describing in relation to breastfeeding. Vicky, for example, who had been prescribed antibiotics by her GP for mastitis did not always have Benjamin attached optimally, and yet she felt breastfeeding was going well. She blamed a bra strap for causing her mastitis but what I saw demonstrated a lack of understanding about other possible contributing factors. This suggested that the support offered had only been reactive and not proactive. Thus, I needed to return to my research protocol and ask questions about the aim of my research and my own identity and duty as research midwife (Ryan et al. 2011). As no further recurrence of mastitis was recorded in her diaries, my dilemma did not recur but had it been, I would have suggested further support.

Reflexivity has also required me to realise that while I write up this thesis the mothers and babies have moved on and yet I am stuck in time within their early weeks following birth.

9 Conclusion

9.1 Introduction

Concerns about the poor breastfeeding rates in the UK and my passion to enhance understanding about the day-to-day experiences of first-time breastfeeding mothers resulted in this exploration of the socio-cultural context of breastfeeding, the challenges mothers face and how they deal with these.

The ‘video diary’ method helped to share mothers’ experiences of breastfeeding in their own home environment.

While some findings from this study are consistent with international research, others offer new insights into mothers’ real-time experiences of breastfeeding on a daily basis. In addition, this study has enabled me to develop the video diary method as a research tool providing new insights into how it might be used to inform future research with childbearing women.

9.2 Original contributions to knowledge

An important finding is that mothers **continued recording their video diaries** for longer than first envisaged in my research proposal (4.5.1). Some might argue that this was because breastfeeding takes longer to establish than previous studies have suggested but I consider the more likely explanation to be that mothers enjoyed talking, even needed to talk about their experiences within their diaries.

9.2.1 Unique role of camcorder

The findings suggested that as mothers recorded their video diaries there was a therapeutic effect. This effect may have been greater than that suggested for other forms of qualitative research (Brown et al. 2010) because the camcorder, was totally under control of the participant and no researcher was present. The

camcorder acted as a confidante, a sounding board and as a potential motivator whenever and wherever the participant chose.

9.2.1.1 A confidante

The camcorder was used by mothers as a confidante and they valued time and space to offload their thoughts and feelings to someone they could trust other than family or friends. Clandestine in nature, mothers recorded their inner thoughts and feelings about life with a breastfeeding baby. The data highlighted the frequency, intensity, depth and lability of emotion that mothers experienced on a daily basis. Having access to the camcorder 24 hours a day empowered them to reveal issues important to them in real-time whenever they felt tension building up, with candid and sometimes outspoken ways of expressing their thoughts and feelings. Expressing emotions and venting frustration in real-time did not require a real-time listener, but still appeared to bring about a cathartic release. This helped mothers think more clearly, bringing about renewed strength to continue breastfeeding. The absence of a real-time listener might have assisted in the undisturbed outpouring of feeling and emotion.

9.2.1.2 A sounding board

Findings revealed the unique role of the camcorder as a sounding board as mothers attempted to come to terms with the unexpected challenges of breastfeeding. The video diary daily facilitated time and space to talk over why their baby was relentlessly feeding and to work out strategies for coping, including how to get back to ‘normal’. Using the camcorder emphasised the daily turmoil and isolation they felt when trying to work out their issues because they perceived there was inadequate support from healthcare workers.

9.2.1.3 A motivator

The data revealed the unique way mothers used the mirror image that they saw of themselves in the camcorder monitor to instigate natural conversations with themselves. The camcorder became a tool that facilitated deep personal reflection which triggered self-awareness and a renewed determination and

resilience to transform from a novice to an expert breastfeeding mother. This was evident from the sequential logging of the video diaries as well as the detailed analysis of them.

9.2.2 Evolving Identities

Findings from this study demonstrated new insights into the evolving nature of mothers' identities because of the frequent identity work that mothers undertook while reflecting within their video diaries. Deep personal reflection, self-awareness, an analysis of their new realities, and the potential for transformation occurred on a frequent basis as they worked out how to negotiate breastfeeding within their own socio-cultural context and develop a new identity as a breastfeeding mother. This was also evident through the ethnographic approach of observing and analysing the unique audio-visual elements together.

9.2.2.1 Early and ongoing moral obligation to take on multiple identities

Findings also offered new insights into how mothers' moral identity work began very early and evolved over time as they grappled with their ideals of what breastfeeding meant for them at the same time as attempting to re-establish a 'normal' life. Within days of giving birth an inner struggle became evident in all of them as they sought to identify what being a breastfeeding mother meant within society, comparing it to what they had been previously and the type of woman they wanted to be in the future. Particularly evident were the early and intense feelings about having a moral obligation to be a good mother alongside a moral obligation to be a good worker. While breastfeeding was often portrayed as hard work, there was little evidence of it being valued or regarded as real work. Whether mothers were expecting to return to paid work in the immediate future or not, they frequently agonised about how the two roles could co-exist, with breastfeeding being an important factor in their ruminations. The forward planning that mothers undertook frequently consumed their diary entries as they deliberated about how to control the time-consuming unpredictable nature of breastfeeding in the early days in order to establish a routine. This involved

planning, practising and evaluating the logistics of breastfeeding with going back to paid work, with frequent and ongoing moral identity work to reappraise their identities according to their needs and socio-cultural circumstances.

9.2.2.2 Embodiment captured by camcorder

Unique to this study was how the camcorder captured the diverse experiences of the embodied nature of breastfeeding on a daily basis, which permeated through to me as the ethnographic observer. The combination between the emotional outpourings which included candid accounts of how mothers were feeling about breastfeeding, alongside the visual representation, evoked a strong sense of being there. The analysis of the visual, alongside the audio data, highlighted the two extremes of embodiment. On the one hand, the visceral nature of breastfeeding involved a reciprocal relationship between mother and baby. On the other hand, the disembodied nature of breastfeeding (5.2.3/8.3.3) was evident in the tension, exhaustion and pain in mothers' faces. My interpretations of the audio-visual data revealed that those mothers who developed a giving approach to mothering and breastfeeding harmonised with the frequency and intensity of breastfeeding, bringing about a reciprocal benefit for both mother and baby. Conversely, those who were preoccupied and resented the time-consuming, unpredictable nature of breastfeeding felt they were fighting a never ending battle, which brought disorientation and discontentment so that they felt robbed of self, both physically and emotionally.

9.2.2.3 The good mother: mixed messages

This study illuminated the frequent and ongoing distress and anxiety caused by the mixed messages portrayed in the media with the 'good mother' ideology promoting breastfeeding and the 'deviant mother' being one who breastfed in public. Already feeling embarrassed and out of place, mothers demonstrated the frequent and ongoing appraisal and reappraisal of their individual 'public and private' identities. This meant that each mother managed breastfeeding in a different way depending on how she perceived she might be judged by others in

her socio-cultural context. For one mother this management of breastfeeding in front of others resulted in extreme feelings of isolation and loneliness.

9.2.3 Consumerism and commodification

Mothers needed to find solutions for their unexpected challenges and to negotiate breastfeeding within their particular socio-cultural context. They searched out information and equipment to assist them in their state of flux (6.2.9/7.4). The audio-visual data demonstrated the extent to which the accoutrements were used, offering new insights into how advertising lured mothers into thinking that they were dependent on specialist equipment to cope. The audio-visual data provided valuable insights into the parenting styles that mothers adopted and how this affected their breastfeeding experience.

9.2.3.1 Commercialisation of breastfeeding on the internet

The data highlighted the frequent need mothers felt to use the internet if they did not get queries answered by healthcare workers or they needed to work out how to manage the unforeseen challenges of relentless feeding. When mothers felt insecure about the frequency of breastfeeding they were most vulnerable to outside influences including the commercial world of breastfeeding on the internet.

9.2.3.2 Breastfeeding paraphernalia

Consistent with international research, this study highlighted the importance that mothers placed on expressing breastmilk and introducing a bottle as a way of managing problems in the early days. This was to fulfil their craving for freedom and independence and involve the father who wanted to experience bonding through feeding. Adding to the literature, this study provided evidence that advertising influenced mothers' decisions related to such paraphernalia.

9.2.3.3 The undermining nature of commodification

Searching the internet exposed mothers to commodities promoting the 'yummy mummy', with an emphasis to look stylish and to cover up all visible signs of

breastfeeding. These generated unrealistic expectations in mothers, with the potential to fuel guilt and failure when they felt they were not conforming to their own socio-cultural standards. When exhausted, mothers invested in commodities that had the potential to undermine their breastfeeding by promoting separation from their baby and 'buy in' to the 'supermum' culture, causing further exhaustion and feelings of failure.

Parenting manuals could damage a mother's self-confidence and faith in breastfeeding, particularly when she was at pivotal points in her breastfeeding trajectory, such as experiencing unexpected feeding patterns. At these points mothers were particularly vulnerable to reading literature that could seriously undermine the physiology of lactation.

9.2.4 The biomedical approach is not working

The findings from this study were consistent with other studies suggesting that mothers were caught up in medicalised surveillance. At best this reassured mothers that they were on the right track but at worst it sabotaged breastfeeding because mothers felt victimised by the perceived authoritarian, didactic, disrespectful approaches used by some healthcare workers.

9.2.4.1 Off track; disconnected relationships

When mothers felt judged or scrutinised, their communication with the healthcare team was affected. This meant that mothers did not always engage in a reciprocal relationship with staff by sharing concerns, thoughts and feelings with them. This suggests that healthcare workers need to be aware that a reciprocal relationship between them and mothers will not develop while mothers feel they are being judged or scrutinised.

9.2.4.2 Scrutiny and sabotage

There were damaging and lasting effects on mothers if healthcare workers were felt to have treated them with a lack of dignity and respect. This was demonstrated through the audio-visual data, which provided evidence of a

roller-coaster of emotions that were expressed daily and sometimes more frequently, as a direct result of encountering healthcare staff who used ‘hands on’ support to assist with attachment, insisted on exposing breasts for observation or humiliated mothers in front of others. The current medicalised approach to support did not provide the consistency, time, respect, support and positive affirmation that mothers needed, leaving them feeling confused, anxious and isolated. If peer support groups had not been accessed in pregnancy they were found to be daunting by mothers with breastfeeding problems, so that they did not return for fear of being judged by other more experienced breastfeeding mothers.

9.2.4.3 Seeking solace with the familiar: friends and family

Consistent with other research, findings highlighted that when partners and family members had faith in breastfeeding, mothers were more likely to be nurtured with positive affirmation which increased confidence. Conversely, when partners were ambivalent about breastfeeding, mothers received less constructive support, felt lonelier and lost confidence and consequently started doubting whether breastfeeding was working. Mothers who accessed friends and family with experience of breastfeeding increased their confidence and faith in breastfeeding. Mothers whose social networks solely included friends who had formula milk fed felt lonely and less confident in breastfeeding. These mothers were more likely to be steered off track by well-meaning relatives who tried to encourage a ‘balance’ back into daily life or the opinions of family members apparently determined to sabotage breastfeeding.

9.2.5 The video diary as a research method

The video diary method brought strengths and limitations to this research as outlined in 8.6.

9.2.5.1 Capturing spontaneity of experience

The data produced by mothers, within their video diaries, were particularly valuable having been recorded almost daily over many weeks. The impulsive nature of recording was evident as mothers turned the camcorder on, in the

spontaneity of the moment, to share what was important to them, often capturing action as it was happening. This offered fresh insights into breastfeeding within the mothers' lives.

9.2.5.2 Unique presence of being there: Personifying the camcorder

Using an ethnographic stance and handing over the camcorder to mothers to record their daily experiences of breastfeeding enabled a unique presence of being there as an invited guest to observe and to hear about some of the most embodied, intimate, emotional, and both joyful and troubled moments during their first few weeks of motherhood (5.2.3/8.6.1/8.6.2). This invitation was felt because, although I was absent, mothers nearly always personified the camcorder, talking with an audience in mind, which was usually me, as the researcher. The camcorder was also used as a tool to rant at other people who had annoyed or upset them, providing additional insights into the socio-cultural challenges mothers faced in the early weeks.

9.2.5.3 Performances of the everyday

New to research about breastfeeding, mothers took up a unique dual role, as creators of their own video diaries and as participants within them, to deliberately create and share their real-time experiences of breastfeeding, including multiple perspectives and performances of socio-cultural life with a breastfeeding baby. Mothers used a range of performance styles with chatty informal dialogues and occasional demonstrations, short planned reports, long reflective discourses, ranting shouts for help and tearful bouts of emotion. As mothers became accustomed to recording, they built a relationship with the camcorder so that their performance style relaxed and they began to offload, pouring out their hearts in unanticipated and spontaneous ways. Mothers' diary entries when recorded alone were more reflective, candid, and emotional than when recorded in the company of others, providing evidence of the clandestine nature of some of the recordings. The performance of breastfeeding in and out of the camcorder's shot provided valuable insights into their culture and beliefs about what is acceptable in front of the gaze of others, including the potential audience of the video diaries.

9.2.5.4 Researcher's influence

Handing over control of the camcorder enabled mothers to make choices about how much they wanted to reveal about themselves which might have been informed by what they thought their audience needed to hear or see. Having guidance suggesting what they might like to include in their diaries meant that in one sense I co-created them with the mothers, but as mothers relaxed into recording, they revealed personal issues in their everyday realities of life with a breastfeeding baby.

9.3 Recommendations

This study has resulted in a number of recommendations for practice (9.3.1), health workers' education, particularly that of midwives and health visitors (9.3.2) and further research (9.3.3).

9.3.1 Recommendations for practice

This study proposes a number of recommendations including:

All new mothers need opportunities to relieve tension by talking to someone on a frequent and regular basis about their thoughts, feelings and experience of breastfeeding without interruption, judgement or advice from another. Mothers also need opportunities to work out their own strategies for coping with a new baby, and, if needed, an outlet for emotional outpouring to bring about a cathartic release and renewed determination to continue breastfeeding. This could perhaps be via online chat, social networking or other online multimedia services.

The healthcare service needs to work with mothers to develop their networks of 'friends' in pregnancy to include experienced breastfeeding mothers who could provide empathic understanding and support and prevent feelings of isolation. These networks need to be wider than family and close friends and include breastfeeding buddy schemes, peer support groups and online social networking groups, like chat rooms and Facebook groups that could offer dedicated support to breastfeeding mothers twenty-four hours a day.

Mothers need to feel supported and valued in a way that reduces the early necessitation to plan ahead with the potential outcome of disrupting breastfeeding. Maternity legislation and maternity leave need to embrace the public health message about breastfeeding and relationship building (Entwistle 2013) so that time, space and money are provided ensuring that mothers are able to take maximum maternity leave with their employment prospects being preserved.

Antenatal education should incorporate information to reassure pregnant women that there is no need to spend money on paraphernalia.

All mothers should be offered a list of books and websites that they can access that will be helpful and not undermining of breastfeeding. This could be developed as part of a research project as identified in the next section 9.3.3.

Information materials for mothers could usefully be developed using extracts from these video diaries.

The healthcare team needs to work with families and partners to prepare them for the realities of breastfeeding, developing practical strategies to support and build confidence in mothers, strategies that do not take them away from their babies. These could include recognition for the work of mothering and breastfeeding, how couples can spend quality time together that embraces breastfeeding, how fathers can feel engaged without the need to use a bottle and how mothers can resume paid employment and breastfeed.

9.3.2 Recommendations for education

This study has highlighted some areas where education for the healthcare team could be improved.

Educational materials using extracts from these video diaries should be developed for students and members of the healthcare team supporting breastfeeding mothers.

Education both in theory and practice for student midwives, health visitors and anyone else supporting breastfeeding mothers needs to include:

- Communication skills that specifically focus on listening skills
- Providing support to sit alongside mothers who are breastfeeding without them feeling watched, judged or handled
- Working with experienced breastfeeding mothers like peer supporters
- Learning how to challenge poor practice such as ‘hands on support’ and authoritarian attitudes
- Raising issues with parents around the commercialisation of breastfeeding and helping them realise that there is no need to spend money on paraphernalia

9.3.3 Recommendations for future research

This study has highlighted some gaps in research.

Action research to develop and evaluate an internet breastfeeding support service, based on telehealth (Giglia and Binns 2014), offered in ‘real-time’, fostering principles of a ‘listening service’ provided by the health service and supported by trained members of the healthcare team or trained breastfeeding counsellors and/or peer supporters.

Action research to develop and evaluate online social networking groups, specifically for breastfeeding support, with service providers or peer support groups facilitating the provision.

Research to explore how employers could better embrace and encourage breastfeeding in the workplace.

Research to explore the impact of parenting manuals on breastfeeding. This could enable the development of a criteria scoring system to evaluate books and websites in relation to breastfeeding which could be rated against the evidence

for the UNICEF UK BFI standards (Entwistle 2013). This rating system could then be used by the healthcare team to recommend books and websites and by mothers to select material that will be helpful in meeting their goals.

Research to explore how relationship-based support can be provided by the health service that does not focus exclusively on monitoring. It would need to explore how a different service provision would impact on mothers' experiences and breastfeeding outcomes.

Further research to explore the use of video diaries within other aspects of midwifery or community care. This could include service users or members of the healthcare team such as midwives and health visitors.

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Appendix 1 Dorset Breastfeeding Support Service

- Breastfeeding parent education in the antenatal period
- A telephone contact following discharge from hospital or home birth to offer support throughout the postnatal period
- Home visits as required
- A face to face appointment with a Breastfeeding Counsellor
- Continued telephone contact for support as required
- Breastfeeding support groups within local Children's Centres where peer support is available
- Referral to the Frenulotomy Service (Tongue Tie) for assessment

(Dorset Health Care University Foundation NHS Trust 2014)

Appendix 2 Literature search strategy

Table 5 Literature search strategy

Research question: What are the everyday experiences of mothers who are breastfeeding their first baby in the early weeks following birth?					
S	Sb	PI	E	R	R
Women's	UK	Breastfeeding	Experience	Research design	Research type
mothers females maternal human	Great Britain Britain England Scotland Wales Northern Ireland NB: not English as ++hits other countries	breast-feeding breast feeding lactating	perspectives embodiment embodied views opinions perceptions feelings	questionnaire survey interview focus group case study observation diary narrative visual	Qualitative Mixed methods
wom* **OR** mother* **OR** female* **OR** Maternal	UK **OR** "United Kingdom" **OR** "Great Brit*" **OR** brit* **OR** England **OR** scot* **OR** welsh **OR** wales **OR** "northern ire*"	breastfe* **OR** breast-fe* **OR** "breast fe*" **OR** lactat*	Experienc* **OR** Perspective* **OR** embodi* **OR** view* **OR** opinion* **OR** perce* **OR** feel*	"qualitative questionnaire*" **OR** "qualitative survey*" **OR** interview* **OR** "focus group*" **OR** "case stud*" **OR** observ* **OR** diar* **OR** narrat* **OR** visual	Qualitative **OR** "mixed methods"

S1= 25,423,995	**S2= 83,066,454**	**S3= 817,573**	**S4= 32,738,659**	**S5 =30,907,102**	**S6 = 1,473,724**
S1 **AND** S2 **AND** S3 = S7					
S7= 29,942					
S7 **AND** S4 = S8					
S8= 5,693					
				S5 **OR** S6 = S9	
				S9 = 26,772,883	
S8 **AND** S9 =S10					
2,305					
Papers not written in English removed = S11					
S11 = 2165					
Peer reviewed only = S12					
S12 =1084					
Up to 2011 = S13					
S13 = 712					
Up to 2009 = S14					
S14 = 533					
1999-2009 = S15					
S15 = 425 including duplicates					
Unique results = 250					
Abstracts hand searched					
20 qualitative studies (+5 papers same studies written in different journals) = 25 papers					
Key authors searched individually searched - 0					
25 papers					
Snowballing method searching reference lists = 2					
Total 27 papers for review					

Appendix 3 The CASP Tool

Screening Questions Bailey et al 2004. (1)

A 'give it a go' breast-feeding culture & early cessation among low-income mothers.

1. Was there a clear statement of the aims ☑ Yes ☐ Can't tell ☐ No

of the research?

HINT: Consider

- What was the goal of the research?
- Why it was thought important?
- Its relevance ✓

↓ Context ✓

↗ to explore key issues that have a bearing on the breastfeeding experience.

→ Because of poor rates of breastfeeding in low income groups. Stark social/geographical differences noted.

Focus on strategies to try & improve breastfeeding rates. Specific focus to explore high drop of rate between hospital discharge + transfer to health visitor.

2. Is a qualitative methodology appropriate? ☑ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the right methodology for addressing the research goal?

Yes. Exploratory in nature.

Pregnancy ✓ Seeks to interpret women's experiences including reasons + decisions to breastfeed, previous exposure to breastfeeding, expectations of support

2nd Interview experiences of labour birth, breast-feeding in hospital, transition to home, support, feelings about feeding

Is it worth continuing?

Detailed questions

3. Was the research design appropriate to address the aims of the research?

☑ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)?

Yes. - Semistructured interviews one in pregnancy second 3-9 weeks old. greater elaboration & explanation of attitudes than surveys.

4. Was the recruitment strategy appropriate to the aims of the research?

☑ Yes ☐ Can't tell ☐ No

HINT:Consider sampling strategy ✓

- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Yes purposive. - via community midwife services, Surestart, Parentcraft classes + special education unit for teenagers.

- Yes first-time mothers with no previous experience of breastfeeding - but were intending to breastfeed.

Discussed informed consent. if appropriate - written- It was not explained what "if appropriate" meant.

5. Was the data collected in a way that addressed the research issue? ☐ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the setting for data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?
- If methods were modified during the study. If so, has the researcher explained how and why?
- If the form of data is clear (e.g. tape recordings, video material, notes etc)
- If the researcher has discussed saturation of data

– in own homes or home of family member or friend if no accommodation – puts more at ease.
Semi structured – interviews with guided agenda. (see 2)
Also encouraged to discuss any other issues of relevance to breastfeeding.
Tape recorded + Field notes

6. Has the relationship between researcher and participants been adequately considered? ☑ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the researcher critically examined their own role, potential bias and influence during
  (a) Formulation of the research questions
  (b) Data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Some reflexivity regarding infant feeding / breastfeeding being a sensitive subject.
Awareness noted that Women/mothers may feel 'judged.
Despite aiming for non-judgemental approach – it may have an affect on Women's responses at interview.

Choice of location – Within mothershomes to help them feel "safe" at ease.

7. Have ethical issues been taken into consideration? ☑ Yes ☐ Can't tell ☐ No

HINT: Consider

- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Introductory telephone call to arrange first interview.
Written project information
If appropriate written consent – ?what this means.
Yes. Health Authority Joint Ethics Committees.
All names changed / personal details to protect anonymity.

8. Was the data analysis sufficiently rigorous? ☑ Yes ☐ Can't tell ☐ No

HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Theoretical underpinning – Grounded Theory. (Strauss + Corbin 1997 Bailey et al 1999)
Full transcriptions made.
Cross-researcher checking by all members of research team.
Key findings drawn out by research team.
Findings presentented at group meeting of local community midwife team – their feedback considered when extracting findings / making conclusions.
Findings supported with quotes from mothers.

9. Is there a clear statement of findings? ☑ Yes ☐ Can't tell ☐ No

HINT: Consider

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researchers arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Yes explicit with headings for extra clarity.
(1) 'Give it a go' culture
(2) Pervasive bottle feeding culture
(3) Experiences of formal support
(4) First few weeks - negotiating a successful breastfeeding trajectory

More than one analyst / cross reader checking.
Limitations highlighted.

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g. do they consider the findings in relation to current practice or policy?, or relevant research-based literature?
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Findings discussed & presented alongside relevant literature.

New areas of research suggested. - greater insight into processes, barriers & opportunities at work.
+ Healthcare professionals views.
+ Attitudes, roles + support from partners, families + friends.

Not generalisable - but transferable to similar contexts.

Appendix 4 Appraisal of papers for Literature Review

Table 6 Papers included in Literature Review

	Author / Title of paper	Participants	Aim / Methodology / analysis	Themes / Findings	Comments including Strengths /Limitations
1	**Bailey et al. 2004** A 'give it a go' breast-feeding culture and early cessation among low-income mothers	Purposive sample 16 x women who expressed an intention to breastfeed at 37 weeks pregnant First baby North Tyneside Low SES	Aim: to explore key issues that have a bearing on the breast-feeding experiences of low income women Qualitative study two semi-structured interviews at 37 weeks in pregnancy and 3-9 weeks post-partum. Analysis: Grounded theory, p242-3 (cited Strauss and Corbin 1997; Bailey et al 1999).	1. Feeding trajectories • 14/16 exclusively breastfeeding on discharge from hospital • 9/16 exclusively breastfeeding at end of 1st week • 7/16 exclusively breastfeeding at end of 3rd week • At 2nd interview (3-9 wks): 5 exclusively breastfeeding, 4 mixed & 7 formula feeding 2. A 'give it a go' breastfeeding culture • Breastfeeding is good for baby • Common misperceptions • Defensive mechanism to cope with expectation of difficulties and potential failure 3. A pervasive bottle-feeding culture • Surrounded by expertise in formula feeding • Bottle-feeding rules applied to breastfeeding hinders success • Theoretical knowledge secondary to embodied knowledge	Strengths: Good literature review to set context. Research design apparent in full –consistent with research aim Cross reader checking across all members of research team validating analysis Findings presented to a group meeting of local community midwives – their feedback considered when extracting findings and conclusions. Findings supported with quotes from mothers Discussion of findings with existing literature. Reflexivity apparent Limitations recognised in relation to participants not saying things for fear of being judged Not generalisable but transferable to similar contexts

				4. Experiences of formal support: breastfeeding in hospital • Mixed report • Feeling a 'lone breast feeder' 5. Experiences of formal support: The transfer from hospital to home • Painful feeding • No access to formal support when needed 6. First few weeks: negotiating a successful breast-feeding trajectory • Introducing a bottle for inadequate milk supply, partner's involvement in feeding, exhaustion, pain, • Guilt	
2	**Bailey and Pain 2001** *same study as 23 Geographies of infant feeding and access to primary health-care	Phase 1: 11 x first-time mothers aged 27-35 Phase 2: 4 more different first-time mothers Aged 25-early 30s Recruited from GP surgeries Range of infant feeding practices	Aim: to access a range of infant feeding experiences in order to raise issues around inform and formal support. Exploratory qualitative study based on 2 phases Phase 1: Face to face interviews with 11 first-time mothers to explore the impact of familial /intimate networks on infant feeding decisions followed by interviews with 12 people within these networks e.g. partners, other family members and friends.	1. Dealing with reality • Nothing prepared them for the reality • Painful feeding • Formal support varied from facilitative to disinterested • Professional women experienced 'peer group coercion' • Assumptions that middle class will breastfeed • Support from breastfeeding women • Looking to informal support to sanction decision	Strengths: Good literature review to set context. Research design apparent in full –consistent with research aim Findings supported with quotes from mothers Reflexivity apparent Field researcher did not disclose that she was a breastfeeding mother as she did not want participants to feel they were being judged in any way.

		Low to high SES Newcastle Upon Tyne	Phase 2: A discussion group and follow up telephone interviews with 5 first-time mothers (including a mother from phase 1) to gain insight into sources of friendship support Analysis: ongoing and iterative (cited Bailey 1999)	2. Family feeding throughout the generations: exposure and expectation • Non professional women find it more difficult to seek support from health professionals 3. Sexualising infant feeding • Tensions and constraints on breastfeeding in and out of the home • Informal networks creating tensions 4. Fitting feeding around paid work • Difficulties combining motherhood and professional life • Stopping breastfeeding to return to work	Discussion of findings with existing literature with 4 recommendations for policy and practice.
3	**Bailey 2007** Modern parents' perspectives on breastfeeding: a small study	Convenience sample 6 x women 5 x men Aged 25-44 10 x white 1 x black Mid – SES	Aim: to explore the decisions and experiences of both parents about breastfeeding, combine-feeding and weaning a child. Interpretive phenomenological study based on semi-structured interviews. Analysis: Interpretive phenomenological analysis (IPA), p149-150. (cited Smith 2003)	1. The woman is most affected 2. Infant feeding is a practical issue • Bottle feeding sometimes linked with return to work • Breastfeeding more convenient • Positive influences from family important • Problems latching on 3. The father's presence is important • Using a bottle to help out with feeding • Team work 4. "Breast is best" • Best for baby	Limited literature review Limited discussion on research design, research trail and analysis maybe due to journal limitations Potential bias from convenience sample – taken from author's family and friends Small sample size No location provided in paper No mention of how the research was explained to participants– but informed consent obtained

				• Good for bonding • Regret when stopping breastfeeding 5. A happy baby is important • Weight gain as a significant factor • Happy health baby is a big baby • Combining breast and formula to meet the demands of a big baby 6. Self-efficacy is relevant • Negative experiences of breastfeeding lowered self-efficacy • Confidence and determination resulted in successful breastfeeding	Reflexivity not apparent
4	**Baker et al. 2005** 'I Felt as though I'd been in Jail': Women's experiences of maternity care during labour, delivery and the immediate postpartum	Convenience sample 24 xmothers from an original cohort of 99 Aged 27-45 Midlands UK Caucasian Low to high SES	Findings from a wider study Aim of paper: to explore the impact of maternity care staff on women's experiences and feelings associated with the childbirth process. Four topics explored 1. Birth of first child 2. Birth of subsequent child 3. Experience of motherhood 4. Women's menstrual cycle Retrospective descriptive study based on in-depth semi-structured interviews with women	1. Perception of control 2. Staff attitudes and behaviours 3. Resources 4. Feeding (p329-333) In relation to breastfeeding • Staff attitudes, pressurised, intimidating and manipulative • Made to feel guilty • Not enough support • Feelings of inadequacy	Strengths: Good literature review to set context. Research design apparent in full –consistent with research aim Findings emerged out of a wider study exploring women's experiences of postnatal dysphoria Strengths: Triangulation during analysis with 3 researchers involved Findings supported with quotes from mothers

			Feminist analysis using open axial coding (cited Strauss and Corbin 1990) and themes, p322 (cited Miles and Hurman 1994).		Discussion of findings set in relation to political context – 'Changing Childbirth' Reflexivity apparent Authors had a range of backgrounds that assisted with interpretation of data
5	**Cloherty et al. 2004** Supplementing breast-fed babies in the UK to protect their mothers from tiredness or distress	Purposive sample 30 x mothers planned to breastfeed but supplementing with formula or EBM Aged 16-45 Caucasian Low to high SES Healthcare workers: 17 x midwives 4 x neonatal nurses 3 x paediatricians 3 x senior house officers 3 x health care assistants Postnatal ward and neonatal unit South of England	Aim: to explore mothers' and health care professionals' beliefs, expectations and experiences in relation to supplementation of breastfeeding on postnatal ward and newborn-baby unit. Ethnographic study approach based on participant observation and interviews Analysis: thematic analysis, p196	1. Mother-led supplementation – • Tiredness and exhaustion • taking too long to feed • Easier option 2. Midwife-led supplementation – • Short term pragmatic solution • If declined at first suggestion, maternal request more likely later 3. Protecting mother from distress • Providing short-term relief and comfort • Midwives' distress 4. Making it easier to give up 5. Protecting mother from feelings of guilt • Closely related to protecting her from tiredness and exhaustion	Strengths: Good literature review to set context. Research design apparent in full –consistent with research aim Analysis reviewed by second researcher. Peer reviewed by two midwives with specific expertise in breastfeeding. Findings supported with quotes from participants Reflexivity apparent Participant observer was a psychologist not healthcare professional- helped her stay as 'naïve observer' Limitation: Restricted to maternity unit. Generalisations suggested with caution Mothers experience sits alongside midwives experiences

6	**Crossley 2009** Breastfeeding as a Moral Imperative: An Autoethno-graphic study	Self	Aim: to explore some of the psychological, emotional and moral aspects of breastfeeding as a cultural phenomenon Autoethnography based on an in-depth case-study in which the author and her partner retrospectively reconstruct their breastfeeding experience through semi –structured dialogue interview by partner. Thematic analysis, p75 with further introspection (cited Ellis 1991) once themes identified.	1. Intention /motivation to breastfeed – • Moral obligation beyond nutrition • Psychological bond • Sign of good mothering 2. Things go wrong: Conflicting interpretations • Rejection – psychological vs. physical interpretation -(between self and husband 3. Bottle feeding – confusion, guilt and shame 4. Conflicting identities – • the 'relational mother' vs. the 'slim fit' person • secret sense of relief • Handing over responsibility • Getting back to normality	Strengths: Findings supported with quotes from interview Discussion of findings set in relation to feminist theory Limitations: Potential bias from exploring personal and emotional experience – And exploring contentions and conflicts with husband's views – interviewed by husband Some reflexivity apparent Retrospective- admitted "We found the actual details difficult to recall" p78
7	**Dykes et al. 2003** Adolescent mothers and breastfeeding: experiences and support needs -- an exploratory study.	Convenience sample Adolescents had breastfed or still breastfeeding 1st phase: 7 x women – 6 x primiparous 1 x multiparous with babies 4 days – 5months Aged 16-19	Aim: to explore the experiences and support needs of adolescent mothers who commence breastfeeding Qualitative multi-method study Phase 1: based on 2 focus groups with adolescents Phase 2: presentation of 4 vignettes to midwives and BFN supporters Phase 2: In-depth semi structured interviews with adolescents	Phase 1 1. Feeling watched and judged • By older people • Stereotyped as bottle feeders • Embarrassed about feeding in front of others 2. Lacking confidence • In breastfeeding ability • Ability to produce milk 3. Tiredness 4. Discomfort • Breast and nipple pain 5. Sharing accountability • With partner	Strengths: Good literature review to set context. Research design apparent in full –consistent with research aim Focus groups – two researchers present increasing effectiveness of data collection Two participants invited back to steering group for ongoing development of research – data validation

		2nd phase – Midwives and Breastfeeding networkers (BfN) supporters – not reported in paper 3rd phase 13 interviewed Aged 14-19 with babies aged 6-10 wks 12 primiparous 1 multiparous white NW England	Thematic network analysis, p393 (cited Attride-Stirling 2001)	• Reducing feelings of being tied down Phase 2 1. Emotional support 2. Esteem support 3. Instrumental 4. Informational 5. Network	Coding by 2 independent researchers increasing validity Findings supported with quotes from mothers Reflexivity apparent Limitation Mostly applicable to primiparous adolescents – 2 multiparous involved – care taken that data did not affect results
8	**Dykes and Williams 1999** *Same study as 9 Falling by the wayside: a phenomenological exploration of perceived breast-milk inadequacy in lactating women	Convenience sample 10 x postnatal women primiparous Exclusively breastfeeding Motivated to exclusively breastfeed for 3 mths Babies aged 1-3 days Aged 21-36	Aim: to explore lived experience of lactating women with particular reference to their perceptions of the adequacy of their breast milk for the purpose of exclusively nourishing their babies Longitudinal phenomenological study based on three in-depth interviews 6,12 & 18 wks Analysis: Thematic analysis, p235 (cited Van Manen 1990). Findings re-contextualised by interpreting with research and existing knowledge.	1. Quest to quantify and visualise • Female failure to manufacture –'I'll try it' • Comparing breast milk with artificial milk – quality and quantity • Weighing the baby 2. Dietary Concerns - "My milk is what I eat" 3. Breast feeding as a challenging journey "falling by the wayside" • Inexperience – "suck & see" • Feeding practices that may undermine production • Incorrect and conflicting advice from HPs	Strengths: Good literature review to set context. Thorough explanation to justify all aspects of research design. Peer supervision with analysis Findings supported with quotes from mothers and discussed with literature Reflexivity apparent Generalisability limited although finding shared with Health Professional groups throughout UK who shared resonance with findings

		White Caucasian Low to high SES North of England		• Baby's behaviour and feeding patterns 4. Giving out and the need for support – nurturing and replenishment • Juggling activities and giving out • Support from significant others, practical assistance, empathy and approval	Limitation: If women knew purpose of study i.e. exploring their perceptions of inadequate milk supply – would that have sewn seeds of doubt in their minds affecting outcomes?
9	**Dykes 2002** *Same study as 8 Western medicine and marketing: construction of an inadequate milk syndrome in lactating women	As above	Aim: to explore women's perceptions related to the adequacy of their breastmilk for the purpose of exclusively nourishing their babies. Longitudinal phenomenological study (cited Heidegger 1992) based on three in-depth interviews at 6,12 & 18 wks Analysis: Thematic analysis, p235 (cited Van Manen 1990). Findings recontextualised by interpreting with research and existing knowledge.	First two themes as above represented 1. Prone to failure • Doubting ability to exclusively nourish their baby – give it a try • Endorsed by healthcare professionals • Lack of confidence continued into breast-feeding experience 2. Product limitations • Quality and quantity 3. Quality control • Emphasis on weight gain • Conflicting information 4. Fuelling up • Relating to mother's diet 5. Correcting the fault • Introducing formula	Dykes 2002 *Same study as 8 Western medicine and marketing: construction of an inadequate milk syndrome in lactating women
10	**Dykes 2005a** * same study as 11	61 x women on postnatal ward 40 x primiparous 21 x multiparous 56 x White	Aim: to explore nature of interactions between midwives and breastfeeding mothers with postnatal ward	1. Communicating temporal pressure • Pressure and demands on midwives 2. Routines and procedures	Strengths: Excellent literature review to set context. Research design apparent in full –consistent with research aim

	A critical ethnographic study of encounters between midwives and breast-feeding women in postnatal wards in England	5 x South-Asians High to low SES 39 x midwives Two hospitals in North of England	Focus more on culture of environment and how midwives delivered care and interacted with mothers Thematic network analysis, p244 (cited Attride-Stirling 2001)	3. Disconnected encounters – reduced opportunity for continuity of care, rushed didactic and monologue communication, disconnected from women's context and personal agenda 4. Managing breastfeeding - technically managed - not relevant to individual circumstances – hands on care 5. Rationing information – time pressures – conflicting information 6. Taking and touching base – time together to build trust and relationship	Findings supported with quotes from participants Excellent application of research in relation to research and clinical practice Respondent validated increasing trustworthiness of data Peer supervision Reflexivity apparent Limitation: Potential Hawthorne effect from being watched
11	**Dykes 2005b** * same study as 10 `Supply' and `demand': brea stfeeding as labour.	As above	Aim: to explore nature of interactions between midwives and breastfeeding mothers on the postnatal ward – paper focus on experiences of women Ethnographic study based on participant observation on PN ward (97 encounters between staff and mothers when breastfeeding discussed) and 106 focused interviews Thematic network analysis, p2286 (cited Attride-Stirling 2001)	1. Providing – biomedical concept • Natural / nutritional / immunity 2. Supplying – • Lack in confidence it can work • Transfer to baby • Unhappy baby meant an unconfident mother • Focus on correct techniques etc 3. Demanding – • Links with notion of a production line • Feeding frequency • Baby good - passive and docile • Breasts as dummies, • Expecting early independence and routine	As above (10)

				4. Controlling • Controlling and managing breastfeeding • Expressing and giving EBM in bottle • Introducing formula • Having formula in just in case • Establishing routine	
12	**Earle 2002** *Same as 13 Factors affecting the initiation of breastfeeding: implications for breastfeeding promotion	19 x women recruited from AN clinic 16-30 yrs age 18 x white 1 x Asian SES low to high	Aim: to explore women's personal experiences and perceptions of breastfeeding Prospective descriptive design based on unstructured interviews at 6-14 wks gestation, 34-39 wks gestation 6-14 wks post birth Analysis: grounded theory approach, open coding, categorising and themes, p207 (cited Strauss and Corbin)	1. Making decisions breast milk or formula milk • As above 2. Knowledge information and breastfeeding promotion • As above 3. Breastfeeding as "everyday": the sexualisation of breasts • As above • Society's view 4. Breast or formula? Men's role 5. Breastfeeding, identity and 'good mothering' • As above • Re-establishing identity as "non-mothers"	Strengths: Good literature review to set context. Research design apparent in full –consistent with research aim Participant validation of manuscripts offered but declined Reflexivity used in analysis Findings supported with quotes from participants Limitation: Does not seek transferability
13	**Earle 2000** *Same as 12	As above	Aim: to explore women's experiences and perceptions of breastfeeding before and after childbirth with particular emphasis on the significance of baby feeding in their lives	1. Baby feeding: making decisions • early decision making outside contact of HPs 2. 'Breast is best' : Knowledge of breastfeeding - • but also scepticism –'I'll try it',' give it a go'	As above (12) Strength: Unstructured interviews encouraged mothers to set own agenda for discussion

	Why some women do not breast feed: bottle feeding and fathers' role.		Prospective descriptive design based on unstructured interviews at 6-14 wks gestation, 34-39 wks gestation 6-14 wks post birth Analysis: grounded theory approach, open coding, categorising and themes, p324 (cited Strauss and Corbin 1990)	• guilt – horrible mother syndrome 3. Bottle feeding and the role of the father • Sharing feeds /sharing care • Easing transition to motherhood • Yearning time away from baby • Wanting paternal involvement	
14	**Graffy & Taylor 2005** What information, advice, and support do women want with breastfeeding?	720 recruited 654 began breastfeeding and completed questionnaires 75% first-time mothers 31 % minority ethnic origin Low to high SES London area	Aim: to examine women's perspectives on the information advice and support they receive with breastfeeding Qualitative approach based on open questions in questionnaire at 6 weeks after birth Thematic analysis used grounded theory approach, p180 (cited Strauss and Corbin 1998)	1. Information about breastfeeding and what to expect • Unprepared for realities of breastfeeding • Feeling tied – little space • Exhausting 2. Practical help with positioning • Needed help until felt confident • Hurried ineffectual help in hospital 3. Effective advice and suggestions • To deal with concern/common problems • On how to express Conflicting opinion 4. Acknowledgement of mother's experiences and feelings • Empathy for feelings • Someone to listen 5. Reassurance and encouragement • Praise helpful	Strengths: Research design apparent in full –consistent with research aim Large scale study increasing transferability across population in UK. Questionnaire development – asked professional and lay supporter advice Piloted questionnaire on 42 mothers Reflexivity apparent Validity increased by: • Using 3 researchers to analyse independently • Triangulation used comparing categorisation of what women found most and least helpful with the conclusion drawn from free text comments on questionnaires.

				6. Support from counsellors • Valued expert knowledge, non-judgemental, reassuring and prepared to listen	• Using respondent validation with last 80 participants increasing trustworthiness of data Limitation: Questionnaire asked women to describe the advice they received – which could have produced a narrow focus – participants did broaden it to include support and information – but didn't talk about instrumental support or supportive network (Dykes et al 2003). This was part of an RCT – intervention group being offered support from breastfeeding counsellor – this may have influenced findings but was only one of many sources of support.
15	**Hawkins and Heard 2001** An exploration of the factors which may affect the duration of breastfeeding by first-time mothers on low incomes - a multiple case study.	10 x first-time mothers of low SES South West England	Aim: to explore the entire breastfeeding experience of women from low SES First of two phase project Qualitative multiple case-study based on interviews antenatally and at 2 weeks, four months and 6 months after birth AND diaries to record any thoughts or issues between interviews.	1. Antenatal findings • Qualities of breast milk • Bonding • Cost • Influences on the decision to breast feed • Participant expectation of breastfeeding – pain & difficulty, frequency and duration – expectation of failure 2. Postnatal findings • Initiation of breastfeeding • Conflicting advice	Strengths: Literature review to set context. Research design apparent –consistent with research aim Findings supported with quotes from participants Some triangulation of sources between interview transcripts, participant diaries and researchers diaries

			Thematic analysis to each case-study. Data from all case-studies were then collated to allow comparison and further analysis, p522 (Burnard 1991)	• Qualities of breastmilk – intrinsic qualities, weak – milk supply, hungry baby 3. Experience compared to expectations • The reality of breastfeeding - better than expected 4. Health Professional advice • Encouraging bottle feeding 5. Embarrassment	Reflexivity apparent Limitations: No age range of participants available Change in plan in relation to analysis –Novice researchers involved. Some starting project – unable to complete analysis due to time, work and personal constraints Little application of diaries mentioned – only for triangulation purposes and possibly interview prompt - no quotes from diaries
16	**Hoddinott and Pill 1999** *Same study as 17 Nobody actually tells you. A study of infant feeding.	Purposive sample 21 x white women primiparous low SES low educational level Inner London	Aim: to look at how communication by Health Professionals about infant feeding is perceived by first-time mothers Grounded theory based on interviews antenatally and between 6-10 weeks postnatally Analysis: Grounded theory approach (cited Strauss and Corbin 1990), framework method of analysis, p225 (cited Ritchie and Spencer 1994) and discourse analysis, p226 Potter and Wetherell 1996).	1. Preparation for motherhood and infant feeding • Inadequately prepared • AN classes and books gave practical information but not emotional preparation 2. A perceived secrecy about the realities of the first few weeks after birth • Developing trusting relationship where silence can be broken • Nobody tells you • Personal and embarrassing 3. Unmet expectations • Feeling a failure • Individualised support • Expert in mothering	Strength: Topic guide for interviews was developed during 4 pilot interviews Reflexivity apparent Both researchers analysed data Analysis was respondent validated increasing trustworthiness of data Findings supported with quotes from participants

				4. Support and help seeking behaviour • Choosing not to access support during difficult times 5. Coping and being a new parent • Out of control • Confidence linked to baby's behaviour • Contented sleeping baby means success	
17	**Hoddinott and Pill 2000** *Same study as 16 A qualitative study of wom en's views about how health professionals communicate about infant feeding.	As above	Aim: to look at how communication by Health Professionals about infant feeding is perceived by first-time mothers Grounded theory based on interviews antenatally and between 6-10 weeks Analysis: Grounded theory approach (cited Strauss and Corbin 1990), framework method of analysis, p225 (cited Ritchie and Spencer 1994) and discourse analysis, p226 Potter and Wetherell 1996).	1. Perceived pressures • Conflicting advice • Unrealistic expectations • Lying to maintain control of decision making 2. Differing goals • HPs breastfeeding - 4 months BF • Women – a contented thriving baby + family wellbeing • Breast is best – judgemental • Hidden realities of breastfeeding • Woman centred/breastfeeding centred 3. Words are not enough • Taking time, watching the feed • Positive affirmation and encouragement rather than being told to 'persevere' • Visual role models - apprentice style learning	As above (16)

				• Judgemental attitudes about positioning and attachment causing feelings of failure and guilt • Failing to perform bodily skills which are natural and easy • Unrealistic expectations • Lack of proactive HP support causes reduced confidence • Hands-on support distressing and embarrassing • HPs insensitive to feelings • Having an expert available • Importance of trusting relationship with HP • Keys to successful breastfeeding - coping with emotions, overcoming embarrassment and gaining body confidence 4. Show, inform, suggest but don't advise • Valuing women with embodied knowledge of breastfeeding • Apprentice style learning • Shattered expectations that it would be easy • Importance of facilitating women to make own decisions	
18	**Johnson et al. 2009**	20 x women recruited to main study –	Aim: to explore the embodied practice of expressing breast milk in the British context Qualitative longitudinal study based on 2 phases.	1. Managing pain whilst still feeding breastmilk • Expressing to avoid pain • Preferring than introducing formula	Strengths: Good literature review to set context.

	Expressing yourself: A feminist analysis of talk around expressing breast milk.	16 x participants selected from total of 20 who took part in study 8 interviews only 8 interviews and diaries First-time mothers Intention to breastfeed Aged 19-36 Average age 30 No significant illness. 15 x white British 1 x Eurasian British Majority high SES South Midlands England	Phase 1: audio diary for 7 days after discharge from hospital followed by semi structured interview Phase 2: audio diary for 7 days - 3 weeks following discharge from hospital followed by semi structured interview Foucauldian discourse analysis (cited Gavey 1889; Weedon 1997) and feminist poststructuralist style of analysis – thematic, p902 (Parker 1992; Willig 2008)	• Negotiating the moral dichotomy between breastmilk as good and formula as bad 2. A solution to the inefficiencies of the maternal body • Knowing how much baby is getting • Faster way of breastfeeding • Sense of bodily control • Provision of adequate nutrition so positioned as good mother 3. Enhancing or disrupting "bonding process" • Involving partner/husband • Enabling others to enjoy intimacy of baby • Bonding through feeding • Less intimate for mother disrupting bonding process 4. Managing feeding in front of others • For going out in public 5. As a route to freedom and way of coping with demands of breastfeeding • Independence – freedom to do other things • Returning to work • Preparing the way for giving a bottle • Managing realities of modern living	Research design apparent in full –consistent with research aim. Longitudinal giving view over time. Detailed explanation about analysis used Reflexivity apparent Diaries enhance interviews increasing validity of data – but only half of women kept diaries Findings supported with quotes from participants Limitations: Not all women kept diaries so less quotes from diaries Predominantly affluent, well-educated population so findings context dependent. May not be transferable to other SES groups

19	**Mahon-Daley and Andrews 2002** Liminality and breastfeeding: women negotiating space and two bodies.	27 x women including 8 x bottle feeding/ Aged 18-24 Mean age 30 Predominantly white SES – middle class Small town north of London	Aim: to explore women's breastfeeding experiences in relation to a theoretical connection of liminality with breastfeeding Qualitative longitudinal study based on participative observation of 16 sessions at mother/baby support group and 30 'loosely' structured interviews Thematic analysis using principles of grounded theory, p67.	1. The medicalisation of breastfeeding • Weighing primary reason for attending clinic • Falling off percentiles – a lone reason for breastfeeding to be discouraged • Threats of bottle feeding if not conforming and failing endangering child • Lack of support for breastfeeding by local healthcare providers • Authority imposed by healthcare provider 2. Breastfeeding as pollution • Leaking of milk, shameful, dirty and out of control • Reticence by 'others' to help clear up BM vomit compared to formula milk vomit • BM impure not to be shared with others 3. Space and breastfeeding • Importance of privacy • Maintaining sexual connotation • Appropriate and inappropriate places to breastfeed • Rituals of position and sitting to maintain privacy • Embarrassment feeding in front of other including family and friends • Marginalisation in workplace	Strengths: Excellent literature review to set context. Research design apparent in full –consistent with research aim. 1 x researcher was a female actively breastfeeding (not taking baby to group) enabling stories to be shared and exchanged Reflexivity apparent Findings supported with quotes from participants Limitation: With researcher sharing stories, was there the potential for mothers to be influenced in their conversations by researcher's own view/stories? Male researcher limited to interviews.

				4. Breastfeeding and time • Time consuming • Not fitting with modern living with routines, structure and fast pace • Bottle feeding fosters more control • Private time and space linked with intimacy with child 5. The body and breastfeeding • Conflict between breast as sexual objects and milk provider • Failure of breastfeeding linked to failing body • Women believe their bodies are inadequate for breastfeeding • An unnecessary bodily function • Mistrust of own instincts	
20	**Marshall et al. 2007** Being a 'good mother': Managing breastfeeding and merging identities.	Breastfeeding women having interactions with midwives or health visitors 22 x women selected for interviews based on factors known to impact on breastfeeding. outcome i.e. SES, age,	Aim: to explore breastfeeding in the context of everyday living with a new baby and how it is valued and managed within wider context of becoming and being a mother and the shift in identity which that implies. Qualitative study based on observation of 158 interactions between mothers and midwives followed by in-depth interviews with 22 women. Domain analysis, p2149-50	1. Factors shaping decisions to breastfeed • Health benefits • Sense of moral obligation by way health professionals sell it • Normal 2. Learning to breastfeed p2152 "Getting started" • Unrealistic expectations • Conflicting information • Not being shown • Hands on 3. Keeping going at home • Leaving hospital, major transition • Not knowing what to do • Needing reassurance	Strengths: Literature review to set context. Research design apparent in full –consistent with research aim. Findings supported with quotes from participants Reflexivity apparent with all three authors from varying backgrounds Limitations: Health professionals acted as gatekeepers to ensure appropriate women approached.

		ethnicity, gaining a diverse sample Range of ethnic groups Low to high SES North of England	(cited Spradley 1980)	• Positive affirmation • Practical and emotional support • Assessing health professionals' advice before following or rejecting 4. "I wasn't sure there was enough milk" • Looking for signs • Unsettled baby undermines confidence in breastfeeding • Lack of observable evidence to reassure • Weight gain • Static or weight loss leading to suggestions of bottle feeding • Growth spurts are temporal 5. Being a good mother • Preserving themselves as good mothers • Good mothering when breastfeeding is going well and baby is happy and healthy • Poor/bad mothering when confidence is undermined, baby is not appearing happy and healthy • Maintaining life balance • Shared responsibility with significant other • Going back to work	Researcher introduced by heath professional so may have been identified as an associate.
21	**McFadden and Toole 2006**	35 x women, aged 17-40	Aim: to discover what women perceived to be the barriers to breastfeeding, what influenced them when choosing their method of	1. Society's attitude to breastfeeding • Perceived reaction of others when breastfeeding in public • Lack of suitable facilities	Strengths: Literature review to set context. Research design apparent in full –consistent with research aim.

	Exploring women's views of breastfeeding: a focus group study within an area with high levels of socio-economic deprivation.	Either pregnant or one or more child aged <4 Living and using services in a Sure Start area Diverse population Selected from 1 adolescent group 1 ethnic minority group 4 groups from nursery school or mother and baby groups Mixed breastfeeding / bottle feeding Low to high SES North-east England	infant feeding and what healthcare interventions might have encourage them to breastfeed Qualitative exploratory study based on 7 focus groups total of 35 women. Group size 3-10 participants. Thematic analysis described briefly, p159-160 (Krueger and Casey 2000)	• Breastfeeding in front of family and friends • Leaking milk • Breastfeeding older child 2. Influence on choice of infant feeding method • Diverse attitudes to breastfeeding • Influenced by family or friends' experiences of breastfeeding • Strong influence of partners (not adolescents or ethnic minority group) • Strong influence by grandmothers in ethnic minority group 3. Knowledge of infant feeding • Lack of knowledge about health benefits • Use of AN classes, books and leaflets 4. Perceptions of professional support • Conflicting opinions • Too busy • Valued but varied 5. Experiences of breastfeeding • Frequent feeding and perceived insufficient milk • Give it a go • Lack of freedom • Insufficient support • Practical benefits of breastfeeding • Emotional rewards	Focus groups moderated by same 2 researchers throughout data collection, extensive field notes used in analysis phase. Reflexivity apparent Interpreter was employed for the minority ethnic group. Women knew each other making group discussion natural – Limitation may have meant taken for granted assumptions Group size small allowing women to talk about personal experience. Verbal summary and key points of focus group respondent validated increasing trustworthiness of the data. Both researchers involved in analysis. Independent verifier to check transcripts and to identify themes. Findings supported with quotes from participants

				6.Women's suggestions • More comfortable facilities to feed • More information in pregnancy	
22	**Murphy 2000** Risk, responsibility, and rhetoric in infant feeding.	36 x mothers from 10 GP practices a subsample of 12 x women were selected, reflecting age, occupational status, and feeding outcome variations – focus was on mothers who elected to breastfeed but later changed to formula feeding 11 x white British 1 x African Caribbean Low to high SES Nottingham England	Aim: to consider how mothers deal with the threat to their identities as good neoliberal citizens and mothers that arise from feeding practices involving introducing formula feeds. Qualitative study based on 6 interviews conducted -one before birth, and remaining five at fixed intervals up to 2 years following births by 2 interviewers with 36 mothers – subsample of 12 used for this paper. Inductive analysis by author and two research associates. Coding framework applied to all interview transcripts (p299-300)	1. Antenatal talk about infant feeding • Health benefits • Moral obligation to baby • Anticipated difficulties & loss of freedom • Formula feeding is risky • Anticipated guilt if breastfeeding fails 2. Rhetoric & construction of moral meanings 3. Postnatal talk about formula feeding • Accountability • Pressure to breastfeed • Called to account • Challenged and criticised 4. The baby - unharmed by formula • Reassessing judgements • Related to baby's current state e.g. weight loss • "Here and now" responsibility for baby's contentment • Endorsed by HPs empathy 5.Beyond the mother's control • Extreme and unusual difficulties • Distancing from interpretation of selfishness or irresponsibility • Involuntary – obstructed by circumstance • Extreme disappointment	Strengths: Research design apparent in full –consistent with research aim. Reflexivity apparent Emerging analysis was discussed at weekly analysis meetings. Coding framework applied to all interview transcripts Findings supported with quotes from participants Limitation: Little information about how subsample was chosen, thus potential bias in selecting 12 out of 36 Appears to have a strong assumptions in the literature review before research presented. Were the interviewees led by the questions? Geographically and historically specific

				6. Physical incapacity • Ineffective body • Inability to produce milk • Pain 7. Blaming others • Insensitive, careless ignorant or negligent professional behaviour • Lack of availability/helpfulness from health professionals • "Hands on" support • Failure to diagnose problems • Family pressure	
23	**Pain et al. 2001** * same study as 2 Infant feeding in North East England: contested spaces of reproduction.	Phase 1: 11 x first-time mothers aged 27-35 Phase 2: 4 more different first-time mothers Aged 25-early 30s Recruited from GP surgeries Range of infant feeding practices Low to high SES Newcastle Upon Tyne	Aim: to explore first-time parent's decisions and experiences of infant feeding in Newcastle upon Tyne Pilot - Exploratory qualitative study based on 2 phases Phase 1: Face to face interviews with 11 first-time mothers to explore the impact of familial /intimate networks on infant feeding decisions followed by interviews with 12 people within these networks e.g. partners, other family members and friends. Phase 2: A discussion group and follow up telephone interviews with 5 first-time mothers (including a mother from phase 1) to gain insight into sources of friendship support	1. Ideologies of motherhood • Value judgements as good or bad mother by health professionals, friends, family members and strangers • Opinions are repositioned depending who is listening • Despite reading manuals and leaflets were unprepared for the realities of breastfeeding • Bottle feeding was admitting defeat • Negotiating a sense of failure 2. Ideologies of fatherhood • 'Good father' and 'good partner' supports woman's feeding choice • Participating to feel valued • Seeking new knowledge to be helpful 3. The intimate/familial circle • Relying on female relatives	Strengths: Literature review to set context. Research design apparent in full –consistent with research aim Findings supported with quotes from mothers Reflexivity apparent Field researcher did not disclose that she was a breastfeeding mother as she did not want participants to feel they were being judged in any way.

			Analysis: ongoing and iterative (cited Bailey 1999)	• Following the norm of family and friends • Seeking out new mothers from similar socio-economic backgrounds 4. The spaces of infant feeding • Demand feeding making breastfeeding unpredictable • Breastfeeding influencing and restricting daily plans and activities • Feeding in front of others at home and away • Forced into a space of defence, inadequate breastfeeding facilities • Breastfeeding limiting paid or professional work	
24	**Sachs et al. 2006.** Feeding by numbers: an ethnographic study of how breastfeeding women understand their babies' weight charts.	Phase 1: Breastfeeding mothers attending child health clinics and breastfeeding support groups. Health visitors. Phase 2: 14 x breastfeeding mothers	Aim: to illuminate the way clinic interactions and weighing episodes shape breastfeeding women's understanding of plotted weight gain and its influence on their ongoing baby feeding decisions Ethnographic study based on: Phase 1: Participant observation of interactions in 20 sessions of a child health clinic followed by short interview with women and longer interview with HV.	1. Frequency and regularity of visits 2. Following the centile • Preferred following middle growth centiles • Using weight to judge breastfeeding – confirmation that breastfeeding is working-centiles most important measure of breastfeeding - powerful form of surveillance 3. Interventions to improve weight gain • Breastfeeding technique • Changing mother's intake • Infant formula • Complementary solid foods	Strengths: Literature review to set context. Research design apparent in full –consistent with research aim Findings supported with quotes from mothers Some respondent validation at phase 2.

		Low to high SES North west England	Plus observations in 14 sessions at breastfeeding support group involving 17 women Phase 2: Three semi-structured interviews with 14 breastfeeding mothers, ASAP after first contact with HV, - baby aged 3 months and 6 months. If breastfeeding stopped, last interview ASAP after ceasing. Total 35 interviews. Analysis: grounded theory, p4 (Strauss and Corbin 2002)	• Changing weighing practices 4. Emotional response	Reflexive diary kept by principal researcher to consider how data was impacting on her. Issues from diary and analysis were shared with two authors – experienced researchers. Limitation: Limited demographics Potential Hawthorne effect with HVs behaving to impress.
25	**Scott and Mostyn 2003** Women's Experiences of Breastfeeding in a Bottle-Feeding Culture.	19 x women 17 x already initiated breastfeeding from 2 days to < 12 months. 13 x mothers breastfed for 12 weeks. Recruited by telephone call having used the peer support intervention. Low SES Glasgow	Aim: to evaluate the acceptability and effectiveness of a peer-support breastfeeding intervention. Focus of paper: breastfeeding experiences in a socially deprived area of Glasgow Qualitative evaluation using 4 focus groups of 3-6 women in each (total 19) Thematic content analysis, p271	1. Prior exposure to breastfeeding • Little or no prior exposure • Different to others in social circle • Influence and confidence from seeing others breastfeed • Unprepared to encounter breastfeeding problems 2. Social support for breastfeeding • Continual pressure to give bottle • Open disapproval/subtle undermining 3. Importance of support provided by trained peer volunteers • Only source of breastfeeding support and encouragement apart from HV's	Strengths: Limited literature review to set context but used in discussion. Research design apparent in full –consistent with research aim Focus groups experienced moderator and second moderator present increasing trustworthiness of data Reflexivity apparent Analysis – themes readily and independently identified by both analysts– good inter-rater reliability

				4.Breastfeeding in public • Embarrassed breastfeeding in public • Went to great lengths to avoid it – expressing, feeding or expressing in toilet, supplementing with formula	Findings supported with quotes from mothers Limitation: Limited demographics – no ages, ethnicity. No mention of ethical approval being sought – perhaps this was an evaluation rather than research – but rationale given why focus groups for qualitative research was used. Consent given for transcriptions and analysis
26	**Shakespeare et al. 2004** Breast-feeding difficulties experienced by women taking part in a qualitative interview study of postnatal depression.	Mothers of 22 GP practices in Oxford. Purposive sampling 39 x mothers with EPDS ≥ 13 at either 8 weeks or 8 months or had received listening visits from HV. Aged 19-42 Low to high SES Oxford	Aim: to explore how women experience breastfeeding difficulties. Qualitative study based on in-depth interviews at 11-19 months Analysis: Qualitative thematic analysis, p 253 (Pope et al 1999)	One third of the sample were affected by breastfeeding difficulties. 1. Committed to breastfeeding with high expectations of success 2. Unexpected breastfeeding difficulties • Exhausting, painful and time consuming • Difficult to learn • Out of control • Failing • Affecting bonding 3. Seeking support for breastfeeding difficulties • Aspects of good and bad professional attitudes • Accessibility • Practical expertise, encouragement and peer	Strengths: Limited literature review to set context but used in discussion Research design apparent in full –consistent with research aim Topic guide for interviews was developed by a group of 5 GP's, 5 HVs, 4 midwives, and a locum consultant psychiatrist and was subsequently modified to explore emerging themes from the first focus groups Third researcher, not involved with interviews, checked on quality of interviews checking they were not too clinical. Reflexivity apparent

				support 4. Finding a way to cope • Learning the skills • Regaining control of emotions by stopping breastfeeding • Needing endorsement to stop • Stopping to prevent postnatal depression • Mixed feeding to regain control 5. Guilt • Failure	All three researcher involved in reading transcripts and analysis Findings supported with quotes from mothers Limitation: Two interviewers were known to participants as doctors, which may have impacted on mothers' responses at interview. Retrospective data at 15 months
27	**Simmons 2002** Exploring inconsistent breastfeeding advice:2.	5 x primiparous or first-time breastfeeding mothers and 1 x multiparous 5 x fully breastfeeding 1x mixed feeding Educated with professional backgrounds 4 x hospital and 4 x community midwives. North of England	Aim: exploring inconsistent breastfeeding advice to first-time breastfeeding mothers but does women's experiences of s breastfeeding experience Qualitative study based on semi-structured interviews with topic guide. Analysis: Framework content analysis, p617 (Ritchie and Spencer 1994)	1. Conflicting advice reinforces a woman's lack of self-confidence in her ability to breastfeed 2. Exploring inconsistent advice • Supplementing breastfeeds with formula • Timing of feeds • Advising the use of bottle teat to aid attaching to breast 3. Ineffective communication • Authoritarian attitudes • Feeling a failure	Strengths: Preliminary pilot study generated research questions for interview. Analysis underwent external review process by an independent body Findings supported with quotes from mothers Limitations: Literature review – separate paper in the series Very brief overview of research design Reflexivity not apparent

Appendix 5 Appraisal of literature using video diary method

Table 7 Literature using/discussing video diary method

	Author Date Name of paper/ book	**Participant Demo-graphics**	**Purpose of paper Purpose for video / Methodology /methods**	**Methods to analyse Strengths and limitations**	**Critique of method /methodology Including strengths and limitations**
1	**Bates 2013** Video diaries: audio-visual research methods and the elusive body.	5 x men 8 x women aged 18-50 years with long-term physical or mental health condition Low to high SES	One component of a multi-method study to explore every day aspects of health and illness with long-term physical or mental health condition. • Asked to make a VD or keep a journal for one month • Discuss any issues at interview Ethnography	• Transcribed • Integrated with interview and journal • Thematic analysis • Supported by extracts from VDs • Emerging themes developed by returning to raw data incorporating the more than textual elements -"multi-sensual" p34 • Editing video footage helped full immersion in audio and visual data p35	**Strengths identified :** • Participant took up an ethnographic position • Video acted as a "third agent"- allowed participant to give a "tour of their own lives" • Participant brought own visual/creative skills deciding how much to reveal of themselves - identities and bodies • Recorded wide range of bodily sensations • Enlivened textual accounts • Generated different ways of knowing, evoking tangible and intangible bodily experiences **Ethics:** Preference re anonymity controlled by participants: Important that participation did not add emphasis on people living in secrecy with long-term conditions **Limitations:** • Did not provide an objective view • Did not capture reality

2	**Bloustien 2003** Girl Making A Cross-Cultural Ethnography on the Processes of Growing up Female. (book)	10 x young women (teen age) Diverse ethnic background Low to high SES	Longitudinal over 15 months Aim: enhanced understanding of the world of teenagers from their perspectives. Ethnography Participants asked to document on video any aspect of their lives they wished, filming and editing whatever they chose Used "compact Hi8 compact video cam" Did not ask to see footage, only to discuss it with researcher – but all of the participants wanted to share their recordings Researcher was also invited by girls to specific events	• Broader social context of their video production • Way in which camera was used to interpret and redefine the girls worlds, in their selection, framing, filming and editing • Used Bourdieu's theoretical framework (1977) for analysis	**Strengths identified :** • "Creative power of representation and play- self-conscious representation, reflexivity and posing" p13 • "Symbolic space to play – to experiment" p13 • Participants had control p46 • A "surveillance or monitoring of self" p46 • "Political tool" – way of presenting other perspectives p52 • "Television host" – interviewing friends p52 • Two approaches – "ask me questions" talking to camera about self, providing opportunities to talk about personal issues or "fly on the wall", pretending camera wasn't there. p53 • Sometimes an imagined audience was – evident – a best friend who couldn't answer back p58 • Working out identities p59
3	**Brown et al. 2010** Capturing the dream: video diaries and minority consumers.	Pacific Island immigrants in New Zealand Limitation: No detail regarding Number of participants Age etc	Purpose of paper: Insights into VD method Visual ethnography 3-stage VD process to investigate consumer "acculturation experiences" of Pacific Island immigrants to New Zealand Stage 1: • Recruitment Stage 2: • Guidance: optional weekly schedule, topics and list of prompts	• Researcher met with participant at end to discuss analysis to enhance credibility of findings • Repeatedly watched video together to clarify meaning No further discussion to suggest how the video diaries were analysed	**Strengths identified:** • Facilitated participants' control over involvement in research • Choice about what to share and omit • Time and space • First opportunity to edit • Acknowledged participants' insights • Chose to be in front of camera or behind camera Participant voice and oratory: • Voice, language and expression • Included native language

			• Recording 6-8 wks • Daily recordings 5mins-2hrs • Researcher met with participant wkly – meetings 10 mins-5hours Stage 3 • Closing interview • Discussion around themes co-constructed from diary Researcher needed to: • build rapport with participant • empathise • spend time with participant to create mutual respect • regular contact • reciprocal sharing		• Discovered cultural preservation, e.g. special celebration days Participant ownership: • Autonomy to tell stories • Ownership developed, became less dependent on researcher's guidance • Enabled personal reflection on life concerns Performance: • Unique perspectives on lives • Performance of culture Reflection: • Reflect on experiences/stories • Interpreted their experiences through reflection – co-creating research findings Partnership: • Participant analysed through layers of reflection – constructed meanings Cognizance: • Potential to motivate transformation Transformation: • As become more relaxed sharing, cathartic – "emotional purging" • Camera became "supportive listener" • Self-evaluation • Transformation of researcher – empathy with participants Saturated description: • Rich descriptions • Multimodal – information • Background sights and sounds

4	**Buchbinder et al. 2005** Assessing adolescents with insulin-dependent diabetes mellitus (IDDM): A multiple perspective pilot study using visual illness narratives and interviews.	5 x adolescents 3 x males 2 x females Aged 13-18 with IDDM Caucasian 3x middle 2x low SES Rural New Hampshire and Vermont United States	To create visual illness narratives • Cameras and tripods provided to document daily activities Participants asked to record: • Most important things about illness • Specific lifestyle and diabetes related issues • Interviews with family and friends • Daily monologues Wkly meeting or telephone contact with researcher Interview 2-4 weeks after completion of video diaries Interview with clinical coordinator	• Used established Video Intervention/Prevention Assessment (VIA) analysis (Rich et al. 2000b) • Examining patterns of behaviour, interpersonal interactions, psychological disposition towards illness • Grounded theory • Coded in NVivo • Key themes of illness explored	**Strengths identified:** Important findings about living with IDDM as an adolescent Visual; element provided evidence of exposed parental involvement **Limitations identified:** Small ethnically homogenous population. Selection bias.
5	**Buchwald 2009** Video diary data collection in research with children: an alternative method.	7 x children Aged 11-17 4 x boys 3 x girls Living with a seriously ill or dying parent Denmark	To describe and understand how children handle their life when a mother or father is dying 3-phase study 1. Interview 2. VD for 1 month 3. Interview re clarification of filming within VD and experiencing using VD as a method Children encouraged to record VD same hour every day to create routine - share feelings, reflections about their day	No discussion about analysis – although a later paper in 2011 discussed this - see (6)	**Strengths identified:** • Familiar with medium • Child could edit and remove clips • Collected thoughts, feelings and actions over extended period of time • "Biographical, historical and educational material" obtained • "Conversational partner" addressing researcher that interviewed them • Recorded verbal and non-verbal expressions • Good for those who had difficulty expressing themselves in writing • Helped children see things more clearly

					Limitations identified: • Could not immediately ask about the data in VD • Non verbal difficult to interpret • Could choose not to video • Could avoid recording when feeling particularly emotional – (I would say this is not necessarily a limitation) • Could put on a performance - (Also could be a strength – this is the everyday) **Ethical issues identified:** • Confidentiality and anonymity maintained • Harm caused by expressing irrepressible emotions
6	**Buchwald et al. 2011** How children handle life when their mother or father is seriously ill or dying.	As above	As above Phenomenological position offered the possibility of gaining an understanding of children's experience Hermeneutic position enabled everyday life to be captured and understood from the child's perspective	Analysis and interpretation was a continual hermeneutical flow throughout research process (Ricoeur 1973, Kvale and Brinkmann 2009) • Transcriptions to textual • Read and re-read texts to provide overall understanding • Structural analysis - searched in text for phenomena in children's life world - emerging from units of meanings and themes • Themes compared, sorted and abstracted	**Strengths identified:** Trustworthiness The transcripts were repeatedly read through comparing and validating them against the themes to make sure no relevant data had been missed by mistake or irrelevant data included **Ethics:** As above

7	**Cashmore et al. 2010** An ethnographic approach to studying the student experience: the student perspective through free form video diaries.	66 x under-graduate students from 3 academic year groups undertaking biological sciences Self-selected 33 males 31 females Majority British 6 x non UK nationals	Longitudinal study – multi sited ethnography – action research – making improvements for future student cohorts Record minimum 5 minute VD on a weekly basis Focus on anything that was important in their lives Focus groups 3 x year	No discussion regarding analysis	**Strengths identified:** • Recordings –20 mins long • Controlled by students • Captured emotions, experiences and insights at specific instants and specific social environments • Not restricted by interview prompts • Students set own reflective research agendas • Longitudinal focus provided continual emphasis on students' experience • Demonstrated fluctuating emotions throughout the year **Limitations identified:** • Busy students so only managed to record every 2 weeks.
8	**Chalfen and Rich 2004** Applying visual research: patients teaching physicians through visual illness narratives.	Not specific about one study but a range of studies using VIA	Paper written to share background to VIA Applied visual anthropology as in (4) Create visual illness narratives as in (4) Results communicated to medical team so they could modify medical treatment in response to patient experience 1st consent covered data collection and analysis phases of research 2nd consent was required to release data for dissemination	• Interpretation involved sensitivity to sociocultural factors including visual data • No specific detail about analysis	**Strengths identified:** • Admitted behaviour on VD that they did not admit to clinician • Based on personal expression • Sought to increase patients' power in patient-clinician communication • Provided ethnographic detail about condition of everyday life • Therapeutic intervention by making it possible for patient to reveal issues • Intrapersonal feedback triggered self-assessment of own behaviour and self-correction • Self-efficacy increased by sharing own stories **Ethical issues identified:** • Confidentiality and anonymity Limitations: • VIA may seem like surveillance but patient controls what was recorded

9	**Chalfen et al. 2010** VIA's visual voices: the awareness of a dedicated audience of voices in patient video narratives.	General paper discussing VIA as an intervention	Aimed at developing improved communication between clinician and patient Compared and contrasted "bio-medical construct of disease" with a "patient's psychological social and cultural experiences of illness" Teach technical side of camcorder only, not how to film and take best shots	Can be up to 700 hrs of video data per project Each participant produced 1-145 hrs of recording Video loggers • watched in real-time • visual and audio logged in detail • selective portions transcribed verbatim described subjective elements e.g. emotions • codes logged on visual narratives on NVivo • several coding cycles looking at key themes • different members of inter-professional team applied theoretic frameworks to the analysis • Grounded theory applied to develop structure (Glaser and Strauss)	**Strengths identified:** • "The authoritative voice" – made declarations on behalf of other people suffering from the same illness. Increasing awareness of the disease • "The critical voice" – challenging the status quo, like policies or practices or stereotypical attitudes • "The therapeutic voice" – let the guard down by sharing deep inner thoughts. Confessional voice gradually emerged where participants (not from something wrongly done) but openly acknowledged feelings, beliefs or prejudices. Communicated vulnerabilities • "Consumer voice" expressing preference about lifestyles and culture • "The pedagogic voice" – teaching the clinicians about their illness • The importance of having a dedicated listener – being seen as well as heard – an awareness that caring professionals would listen and respond while respecting autonomy and privacy
10	**Chung et al. 2013** Exploring the perspectives of obese adolescent girls.	14 x obese girls aged 12-20 years	VIA method to explore perspectives and experiences of obese adolescent girls Asked to: Teach clinicians about experiences by recording their lives on VD revealing issues faced & how they responded to them including thoughts & feelings. Collected over two weeks During 2nd week standardised suggestions provided	Grounded theory approach • Logged and coded both audio & visual data using Transana and NVivo • Imported logs into NVivo • Coded emerging themes as free nodes - audio and visual • Defined modified and refined nodes	**Strengths identified:** Prompts given - prior studies suggested they would trigger own ideas without directing or compromising the integrity of personal narratives - p1370 (Rich et al. 2005)

				• Built conceptual relationships between nodes developing conceptual trees of related themes	
11	**Cooley et al. 2014** Introducing the use of a semi-structured video diary room to investigate students' learning experiences during an outdoor adventure education group work skills course.	29 x mechanical engineering under-graduate students Purposive sampling to provide deepest possible experience	To explore the learning experiences of Higher Education (HE) students taking part in a 3-day group skills course. Inspired by reality TV - Big Brother Video diary room to take people out of an experience into a private space to reflect on experience in front of camera Semi structured questions to direct responses to answer the research question at same time as giving flexibility to share personal perspectives.	Inductive thematic analysis Rich and descriptive account of patterns and themes which were strongly linked to data rather than fitting to pre-existing framework p110 (Braun and Clark 2006 and Howitt 2010). A semantic realist approach - participants experiences and perspectives were analysed using an explicit interpretation of what was said rather than looking at underlying meaning and structure (Braun and Clarke 2006)	**Strengths identified:** • Questions for diary room were developed by 4 x researchers in discussion forum and independently verified by qualitative researcher • Overcame difficulties people faced when expressing themselves through written diaries • Increased depth and freedom of speech • Less reliance on rapport of researcher • Research could listen more - less opportunity of judgmental reactions at the time • Space given to reflect on questions • Encouraged student reflection enhancing student learning
12	**Cotton et al. 2010** Using observational methods to research the student experience.	Diary section 12 x students Plymouth UK	Not specific about one study but a range of studies using observation. Example 3: Video, audio and written diaries by student participant observers in the field. Provided with video camera, voice recorder and notebook Asked to spend at least one hour in total during the 7-day field course	Analysis of video diaries (cited Orion and Hofstein 1994) • VDs extremely time consuming to transcribe • Transcribed with additional notes • Iterative process of reading and re-reading looking for similarities between accounts	**Strengths identified:** • Good comparison between types of diaries used • VDs produced lengthy accounts, often collective with other students • Immediately comfortable captured first hand lived experience of field course with cameras • Real-time style of recording • Easy enjoyable and interesting – found it addictive

				• Observation, rich data, basic thematic analysis, playing back recordings • Basis thematic analysis can be done in real-time whilst playing back recordings	• Audio-diaries less time consuming to transcribe. More formal, more self-conscious, less personal and reflective than written diaries. • Richness of data reduced • Written diaries more intimate but retrospective as written in evening so impact of memory on detail
13	**Dowmunt 2001** Dear Diary: video diaries, subjectivity and media power. (conference paper)	40 x adolescent girls	Enormous longitudinal project from 4-21 years. Auto-biographical. Adolescent stage VDs developed by BBC "Girls, Girls, Girls" but taken on to broadcast by Channel 4	175 hours of VD diary material, watched and edited down to 12 short (3 minute) programmes -diarists involved in process Broadcast on mainstream TV	**Strengths identified:** • A "particular voice that implicates the individual subjectivities" • Intimacy, addressing camera in an intimate and personal way, confidante • Companionship • Something to talk to that doesn't answer back • Sense of freedom • Used camera as power and authority over an adult to avoid/minimise reprimand • Private process of self-exploration even though ultimately for an audience • Spontaneity, more authentic on own than with friends – more of an 'act' in front of friends – didn't worry about appearance • Authors of own representation **Limitations identified:** • Danger of speaking too much • Self-expression rather than self-representation • Using diary for political voice • Opinions from a particular point of view (I would suggest these represent the individual's perspective on life)

14	**Dowmunt 2007** "Minding the Gap": Reflections on media practice & theory.	General paper about media practice with reference to VD as above	Community video Asking vulnerable speak and represent themselves Creating personal autobiographical and diary film-making for broadcast	Not discussed	Strengths identified: Close filmic analogy to written diary
15	**Edinburgh et al. 2011** It's called "Going Out to Play": A video diary study of Hmong girls' perspectives on running away.	10 x Hmong adolescent girls who had run away and had disclosed extra familial sexual abuse Aged 13-16 yrs USA	To identify self-perceived influences on Hmong adolescent girls' decisions to run away, return home. To describe activities and risks involved in while on the run VDs created using prompts to open questions - to reflect on what is going on in life Diaries entries recorded on multiple days lasting 3-10 mins	• VD's viewed multiple times • Spoken words transcribed • Coding using Atlas.ti (Sandelowski et al. 2007) • Categorising looked for codes with commonality	**Strengths identified:** Research team involved in corroborating analysis **Limitations:** Participants did not always answer every question Maybe specific to Hmong adolescents rather than any immigrant adolescents Did not include parent perspectives
16	**Gerver and Segal 2011** Dear Diary: Improving data quality and creating an engaging experience through video.	1. Women aged 25-45 yrs who suffered heavily from seasonal allergies and used a variety of medications to alleviate symptoms 2. Women who ate ice cream and frozen yogurt	Paper compared video with written diary 1. Webcam VD - record at least twice a day am/evening about allergy symptoms or capture when they are occurring for a two week period 2. Written diary - asked to respond to a number of questions for 3 days about food consumption.	VD analysis included: • Linguistic and paralinguistic characteristics, intonation, pitch, tone of voice, pace of speaking, pausing, sighing, level of calm/agitation, humour, laughter, snuffled voices • Non-verbal data, body language and emotions, severity of symptoms	**Strengths identified:** • Richness of insight - raw emotion • Compelling, shows depth and poignancy • Increases accuracy of seeing symptoms when recorded at the moment • More complete picture than relying on the subjective memory • Excellent for academic conferences **Limitations:** Number of participants not given for written diaries

17	**Gibson 2005** Co-producing video diaries: The presence of the "Absent" Researcher.	10 x men with Duchenne muscular dystrophy (DMD) Aged 22-36 Dependent on ventilation for all or part of the day. Mixed SES. Canada	Ethnomethodology Video accounts exploring young men's experiences of Duchenne Muscular Dystrophy As above Used hands free cameras – for independent use, e.g. mounted on baseball cap, or on bag hung on wheelchair Verbal and written guidance given regarding suggestions VD 15-90 mins per person and 1-8 separate episodes	Used Bourdieusian theoretical framework to examine video using metaphors drawn from film industry – 'movie method' • Audience – what audience is the video orientated to? • Scene – what identity aspects are being addressed and how? • Director – who was involved in directing the video, what does this reveal about the participant and /or his relationships? • Role – what role/s or subject positions are being expressed and performed? • Cut – what is not included in video and what does this reveal about identity construction?	**Strength identified:** • Verbal and non verbal data • Permanent recording provided advantage over observations enabling repeated series of analysis • Intentionally created from different social situations • More direct understanding of patients' experiences than data controlled by researcher **Limitations identified** • Reflexivity required – influence of absent researcher – medical focus adopted by participants knowing researcher was a physiotherapist – giving guidance meant co-producing VD • Some participants couldn't make their own VDs and got other people to film for them, 2x participants asked researcher – thus co-created Analysis restricted to framework – is this truly explorative and qualitative in nature? With a vast amount of data it focused the analysis and enabled a thorough exploration of the data related to the questions
18	**Gibson et al. 2007** Men on the margin: A Bourdieusian examination of living into adulthood with muscular dystrophy.	10 x men with Duchenne muscular dystrophy (DMD) Aged 22-36 Dependent on ventilation for all or part of the day. Mixed SES.	Ethnographic case-studies Phase 1: In-depth interview Phase 2: VD- everything over the course of one week that he believed would reveal his life	VD: total of 5.7 hours of video tape. Audio element transcribed - textual log (Rich et al. 2000). All textual and video data were imported into NVivo 2.0. Each case analysed using flexible coding and set of open questions consistent with research question and Bourdieusian framework	**Strengths:** VDs offered new insights into participants going out of the house **Limitations:** This paper presented mostly interview data

		Canada		Video further analysed using movie method (Gibson 2005)	
19	**Holliday 2004.a** Filming "The Closet": The role of video diaries in researching sexualities.	Recruited through snowballing, one participant gave camera to next participant 15 x participants	Aim: "to explore the nature of queer performance…to capture identity performances" p1598 Ethnography Initial interview with each participant to explain research Written guidance given VD for 2 months	Coded to identify points of similarity and difference and recurrent themes Sections of different diaries edited together around particular themes	**Strengths identified:** • As in 20 & 21 • Created self-representations • Performances of identities • Active, empowering process • Reflective through watching, recording and editing own VDs • Editorial control passed to participant • More complete than audio data • Different styles noted- performing with others (entertaining) and performing with self (intimate, self examining) • Confessional could be cathartic • Openness in diary entries were representations **Limitations identified** • 'Capturing the flavor' of the VDs in text – within word limits • One way conversation – frustrating when needed to clarify points in VD.
20	**Holliday 2004.b** Reflecting the self.	15 x participants	To examine performative nature of queer identities, reflecting lives, experiences and explanation of subjects To capture narratives of experience and lived cultural practices PLUS the visual nature of the construction and display of identities through cultural products – e.g. clothes and other aspects of habitus	Analysis requires reflexivity of researcher – Self-awareness, self-scrutiny, consider own position in research process No detail how it was done.	**Strengths identified:** • As in 19 & 21 • Enabled confession – an audience focusing on listening • Space and power to which normal circumstances prevent **Limitations identified** • Risk of misinterpretation by others

					• Seeing self – "narcissistic images produces candour" – not withholding secretes from self p6. • Fixing meaning to what participants say • "Empowering passive viewers, active producers"
21	**Holliday 2007** Performances, confessions, and identities: Using video diaries to research sexualities.	15 x participants	"Queer methodology" applied Same as above (19 &20)	• Same as (19) • Included audio and visual signifiers of sexuality and style in which VDs filmed	**Strengths identified:** • As in 19 & 20 • Familiarity with concept of VDs from TV • Free to record and re-record but editing power not used • Visual identities running alongside narration of identity • "No truth beyond the performance" Plus strengths highlighted in 19 & 20
22	**Iivari et al. 2014** Video Diary as a means for data gathering with children - Encountering identities in the making.	12 x boys 11 x girls VDS over 4 days	To explore nature and use of video diary method with children	Nexus analysis Discourse analysis inductive collaborative analysis with whole research team	**Strengths identified:** • Participants recorded from different positions: "a new broad caster", a diarist, a "stage performer" & school homework. • Participants changed positions between recordings • Self-representation & identity construction **Limitations:** Lack of researcher control, not all participants engaged
23	**Jackson et al. 2012** 'The Wholeboy mansion image': Girls' fashion.	71 x girls in primary or intermediary schools New Zealand	To explore how girls negotiate contemporary post feminist meanings of femininity marketed to them in fashion. VDs - To record about 10 minutes every day for one month - some guidance but not prescriptive	• Video transcriptions using Transana - • Visual - written transcript including non-verbal data e.g. movement, gesture • Repeated close readings of transcripts and viewings of VDs	**Strengths identified:** • More embodied representation of self • Filming girls in their 'real world' - produced in specific context • Bedroom conveyed sense of material lives and lived culture of girlhood in a private 'girl-space' Ethical issues discussed with participants about filming

			Followed up by focus groups Repeated one year later	• Key meanings deduced	
24	**Jefferies and Hyde 2009** Listening to the learners' voices in HE: how do students reflect on their use of technology for learning?	54 x students 34 x females 20 x males aged 18-25 at University or Further Education College 18 different programmes of study	To explore students' experience of learning in a technology rich environment Students asked to keep reflective diaries – collected over a five day period at 6 month intervals Students could select medium - webcam, camcorder or voice recorder Each day – brief recording in the morning about plan for the day and a 5-10 min recording in the evening, re what they had achieved, how they had studied and answer to a set of supplementary questions to meet research question. Plus focus groups and some telephone interviews.	• Transcribed • Colour coded according to main project themes • Concept maps created for each student's diary detailing reflections on learning • Further colour coding of quotes relating to research question created from transcripts	**Strengths identified:** • Digital voice recorder and cam recorder were the favourite technology for recording • Video recorder best quality recording • Reviewed by another researcher using NVivo **Limitations** • Some students preferred voice recorder over video recorder because their facial expressions weren't seen
25	**Kahu 2014** Increasing the emotional engagement of first year mature-aged students: Interest and belonging.	19 x mature-aged (aged over 24 years) under-graduate distance students New Zealand	To examine the emotional engagement in distance study Interviews and VDS VDs to find out what participants were thinking doing and feeling - After researcher listened to VDs, prompts sent by email to students to encourage deeper reflection	Transcribed in full Thematic analysis (Braun and Clarke 2006) Emotions, aspects of context, events and consequences. Seeking interpretation and explanation	**Limitations -** Lengthy transcribing process
26	**Kindon 2003**	A Maori tribe in Aotearoa New Zealand	Ethnography	Analysis not discussed	**Strengths identified:** • Effective way of reaching powerless • Assisted participants to critically analyse their own realities

	Participatory video in geographic research: a feminist practice of looking?	No number given for participants	To explore the relationships between place, identity and 'social cohesion' in communities in the Aotearoa, New Zealand. Community development project.		• Assisted "feminist practice of looking alongside rather than looking at" • Participant in control of technology • Participant controlled how they represent themselves • Holistic transformation potential • "Observant participant rather that participant observer"' **Limitations identified:** • High level of commitment from researcher
27	**Larkin and Jorgenses 2014** Using video diaries to record student attitudes and emotions towards matematics in year three and year six students.	105 x year 3 and year 6 students	To explore attitudes of mathematics in primary school children Using IPAD - created a diary room on a tent	Selective transcribing using NVivo p375 Reflexivity paramount	**Strengths identified:** • Encouraged authentic reflection • Range of views suggested authenticity • Children became central agents of data collection • Power relationship between children and researcher reduced • Addressed researcher - salutations • Included highly personal information **Limitations:** Ethical issues: when students disclosed issues of concern unrelated to maths Tent meant children may have been overheard Confidentiality issues related to sharing concerns unrelated to mathematics Challenge of interpreting visual data
28	**Muir 2008**	Not a study Toolkit	Purpose of paper: A toolkit to provide a basic introduction to participant produced video Produced by Real Life Methods, part of the national Centre for research methods .	**Strengths identified:** • Makes it easier for participants to record and reflect on everyday life experiences that might otherwise not be noticed or remembered • Participants can access areas of everyday life that are inaccessible to researcher • Access to worldviews • Giving participants a voice	

	Toolkit # 04 Participant produced video: Giving participants camcorders as a social research method.		Information about cameras / cost / quality/ size p4.	• Familiar with practice and VDs on TV • Participants find it fun **Limitations identified** • Camera in control of participants – may not get video footage you want • Hours of unused footage • Can overestimate the degree of participant empowerment, instead participant could feel burdened/nervous	
29	**Noyes 2004** Video diary: a method for exploring learning dispositions.	6x primary-school children England	Case study approach exploring children's' habitus using a group of children transferring from year 6 to comprehensive secondary school. 1st phase - observation in classroom and interviews 2nd phase – 7 week period - VDs Had a rota to use the diary room A forum where student could talk about self Video footage not reproduced or made openly available to others 3rd phase – reviewed VDs with children Subsequently parents of the children were interviewed	Analysis was staged approach • After first viewing, critical incidents/ key memories in video diaries identified & transcribed • Use of NVivo in order to handle qualitative data in graphical hierarchies but with increased cross-linking • Noyes asks- because of richness of the visual data - when does he move away from primary data if at all? • Multiple viewing enabled familiarity and a focus on body language, eye contact etc • Joint reviewing of tapes with participants – no child wanted to amend data but the discussion produced extra data	**Strengths identified:** • Representations of students • Talked more freely than interviews – more compelling • Performance styles, humorous but poignant • Visuals enhanced understanding, e.g. body shape, body language, hairstyle, clothing, all reflecting child's identity • Confidence in someone listening • Interchanged between audiences. • "Private /public understanding of audience" • "Confidante, listening ear, counsellor" • Identities they chose to share • Spending time with camera, helped to "normalize behaviour" – more like what was observed elsewhere – less of a performance • Talking frankly about emotions relationships etc • Helped participants make sense of experience • Camera listened where others might not • Fuller representation of social life and habitus

					Limitations identified • Took time to build relationship with camera • Describing visual in text format
30	**Pocock 2009** Proposing Video Diaries as an Innovative Methodology in Tourist Experience Research.	3 x returnees from long term travel to London France and Colombia, plus up to 5 of their significant others New Zealand	To explore concepts of home for returned long-term travellers To gain emic understanding of the complex reality of the social phenomenon of returning from long-term travel to 'home' Interviews and VDs 3 staged process 1. Conversational interviews with participants and up to 5 significant others to set context, build rapport and start returnees to start conceptualising their "home 2. VDs with guidance prompts 3. Interview with returnee to review mind map from analysis	Hermeneutic ontology and interpretive epistemology Hermeneutic cycle of understanding Reflexivity - acknowledging own influence (31) adds to this	**Strengths identified:** • Privileged the situation of each individual • Showed visually and explained verbally personal meanings of experience • Holistic, richer, sensory understanding • Control given to participant - power to share or omit • "Cathartic release" • Participants' voice was dominant • Participant as "co-researcher, expert in the field" **Limitations identified:** • Dependant on participant's personality and selectivity • VDs might not meet researchers aim • Possibility of "emotional deluge" • "Selective biased view" about relationship with others (but this is the participant's perspective) • Need more research to establish which technology intrudes on personal and deep conversations • Need more research to explore respondents' characteristics and their impact on the quality and reliability of VD data

31	**Pocock and McIntosh 2013** Long-term travellers return, 'Home'?	As above (30)	As above (30) Length of VDs varied 3.5 mins – 4 hrs 42 mins Participants kept camera for as long as was required Sought emic understanding through vicarious experience rather than representing or generalising	Inductive thematic analysis – not based on researcher's theoretical perspective but data driven Preferred to let data speak for itself but recognised researcher's interpretations reassert voice over participants	**Strengths identified:** Credibility – using participants own words to create thick descriptions
32	**Pini 2011** Girls on film: Video diaries as 'auto-ethnographies'	29 x young British women 23 x white, 6x black, 1 x Asian Aged 16-21 years	Auto-ethnography To examine how social class came to inform these different women's' life trajectories	This paper was a critique of this research study: **Aims for:** ● Empowering for participants to tell own story ● Participants very used to technology ● Confessional nature aims authenticity based on participant's experience ● **Limitations highlighted**: Participants were intensely aware of being watched ● Change of voice when people were present during recording, altering authenticity of recording ● Some participants appeared to be performing to the camera ● Working class women hated it, because it put them under surveillance, feeling subject to analysis	
33	**Rees 2010** Identities as performances: Encouraging visual methodologies in medical education research.	Theoretical paper	To explore use of VD in medical education	**Strengths identified:** ● "Triadic interaction between participant, camcorder and researcher" ● All diarists have an imaginary reader ● VDs reflect identities, visual demonstrations alongside narration and performance of identities ● Connection between visual images and experienced realities constructed through individual subjectivity and interpretation of images (Pink 2001)	

				• Reflexivity so that subjectivity in constructing and representing knowledge through visual is embraced • Collaborative approach between researcher and participant • Not typical power relationships between researcher and participant because control given to participant	
34	**Rich et al. 2000a** Asthma in Life Context: Video Intervention/Prevention Assessment (VIA).	20 x young people diagnosed with moderate to severe asthma Aged 8-25 10 male 10 female 10 black, 7 white, and 3 mixed race.	Phenomenology To determine whether medical information gathered might be augmented by VDs Patients asked to show the clinicians the realities of managing chronic disease in the contexts of their lives Medical history taken at interview + questionnaire VD 4-8 weeks – "teach us about your asthma"	VDs ranged from 4-78 hours. Analysis see below (20)	**Strengths identified:** • Behaviour might have been more normal than in clinical setting e.g. demonstrating how to use inhaler • Allowed patients to reveal dislikes and obstacles with taking medication • Participant controlled information sharing • Expanded knowledge of disease beyond medical history **Limitations identified:** • Cost of camcorders • Resource intensive - time taken to view videos
35	**Rich et al. 2000b** Video intervention/ prevention assessment: a patient-centered methodology for understanding the adolescent illness experience.	See above (34)	As above in (34) Ethnography Guidance standardised list of suggestions Encouraged to interview family and friends with open questions Plus daily monologue to reflect on day's activities	• Logged time codes to locate specific observations to allow parallel observations by different loggers • Ensure 'diachronic interrelater reliability' p158 • Transcribed or paraphrased verbal content e.g. monologues and conversations • Subjective comments on tone and meaning of scene in relation to VIA participant	**Strengths identified:** • Showed disease in situ • "Indiscriminate and uncompromising gaze of camera " of what selection of perception and memory might have filtered out at interview/medical history • VIA enabled patients to work out health risks for themselves and develop interventions with advice from specialist • Unexpectedly frank – "unselfconscious portrayals" (I would say sometimes participants are very conscious- because they can see themselves in the camera's monitor)

				• Developed VIA framework to analyse general condition / specific health issues	**Limitations identified:** • Selection bias by participants
36	**Rich et al. 2005** Achieving independence: The role of parental involvement with adolescents with spina bifida.	Ten participants Aged 12-19 6 x Males 4 x Females 2 x black 6 x white, 2 x Hispanic with spina bifida. Visual	Aim: use Video Intervention/ Prevention Assessment (VIA) to document day to day lives. VDs 8-12 weeks: especially activities in a day, and a daily personal monologue about their experiences	• produced 122 hours of visual narratives • Narratives were logged, then coded using NVivo 2.0 • Themes related to independence and parental involvement were established using grounded theory.	Brief paper, only findings given
37	**Rich and Patashnick 2002** Narrative research with audiovisual data: Video Intervention/ Prevention Assessment (VIA) and NVivo.	General paper discussing VIA	VIA draws on ethnography As all papers on VIA (3,5,6,20,21,22,13)	• Interprofessional team employed • Theoretical frameworks from different disciplines applied • Trialled 3x different software programmes to facilitate analysis 'The observer, ATLAS.ti and NVivo • NVivo selected because it responded effectively and sensitively with data • Loggers watched VDs straight through	**Strengths identified:** • Amateur in quality but first-hand raw records of illness • Objective and subjective data • Multi-faceted nature of human experience recorded, logged and analysed • Reduced clinician patient power • Observation of disease in 'real-life' • Insights into the subjective experience and perspective of illness • NVivo significantly enhanced the analysis process

				• 2nd time logged records from two approaches - objective of what is seen and heard, subjective, what is shown and how it is shown (examples given in paper) • Logs time coded for easy cross referencing • Logs transferred to NVivo • Logs coded on multiple levels • Questions asked of data by multi-professionals, e.g. psychologist, anthropologist, social worker • Research team triangulated data with data from interviews, medical history questionnaires	
38	**Roberts 2011** Video Diaries: a tool to investigate sustainability-related learning in threshold spaces.	28 x under-graduate students on a field trip to Uganda from UK	To investigate the process of transformative learning in the context of education and sustainability	Case study approach using grounded theory Some dialogue transcribed	**Strengths identified:** • Visual data gave rich data - emotions • Intimate relationship with camera • Encouraged self-examination • Captured "trains of thought" - Nonlinear - disjointed • Recorded the immediacy of the moment • Trust between researcher and participant enhanced • **Limitations:** Restricted further investigation - through dialogue • Performance in front of camera

39	**Rodd et al. 2013** 'I felt weird and wobbly'. Child-reported impacts associated with a dental general anaesthetic .	10 x children 8x girls 2x boys aged 7-13 years who had a dental extraction under GA in UK	To gain a greater understanding of the physical and psychological impacts of dental extraction from a child's perspective. Interview 2 weeks before dental extraction - VD's commenced - guidance given with suggestions - 2nd interview within 2 weeks after extraction	• Transcribed • Narrative approach to analysis • Coded to identify emerging themes and frameworks	**Strengths identified:** • Children experienced at using technology • Children interviewed parents and siblings • Ownership of diary • Removed power imbalance between researcher and child • Contemporaneous - reducing potential for recall bias **Limitation:** • Short follow up period
40	**Scott et al. 2012** Bioscience students' first year perspectives through video diaries: home, family and student transitions.	64 x under-graduate students Leicester	To explore student experience over first year in university VDs - to record 5 mins per week in first semester and every 2-3 weeks in second semester. No instructions. Follow up with focus groups Ethnography - multi-sited	Thematic analysis using NVivo	**Strengths identified:** • No topic guide avoiding staff bias and encouraging open discussion • Contemporaneous recording - no reliance on memory • Captured emotions • Provided a sense of self and identity • Insights into student transition
41	**Sunderland and Denny 2002** Performance and partners: consumer video documentaries in ethnographic research.	General paper discussed uses of VDs with consumers	Ethnography VDs used for commercial use. Videotape documenting products which are self produced by consumers.	30 mins to 1 hour Thematic editing	**Strengths identified:** • Performance did not make it any less real - "for when is social life without performance" • Create and present participants' sense of reality, not captured in ethnographic notes • "Performance of routines are themselves embodiment of culture" • Enhances understanding through a "cultural lens"

					• An understanding of participants perspectives were enhanced **Limitations:** • Record was never total • “Camera’s eye was a narrow lens, placed and directed by a human eye” • Researchers presence always existed

Appendix 6 Letter of Invitation

REC Reference number: 10/H0502/64
6 February 2011 (Letter of invitation - version 3)

Letter of Invitation

Bournemouth University

Dear

Re: Exploring women's breastfeeding experiences using video diaries.

I am a PhD student at Bournemouth University. I am writing to you because you are about 28-30 weeks pregnant and expecting your first baby. I would like to invite you to take part in a research study about women's experiences of breastfeeding.

Before you decide, it is important for you to understand why the research is being done and what it will involve. Please read the enclosed information leaflet carefully. Do talk about it with your family, friends, and your midwife too if you wish. You can contact me or my supervisor by phone or email if you have any questions.

If you are interested in taking part in the study, please complete the reply slip enclosed with this letter, and post it back to me in the stamped addressed envelope by ....date within 3 weeks... If I receive the names of more people than I require for the study, I will need to select women from a variety of ages and areas of Dorset. I will therefore contact you within two weeks of receiving your reply to let you know if you have been selected for the study or not.

If you are selected, I will then arrange to visit you in your home when you are about 32-35 weeks pregnant, at a time which is convenient for you and your family. I will explain the study further and answer any questions you may have. If you agree to take part in the study, I will ask you to sign a consent form and then make the necessary arrangements for you to start filming.

Thank you for taking the time to read this letter.

Yours sincerely

Alison Taylor

PhD Student
School of Health and Social Care
Bournemouth University
Royal London House
Christchurch Road
Bournemouth
Dorset BH1 3LT
Phone: 01202 961548
ataylor@bournemouth.ac.uk

Professor Prof Edwin van Teijlingen
Dr Kath Ryan
Emerita Professor Jo Alexander

PhD Supervisors
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Phone: 01202-961564
vanteijlingen@bournemouth.ac.uk

Reply slip

If you are interested in taking part in the research study, please complete this slip and return it in the stamped addressed envelope.

Please tick

I confirm that I have read the attached information sheet ☐

I am interested in taking part in this study and I am willing to meet the researcher to find out more about what is involved. ☐

Name.....

Address .....

.....Post code.....

Contact/mobile number .....

Email ..... Date of birth.....

Job before commencing maternity leave (if any) .....

Partners' job (if any) .....

Please tick ethnic group

White		Black or Black British	
English		Caribbean	
Other British		African	
Irish		Any other Black background	*Please write in*
Any other white background	*Please write in*		
Asian or Asian British		**Other ethnic group**	
Indian		Arab	
Pakistani		Gypsy/Romany/Irish Traveller	
Bangladeshi		Any other	*Please write in*
Chinese			
Any other Asian background	*Please write in*		
Mixed			
White and Black Caribbean			
White and Black African			
White and Asian			
Any other mixed background	*Please write in*		

The personal data collected on this form will be held securely and will only be used for the management of the project by those persons with a strict need to know it as part of the project. It will not be kept longer than necessary for the carrying out of the project.

Appendix 7 Participant Information sheet for women & their families

Reference number: 10/H0502/64 20 December 2010 - version 4

Bournemouth University

Participant Information sheet for women and their families

Exploring women's breastfeeding experiences using video diaries

PhD Student:
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Phone: 01202 961564
vanteijlingen@bournemouth.ac.uk

Hello

My name is Alison Taylor. I am a PhD student at Bournemouth University. I am inviting you to take part my research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please read this information carefully. Do talk about it with your family, friends, and your midwife too if you wish. Ask me if you have any questions. You can contact me by phone or email. If you are interested in taking part I will arrange a visit to your home before your baby is born to explain the study further and answer any questions you may have.

Why is the study being done?

The purpose of this study is to find out what it is like to breastfeed from the mother's point of view in the first days and weeks following birth. I want to find out about the day to day experiences of breastfeeding, including any difficulties new mothers face, any support that is received, as well as the enjoyable aspects of breastfeeding.

Why have I been invited?

You have been given this leaflet because you are expecting your first baby and I want to find out what it is like to breastfeed when a mother has not breastfed before.

Do I have to take part?

No you don't. It is entirely your choice. If you choose not to take part or decide to withdraw at any stage in the study, it will not affect the care you receive now or in the future from any health care worker or breastfeeding supporter.

What will happen to me if I take part?

If you consent to take part you will be provided with a video camera. I will deliver the camera to your home at a convenient time for you after your baby has been born and you have

commenced breastfeeding. You and your family will be shown how to use it and I will leave you with a set of simple instructions.

I will ask you to keep a video diary of your breastfeeding experiences. I will ask you to record everything and anything that you would like to share with me about breastfeeding and what it is like for you and your family. To make it easier you can ask other members of the family to film you. It would be helpful to record some video of you with your baby but only if you consent to your baby being recorded in this way. A separate question on your consent form will ask you about this.

I will also ask you to sit in front of the camera at least once a day to speak to it, as if it were your diary. I would like you to talk about whatever is on your mind including your dreams, successes, problems, and frustrations related to breastfeeding and to tell the camera what has been happening in the day. This will be a bit like reality TV.

You can also film any other people to show what family life is like when you are breastfeeding. However, they must agree and consent to being filmed by signing a 'consent in principle' form. I will then contact them myself to ensure they understand and are happy to be included in the research. If they do not agree and do not sign the 'Future use of the video diaries - consent' form, I shall edit them out of the video for confidentiality reasons.

You will be shown how to view the film and how to cut out any bits of film that you are unhappy with or would not like included in the research. The video film will be recorded onto a memory card. Every three days I will visit you to collect the video footage and to bring more memory cards.

I will ask you to continue filming daily until you think your chosen method of feeding has become established or until your baby is 8 weeks old.

What happens if I bottle feed?

This study is about breastfeeding. You need to be breastfeeding to take part in the study. However, if during the course of the first few days or weeks you start bottle feeding then I will ask you to continue filming until you think your chosen method of feeding, breast or bottle or both, is established.

What if my baby is born prematurely or is ill?

This study is looking at women's experiences of breastfeeding their full term healthy babies. If your baby is born before 37 weeks of pregnancy or your baby is unwell at birth then you will not be included in the study.

How will the video films be used by the researcher?

Each time I come and collect the video film from you, you will be asked to sign a form called 'Future use of my video diaries'. If you sign this form, you hand over copyright of the video films to Bournemouth University. This will allow me to use the video film for my research, to publish the findings and to use them in the education of midwives and other supporters of breastfeeding women. I will only use your contribution in the manner that you have agreed to, and the material will not be exploited commercially. You will be given your own personal copy of the signed consent form to keep.

I will collect video film from eight different breastfeeding women. Therefore each of your video films will be labelled with a code and a number to identify the sequence of events. I will watch the recordings many times to find issues that are important to mothers who are breastfeeding. During the analysis, the video clips and any other research data will be kept strictly confidential and stored on password protected computers in accordance with the Data Protection Act (1998).

What will happen to the findings of the research study?

The findings from this research will be written up as a PhD thesis, which will include some of the video clips. I will report the findings of the research sensitively and will not make any judgements about your actions and decisions.

The findings will be published widely in journals relating to care and support for breastfeeding women. Because the video footage will be so important to illustrate what I find in the research, I may also publish the findings along with some of the video clips on the internet and present them at conferences. I will also use the findings and video clips in the education of midwives and other supporters of breastfeeding women, so that the provision of support can be improved.

Will my taking part in this research be kept private?

Because you will be filming yourself and others within your family, it will be very difficult to keep the images confidential or anonymous. Therefore, I cannot guarantee your privacy when I publish the findings, as those who view the film, may recognise you. This will be similar in some ways to reality TV programmes where people may be recognised.

If you wish to remain less identifiable, particularly within written reports of the research, you will be invited to choose an alias name for yourself and others. I will also ask you not to film any identifiable locations such as the house number and street name.

Before giving me the videos, you may view them and cut out any footage that you do not want used for the research.

What if I decide to withdraw from the study?

You are free to leave the study at any time. If you decide to leave before publication of the findings, all the videos will be destroyed. However, if you decide to leave following publication of the findings, then the video footage will be removed from any web pages and destroyed. However, some of the video clips may have already been viewed by members of the public and it will be impossible to remove all existing copies from circulation.

What are the disadvantages and risks of taking part?

As I have previously said, because you will be recording yourself on video, confidentiality and anonymity cannot be maintained and therefore anyone who watches the video clips may recognise you. That is why it is really important for you to edit your video and cut out any unwanted footage that you do not want included in the research.

You may think that it will be time consuming to film every day but you can record as much or as little as you feel able. You may also feel a bit emotional at times. Whilst these emotions are important to capture in order to find out what it is like to breastfeed, I do not want to cause you any added stress. Therefore, you are free to record when and where you feel comfortable and no more.

To ensure that I cause a minimal amount of disturbance to you and your family, I will try to visit you to collect the videos only at times that are convenient to you.

If you are experiencing difficulties with breastfeeding, I will not be able to provide advice or support as this would alter your overall experience. However, I would be able to recommend another health professional or specialist breastfeeding support worker for you to contact.

What are the possible benefits of taking part?

This will be a unique opportunity for you to record your journey into motherhood. You can record the video whenever it is convenient to you. At the end of the study you will be offered your own personal copy of all the video footage which will be a memorable record to look back on.

By sharing your experiences of breastfeeding you will provide valuable information that could help midwives, health workers and other breastfeeding supporters to understand the needs of breastfeeding women better. This information can be used to improve support for breastfeeding women through education and training. Your breastfeeding diaries may also provide helpful insights for other mothers who are breastfeeding.

Are there any other limits to confidentiality?

In line with the law of this country, I will be compelled to report to the authorities any images suggesting serious harm to others such as abuse or neglect of children.

Working with young children, pregnant women and new mothers.

As a researcher working with pregnant women, newly delivered mothers, newborn babies, and other children, I have an up-to-date Criminal Record Bureau (CRB) check.

Who is funding the study?

My PhD study is being funded by Bournemouth University. The video cameras have been funded by the Iolanthe Midwifery Trust.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your interests. This study has been reviewed and given a favourable opinion by Southampton & South West Hampshire Research

Ethics Committee. It has also been approved by the Postgraduate Research Ethic committee at Bournemouth University.

What do I do if I am interested in taking part?

Complete the reply slip included with the letter of invitation and send it to me within three weeks of receiving this leaflet in the prepaid addressed envelope. When I receive the reply slip, I will contact you to arrange to visit you at home at your convenience. Other family members are invited to be at the meeting too. At that meeting, I will explain the study to you again and answer any questions that you may have. This meeting may take up to one hour. If you are willing to take part, I will ask you to sign a consent form. I will also ask any of your family members to sign a consent form if they are also willing to join in. I will give you your own copy of the consent form. I will show you how to use the video camera and then leave it with you for a week so that you can practise using it. After that time I will collect the camera returning it to you after your baby is born and you have returned home.

Contact for further information

I hope that this information sheet has told you what you need to know about this research study before deciding whether or not to take part. If you have any queries at all about the project or wish to make a complaint, please telephone Alison Taylor on 01202 961548, or Edwin van Teijlingen and Jo Alexander on 01202 961564.

If you would like independent information or advice you can contact PALS (Patient Advocacy and Liaison Service) on phone 01202 448499, text 07758 272495 or email pals@poole.nhs.uk.

Many thanks for taking the time to read this information leaflet.

Appendix 8 Consent to participate in research project: mother & baby

Bournemouth University

REC Reference number: 10/H0502/64

13 February 2011 – version 4

School of Health and Social Care

Consent to participate in Research Project: Mother and baby

Title of Research Project: Exploring women's breastfeeding experiences using video diaries

Name of Researcher: Alison Taylor, PhD student at Bournemouth University

Bournemouth University Research Supervisors: Prof Edwin R. van Teijlingen

Other Research Supervisors: Dr Kath Ryan and Emerita Prof Jo Alexander

Please initial box

1. I confirm that I have read and understood the information sheet (dated 21 October 2010) for the above project. 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 and without my medical care or legal rights being affected. ☐
3. I agree to take part in the above project. ☐
4. I agree to include my baby in the project. ☐

Name of Participant (block capitals)	Date	Signature

Royal London House
Christchurch Road
Bournemouth Dorset
BH1 3LT
United Kingdom

hsc@bournemouth.ac.uk
www.bournemouth.ac.uk/hsc

Appendix 9 Guidelines for keeping your video diary

Alison Taylor

Guidelines for keeping your video-diary

I would like you to keep a video diary of your breastfeeding experiences. Please record everything and anything that you would like to share with me about breastfeeding and what it is like for you and your family. **Record whatever is important and relevant to you at the time, however trivial it might feel to you.**

For each video-recording please tell me:

- The date and time of day
- Where you are recording
- What you have just been doing
- Whether you are alone/what is going on around you

You can ask a family member to film you if that would make it easier. If you can, try to ensure there is not light behind you because that will darken your face! There is also a little light on the camera that may be helpful.

It would be helpful to record some video of you with your baby if you're happy for your baby being recorded in this way. You may be doing something at the time and chatting to the camera as you are recording or you may just record various activities as they are naturally occurring. Both are really useful.

In addition to any other recordings, I would like you to sit in front of the camera once a day (with or without your baby) but on your own to speak to it, as if it were your diary. Please talk about whatever is on your mind including your dreams, successes, problems, and frustrations related to breastfeeding and to tell the camera what has been happening that day. Record for as long or as short as you like.

Here are some ideas of things that you might like to record or talk about to the camera but don't feel restricted by this list:

- Your experience of breastfeeding your baby
- Your thoughts about breastfeeding
- How you are feeling before you start to breastfeed
- What you are feeling and thinking when you are actually breastfeeding
- How you are feeling after a breastfeed
- The most pleasurable aspects of breastfeeding and how this make you feel
- What you dislike or find difficult about breastfeeding and how this make you feel
- Any problems that are occurring as they are happening
- Any advice that you receive about breastfeeding and who gave it
- Demonstrations or images of how you are breastfeeding or any equipment you may be using
- Any decisions you make about feeding your baby
- Things you like to do before or after a breastfeed
- Going out
- How you are finding being a mum and what it is like looking after your baby
- What is going on more generally in your life and how you are feeling about this
- Interactions and discussions with family and friends relating to feeding your baby - (if you film them they must agree to take part and please ask them to sign a consent form first)

Appendix 10Provision opinion from National Research Ethics Service and responding letter

NHS
National Research Ethics Service
Southampton & South West Hampshire REC (A)
Building L27
University of Reading
London Road
Reading
RG1 5AQ

Telephone: 0118 918 0567
Facsimile: 0118 918 0559

28 September 2010

Mrs Alison M Taylor
Senior Lecturer in Midwifery
Room 609, Royal London House
Christchurch Road
Bournemouth
BH1 3LT

Dear Mrs Taylor

Study Title: **Using video diaries to explore women's experiences of breastfeeding in the early weeks**
REC reference number: **10/H0502/64**
Protocol number: **N/A**

The Research Ethics Committee reviewed the above application at the meeting held on 14 September 2010. Thank you for attending to discuss the study.

Documents reviewed

The documents reviewed at the meeting were:

Document	*Version*	*Date*
Investigator CV		03 August 2010
Protocol	1	30 July 2010
Supervisor CV - Dr Kath Ryan		03 August 2010
Supervisor CV - Prof Jo Alexander		03 August 2010
REC application		04 August 2010
Covering Letter		30 July 2010
Letter from Sponsor		02 June 2010
Letter of invitation to participant	1	12 July 2010
Participant Consent Form: Appendix 4 - Future Use of My Video Diaries - Mother and Baby	1	12 July 2010
Participant Information Sheet: Appendix 8 - Children under 6	1	12 July 2010
Participant Information Sheet: Appendix 5 - Friends and Family members	1	12 July 2010
Participant Information Sheet: Appendix 9 - children aged 6 - 10	1	12 July 2010
Participant Information Sheet: Appendix 2 PIS for women and their families	1	12 July 2010
Participant Information Sheet: Appendix 10 - Children aged 11 - 16	1	12 July 2010
Participant Consent Form: Appendix 3 Consent form for mothers and their babies	1	12 July 2010

This Research Ethics Committee is an advisory committee to South Central Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

Participant Consent Form: Appendix 6 - Friends and family	1	12 July 2010
Participant Consent Form: Appendix 11 - Parent's consent for children	1	12 July 2010
Participant Consent Form: Appendix 12 Future Use of My Video Diaries - Children (Parent's consent)	1	12 July 2010
Participant Consent Form: Appendix 7 - Future Use of My Video Diaries - friend or family	1	12 July 2010
Evidence of insurance or indemnity		02 June 2010

Provisional opinion

- The Committee asked the Researcher to clarify how they would go about ensuring that all that appear in the videos have consented to be included. The Researcher acknowledged that they would need consent for all parties that appear on the videos and that they would ensure this was done by watching all the videos first and then noting those who are included and then clarifying if they already have consent or whether they need to get consent.
- The Committee asked the Researcher to outline how they would deal with any health concerns that arise from the videos. The Researchers advised the Committee that they would be able to report any concerns they had to the appropriate people, but also that they would be able to refer any participants that come to them to appropriate help. The Researcher assured the Committee that they felt this was a very important responsibility for the researcher team.
- The Committee asked the Researcher to clarify the role of the internet, in the broadcasting and usage of the videos. The Researcher advised the Committee that they were keen to create a system whereby Mothers would be informing other Mothers and that this was their motive for making the videos publicly available. The Researcher added that they would make it clear to participants that the videos may be removed after their upload.
- Further to clarification of Consent, the Committee suggested to the Researchers that there is a distinction between the study and the educational materials they wish to create, and that once they have the created the final versions of the videos, it would be possible for them to seek consent retrospectively.

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.

The Committee delegated authority to confirm its final opinion on the application to the Chair.

Further information or clarification required

1. The Committee request written assurances that the anyone featuring in the videos, other than the study participant, that they plan to publish, would have to either have consent to participate or be censored out and be unidentifiable.

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 04 February 2011.

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H0502/64	**Please quote this number on all correspondence**

Yours sincerely

Dr Iain MacIntosh
Chair

Email: w.goodyear@nhs.net

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments.*

Copy to: *Dr Kath Ryan*

Southampton & South West Hampshire REC (A)

Attendance at Committee meeting on 14 September 2010

Committee Members:

Name	*Profession*	*Present*	*Notes*
Mr Richard Andoh	Pharmacist	Yes	
Rev'd Dr Rosemary Baker	Consultant in Learning Disabilities	Yes	
Mrs Ita Berry	Clinical Psychologist	Yes	
Dr Paul Diprose	Consultant Anaesthetist	Yes	
Mrs Grania Howard	Operating Department Practitioner	Yes	
Mr Clifford Kilgore	Nurse Practitioner	Yes	
Dr Simon Kolstoe	Academic Research Scientist	Yes	
Dr Mary Lanyon	Retired Veterinarian	Yes	
Dr Iain MacIntosh	Consultant Paediatric Intensive Care	Yes	
Dr Chris Markham	Senior Lecturer in Health Service & Research	Yes	
Mrs Jane Ogden-Swift	Manager	No	
Miss Ria Skelton	Research Fellow	No	
Mrs Margaret Stephens	Senior Specialist, Speech & Language Therapist (Adult Neurology & Elderly Care)	Yes	

Also in attendance:

Name	*Position (or reason for attending)*
Mr Will Goodyear	Temporary Coordinator

Bournemouth University

Room 609
Royal London House
Christchurch Rd
Bournemouth
Dorset
BH1 3LT
Tel: 01202 961548
Email: ataylor@bournemouth.ac.uk

8th November 2010

Dr Iain MacIntosh
Consultant Paediatrician and Chair
National Research Ethics Service
Southampton and South West Hampshire REC (A)
Building L27
University of Reading
London Road
Reading
RG1 5AQ

Study title: **Using video diaries to explore women's experiences of breastfeeding in the early weeks**

REC reference number: **10/H0502/64**

Dear Dr MacIntosh,

Many thanks for reviewing my application for the above research study on 14 September 2010. The discussions were most helpful in refining the consent issues in relation to additional people who may be filmed as part of the mothers' video diaries.

I confirm that if the mother wishes to film anyone who has not already met me and provided written consent to feature in the video diary, that she will initially give information using the Participation Information leaflet for friends and family (Appendix 5). Having read the information and before filming, the additional person may want more information and could phone me or one of my research supervisors to ask questions. If the person is willing to be filmed, the mother would then gain consent in principle by asking him/her to complete the 'Consent in Principle' form (Appendix 6). This includes providing contact details for me to contact them.

When collecting the video memory cards, I would notice that the additional person had been filmed because the 'Consent in Principle' form had been completed (alternatively I would notice the additional person on first viewing). I would then contact that person to arrange to explain the research in full, ensuring he/she has all the necessary documentation, provide the opportunity to have questions answered, gain consent for their video contribution to be used in the research study, including analysis and dissemination and gain release of copyright. This written consent would be recorded on the 'Future use of video diaries - consent' form (Appendix 7). If consent was withheld, or otherwise unavailable, the related section of the video would be censored out.

I am enclosing two copies of the research protocol including all the appendices for final review. One copy has all the tracked changes so that you are able to identify key changes made as a result of your recommendation. The second copy is a complete version without tracked changes for easier viewing and reading.

I trust that this meets the Committee's requirements to gain valid consent from additional people visiting the mother, so that I am able to use their video contribution in this research study including analysis and dissemination of the findings. I look forward to your response.

May I take this opportunity to thank you again for reviewing this study.

Yours sincerely

Alison Taylor

Senior Lecturer in Midwifery

PhD student

Appendix 11Participant Information sheet for friends and other family members

REC Reference number: 10/H0502/64 20 December 2010 - version 5

Participant Information sheet for friends and other family members

Exploring women's breastfeeding experiences using video diaries

PhD Student:
Alison Taylor
Centre for Midwifery,
Maternal & Perinatal Health
School of Health and Social Care
Bournemouth University
Royal London House
Christchurch Road
Bournemouth
Dorset BH1 3LT
Phone: 01202 961548
ataylor@bournemouth.ac.uk

PhD Supervisors:
Prof Edwin van Teijlingen
Dr Kath Ryan
Emerita Prof Jo Alexander
Centre for Midwifery,
Maternal & Perinatal Health
School of Health and Social Care
Bournemouth University
Royal London House
Christchurch Road
Bournemouth
Dorset BH1 3LT
Phone: 01202 961564
vanteijlingen@bournemouth.ac.uk

Hello

My name is Alison Taylor. I am a PhD student at Bournemouth University. I am inviting you to take part in my research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please read this information carefully. Do talk about it with .....Mother's name..... If you have any questions, you can contact me by phone or email.

Why is the study being done?

The purpose of this study is to find out what it is like to breastfeed in the first days and weeks following birth from the mother's point of view. I want to find out about the day to day experiences of breastfeeding, including any difficulties new mothers face, any support that is received, as well as the enjoyable aspects of breastfeeding.

Why have I been invited?

You have been given this leaflet because you are a friend or relative of ...mother's name... and she is taking part in a research study to find out what it is like to breastfeed.

Do I have to take part?

No you don't. It is entirely your choice. If you choose not to take part or decide to withdraw at any stage in the study, it will not affect your medical or legal rights.

What will happen to me if I take part?

If you consent to take part, you agree to be videoed by .....mother's name.... or a member of her family to show what family life is like when she is breastfeeding. Before you are filmed, ...mother's name.... will ask you to complete a 'Consent in Principle' form which will include your contact details. Once you

have been filmed, you can ask ...mother's name.... to view the film and to remove any bits of video that you would not like to be included. After the video has been given to me, with the 'Consent in Principle' form, I will contact you and arrange to speak with you individually. I will explain the research, ensure you understand what it means to be involved and answer any of your questions. If you consent to using the video in my research I will ask you to sign 'The future use of video diaries – consent' form. Without this signature, I will not use your contribution and delete it from the video footage.

How will the video films be used by the researcher?

Each time I collect the video film, I will collect any 'Consent in Principle' forms. I will then contact you as explained above and if you agree for your video contribution to be used in the research, I will ask you to sign a 'Future use of the video diaries – consent' form. When you sign this consent form you will be consenting to your inclusion in the research and handing over copyright of the video films to me. This will allow me to use the video film for my research, to publish the findings and to use them in the education of midwives and other supporters of breastfeeding women. I will only use your contribution in the manner that you have agreed to. You will be given your own personal copy of the signed consent form to keep.

I will collect video film from eight different breastfeeding women. Therefore each film will be labelled with a code and a number to identify the sequence of events. Along with video film from other mothers who take part in the study, I will watch the video footage many times to find themes that are common to mothers who are breastfeeding. During this analysis, the video clips and any other research data will be kept strictly confidential and stored on password protected computers in accordance with the Data Protection Act (1998).

What will happen to the findings of the study?

The findings from this research will be written up as a PhD thesis which will include some of the video clips. I will report the findings of the research sensitively and will not make any judgements about your actions or discussions. The findings will be published widely in journals relating to care and support for breastfeeding women. Because the video film will be so important to illustrate what I find in the research, I may also publish the findings along with some of the video clips on the internet and present them at conferences. I will also use the findings and video clips in the education of midwives and any other supporters of breastfeeding women, so that the provision of support can be improved.

Will my taking part in this research be kept private?

Because you will be filmed by video camera, it will be very difficult to keep the images confidential or anonymous. Therefore, I cannot guarantee your privacy when I publish the findings, as those who view the film, may recognise you. This will be very similar to reality TV programmes where people may be recognised. If you wish to remain less identifiable, particularly within written reports of the research, you will be invited to choose an alias name for yourself.

What if I decide to withdraw from the study?

You are free to leave the study at any time. If you decide to leave before publication of the findings, all the video films where you have contributed will be destroyed. However, if you decide to leave following publication of the findings, then the video films will be removed from any web pages and destroyed. However, some of the video clips may have already been viewed by members of the public and it will be impossible to remove all existing copies from circulation.

What are the disadvantages and risks of taking part?

As I have previously said, because you will have been recorded on video, confidentiality and anonymity cannot be maintained and therefore anyone who watches the video clips may recognise you. That is why it is really important for you to ask mother's name ..... if you can view and edit out any unwanted video that you do not want included in the research.

What are the possible benefits of taking part?

This will be a unique opportunity for you to contribute to mother's name journey into motherhood. At the end of the study mother's name will be given her own personal copy of all the video footage which will be a memorable record to look back on. By sharing in the video diary you will provide valuable information about family and home life when a mother is breastfeeding her baby in the early weeks after birth. This information could help midwives, health workers and other breastfeeding supporters understand the needs of breastfeeding mothers and their families better. This information can be used to improve support for breastfeeding women through education and training. These breastfeeding diaries may also provide helpful insights for other mothers who are breastfeeding.

Are there any other limits to confidentiality?

In line with English law, I will be compelled to report to the authorities any images suggesting serious harm to others including abuse or neglect to children.

Working with young children, pregnant women and new mothers.

As a researcher working with pregnant women newly delivered mothers and children, I have an up-to-date Criminal Record Bureau (CRB) check.

Who is funding the study?

My PhD is being funded by Bournemouth University. The video cameras have been funded by a charity called the Iolanthe Midwifery Trust.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your interests. This study has been reviewed and given favourable opinion by Southampton & South West Hampshire Research Ethics Committee. It has also been approved by the Postgraduate Research Ethic committee at Bournemouth University.

What do I do if I am interested in taking part?

Complete the 'Consent in Principle' form that accompanies this information sheet. Leave this form in the envelope provided with the mother. I will collect it when I next collect the memory cards. I will then contact you and if you are happy for me to use your contribution in the research and dissemination of findings, I will ask you to complete the 'Future use of the video diaries - consent' form.

Contact for further information

I hope that this information sheet has told you what you need to know about this research study before deciding whether or not to take part. If you have any queries about the project or wish to make a complaint, please telephone Alison Taylor on 01202 961548 or Edwin van Teijlingen and Jo Alexander on 01202 961564.

If you would like independent information or advice you can contact PALS (Patient Advocacy and Liaison Service) on phone 01202 448499, text 07758 272495 or email pals@poole.nhs.uk

Many thanks for taking the time to read this information leaflet.

Appendix 12‘Consent in Principle’ form: Friends and family

REC Reference number: 10/H0502/ 13 February 2011 - Version 5

Bournemouth University

School of health and Social Care

‘Consent in Principle’ form: Friends and family

Title of Research Project: Exploring women's breastfeeding experiences using video diaries

Name of Researcher: Alison Taylor, PhD student at Bournemouth University

Bournemouth University Research Supervisors: Prof Edwin R. van Teijlingen

Other Research Supervisors: Dr Kath Ryan and Emerita Prof Jo Alexander

Please initial box

1. I confirm that I have read and understood the ‘Participant Information sheet for families and friends’ (dated 21 October 2010) for the above project. ☐
2. I have had the opportunity to consider the information, and am willing to be filmed by ..... or a member of her family. ☐
3. I understand that **BEFORE the Researcher can use the film in her research project or publish the findings** she will need to contact me to explain the project in full, ensure I understand my involvement in the project, and gain written consent from me. ☐
4. I understand that if the Researcher is unable to contact me to gain consent or I do not wish to give my consent then she will delete any portions of the film featuring me. ☐

The personal data collected on this form will be held securely and will only be used for the management of the project by those persons with a strict need to know it as part of the project. It will not be kept longer than necessary for the carrying out of the project.

I will make no claim for any reason to the Researcher or the University in relation to the data contained in this form, except as permitted by law.

Name _____ Email address_____

Address _____ Tel /mobile Number _____

_____ Postcode_____

Signature _____ Date _____

Royal London House
Christchurch Road
Bournemouth Dorset
BH1 3LT
United Kingdom

hsc@bournemouth.ac.uk
www.bournemouth.ac.uk/hsc

Appendix 13 Favourable ethical opinion from National Research Ethics Service

NHS

National Research Ethics Service

Southampton & South West Hampshire REC (A)
Building L27
University of Reading
London Road
Reading
RG1 5AQ

Telephone: 0118 918 0567
Facsimile: 0118 918 0559

27 January 2011

Mrs Alison M Taylor
Senior Lecturer in Midwifery
Bournemouth University
Room 609, Royal London House
Christchurch Road
Bournemouth
BH1 3LT

Dear Mrs Taylor

Study Title:	**Using video diaries to explore women's experiences of breastfeeding in the early weeks**
REC reference number:	**10/H0502/64**
Protocol number:	**N/A**

Thank you for your letter of 08 November 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Vice-Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, 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.

This Research Ethics Committee is an advisory committee to South Central Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) 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 the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

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 final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Covering Letter		30 July 2010
Letter from Sponsor		02 June 2010
Letter of invitation to participant	v2	21 October 2010
Investigator CV		03 August 2010
Response to Request for Further Information		08 November 2010
Participant Information Sheet: Appendix 2, for women & familes, without tracked changes	v3	21 October 2010
Participant Information Sheet: Appendix 8, under 6 yrs, without tracked changes	v2	21 October 2009
Participant Information Sheet: Appendix 10, 11-16 yrs, without tracked changes	v2	21 October 2010
Participant Information Sheet: Appendix 2 - for women & families, tracked changes	v3	21 October 2010
Participant Information Sheet: Appendix 8, under 6 yrs, with tracked changes	v2	21 October 2010
Participant Information Sheet: Appendix 10, 11-16 yrs, with tracked changes	v2	21 October 2010
REC application		04 August 2010
Participant Information Sheet: Appendix 9, children 6 - 10 yrs, without tracked changes	v2	21 October 2010
Participant Information Sheet: Appendix 5, for friends & families, without tracked changes	v4	21 October 2010
Participant Consent Form: Appendix 3 - for mothers, with tracked changes	v2	21 October 2010
Participant Information Sheet: Appendix 5, friends & family, without tracked changes	v4	21 October 2010
Participant Consent Form: Appendix 6, friends & family, with tracked changes	v3	21 October 2010
Participant Consent Form: Appendix 3, for mothers, without tracked changes	v2	21 October 2010
Participant Consent Form: Appendix 6, friends & family, without tracked changes	v3	21 October 2010
Participant Consent Form: Appendix 11, for children,	v2	21 October 2010

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The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

with tracked changes		
Participant Consent Form: Appendix 11, for children, without tracked changes	v2	21 October 2010
Participant Consent Form: Appendix 12, future use of video, for children, with tracked changes	v2	21 October 2010
Participant Consent Form: Appendix 12, future use of video, for children, without tracked changes	v2	21 October 2010
Supervisor CV - Dr Kath Ryan		03 August 2010
Supervisor CV - Prof Jo Alexander		03 August 2010
Evidence of insurance or indemnity		02 June 2010
Protocol	v3, without tracked changes	21 October 2010
Protocol	v3, with tracked changes	21 October 2010
Participant Consent Form: Appendix 4, for future use of video diaries, with tracked changes	v2	21 October 2010
Participant Consent Form: Appendix 4, for future use of video diaries, without tracked changes	v2	21 October 2010
Participant Consent Form: Appendix 7, future use of video clips, with tracked changes	v3	21 October 2010
Participant Consent Form: Appendix 7, future use of video clips, without tracked changes	v3	21 October 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

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.

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
- 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.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H0502/64	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Iain MacIntosh
Chair

Email: scsha.swhreca@nhs.net

Enclosures: "After ethical review – guidance for researchers" *[SL-AR1 for CTIMPs, SL- AR2 for other studies]*

Copy to: *Dr Kath Ryan*

This Research Ethics Committee is an advisory committee to South Central Strategic Health Authority

The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England

Appendix 14 Research Governance Department letter

Poole Hospital NHS
NHS Foundation Trust
Research Governance Department

14 March 2011

Alison Taylor
Bournemouth University
Room 609
Royal London House
Christchurch Road
Bournemouth, Dorset
BH1 3LT

Dear Alison

Re: Using video diaries to explore women's experiences of breastfeeding in the early weeks
REC reference number: 10/H0502/64
EudraCT number: N/A
NIHR CRN Portfolio Number: N/A
Protocol Ref: V3

We are pleased to advise you that this Trust has given approval to be used as a Person identification Centre for the above study.

Conditions under which this approval is given can be found at http://dorsetresearch.org. Please notify the Research Governance Department if there are any changes in the above named study relating to these conditions.

Documents reviewed were in accordance with current versions listed in the favourable ethical opinion correspondence received from the Southampton and South West Hampshire Research Ethics Committee dated 27 January 2011.

Yours sincerely

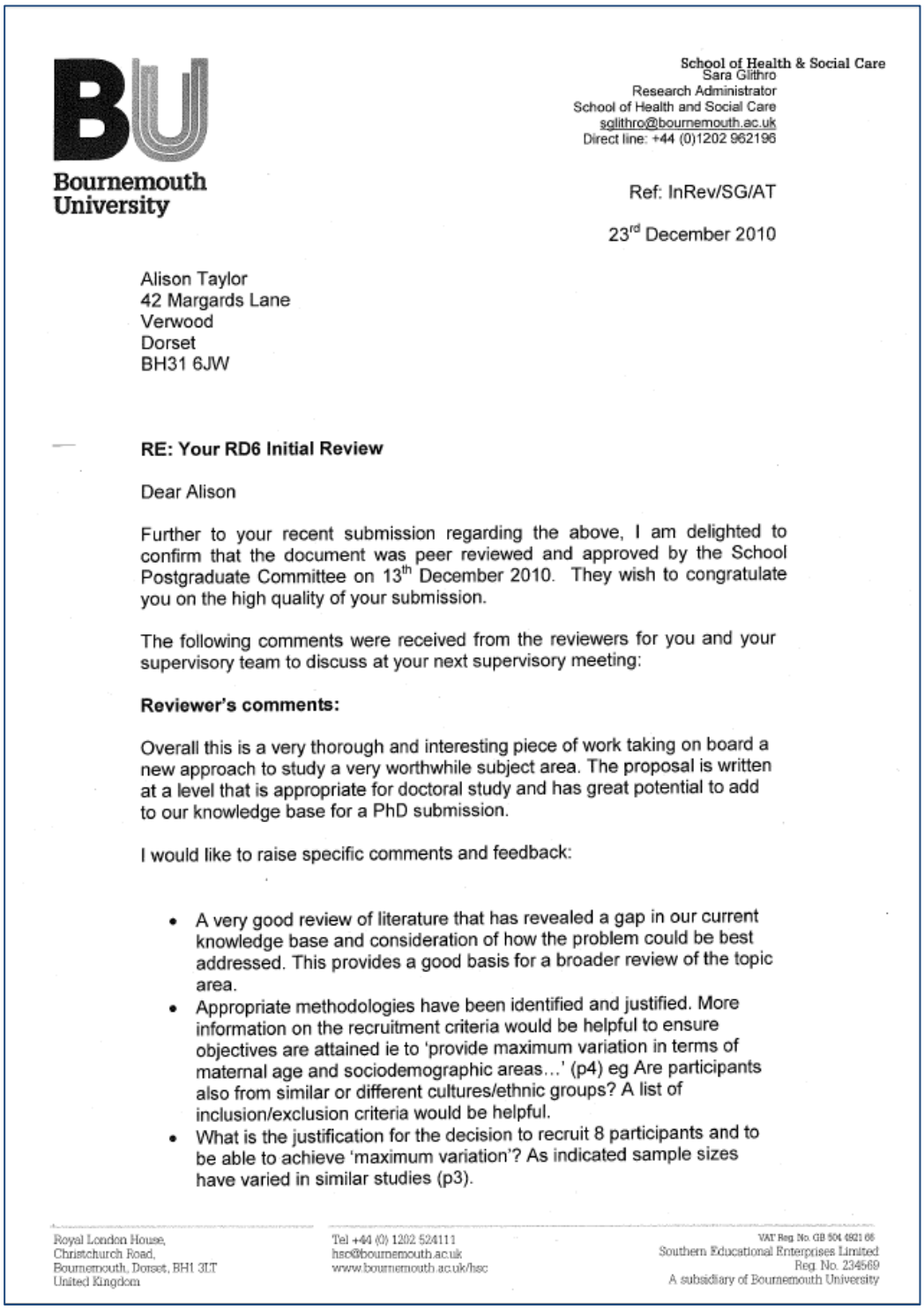
Martin Smits
Director of Nursing & Patient Services

Cc: kryan@bournemouth.ac.uk; Helen Williams & Sandra Chitty

Please send all correspondence relating to this study to:
Research Governance Manager
Research Governance Department
Poole Hospital NHS Trust
Longfleet Road
Poole, DORSET, BH15 2JB

Research Governance Department, Cornelia House, Poole Hospital NHS Foundation Trust, Longfleet Road, Poole, Dorset BH15 2JB

Appendix 15 Bournemouth University Ethic Review Letter



Bournemouth University

School of Health & Social Care
Sara Glithro
Research Administrator
School of Health and Social Care
sglithro@bournemouth.ac.uk
Direct line: +44 (0)1202 962196

Ref: InRev/SG/AT

23rd December 2010

Alison Taylor
42 Margards Lane
Verwood
Dorset
BH31 6JW

RE: Your RD6 Initial Review

Dear Alison

Further to your recent submission regarding the above, I am delighted to confirm that the document was peer reviewed and approved by the School Postgraduate Committee on 13th December 2010. They wish to congratulate you on the high quality of your submission.

The following comments were received from the reviewers for you and your supervisory team to discuss at your next supervisory meeting:

Reviewer's comments:

Overall this is a very thorough and interesting piece of work taking on board a new approach to study a very worthwhile subject area. The proposal is written at a level that is appropriate for doctoral study and has great potential to add to our knowledge base for a PhD submission.

I would like to raise specific comments and feedback:

- A very good review of literature that has revealed a gap in our current knowledge base and consideration of how the problem could be best addressed. This provides a good basis for a broader review of the topic area.
- Appropriate methodologies have been identified and justified. More information on the recruitment criteria would be helpful to ensure objectives are attained ie to 'provide maximum variation in terms of maternal age and sociodemographic areas…' (p4) eg Are participants also from similar or different cultures/ethnic groups? A list of inclusion/exclusion criteria would be helpful.
- What is the justification for the decision to recruit 8 participants and to be able to achieve 'maximum variation'? As indicated sample sizes have varied in similar studies (p3).

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Reg. No. 234569
A subsidiary of Bournemouth University

Appendix 16 Participant Information Sheet for children under 6

Bournemouth University

REC Reference number: 10/H0502/64

21 October 2010 - version 2

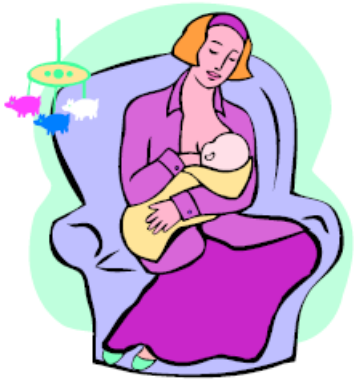
Participant Information sheet for children under 6

Exploring women's breastfeeding experiences using video diaries – 'Finding out about mums who breastfeed their babies'

This leaflet is intended for the parent or guardian to read to the child.

Hello

My name is Alison.
I am asking you to take part in research.
Mum or Dad will read this leaflet to you to explain all about it.



What is research? Why is this research being done?

Research is a way we try to find out answers to questions.
I am trying to find out what it is like for a mum to breastfeed her new baby.

1

Why have I been asked to take part?

You have been asked because you are a friend or relative of ...mother's name.... and she is taking part in this research.

Do I have to take part?

No you do not need to take part.

What will happen to me if I take part in the research?

If Mum or Dad agree, you will be filmed with a video camera by them or someone else in the family.

After you have been filmed you can see yourself on the film.
If you do not like any bits of the film, with you on it, you can ask for it to be taken out.

What happens when the research stops?

If your Mum and Dad agree I will use the film to find out what breastfeeding is like for mums.

I will use the film to tell other people what it is like to breastfeed a baby.

I will use the film to teach people how to help other breastfeeding mums.

Will the video be kept private?

Anyone who watches the video may know who you are.

If you want to be called something different in the video, you can choose a pretend name.

What if I don't want to take part in the research anymore?

You can ask for the video camera to be stopped at any time.

You can ask for your bit in the film to be cut out of all or some of the film.

What are the bad things about taking part?

You may not like it if people know who you are when they watch the film.

What are the good things about taking part?

You will be able to watch yourself on the film.

You will help me find out about family life with a new baby. This will help people to look after breastfeeding women better.

What do I do if I would like to take part?

Talk to your Mum or Dad first.

If they agree, ask your Mum or Dad to fill out the 'Consent in Principle' form. You can sign this too. Once I have collected the film, I will phone your Mum or Dad so that I can meet with you. I will tell you and your Mum and/or Dad what the research is about. I will ask if you are all happy for me to use the video in my research and to tell people about it afterwards. If you are happy, I will ask your Mum or Dad to complete and sign the form called 'Future use of the video diaries - consent' form.

Contact for further information

If you want to know more about this research your Mum or Dad can phone me or another person who knows about this research. We can then answer your questions. Our phone numbers are on the bottom of the page.

Thank you for reading this leaflet

Contact details

PhD Student:
Alison Taylor

School of Health and Social Care
Bournemouth University
Royal London House
Christchurch Road
Bournemouth
Dorset BH1 3LT
Phone: 01202 961548
ataylor@bournemouth.ac.uk

PhD Supervisors:
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Dr Kath Ryan
Emerita Professor Jo Alexander
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Appendix 17 Participant Information sheet for children aged 6-10

REC Reference number: 10/H0502/64
21 October - version 2

Bournemouth University

Participant Information sheet for children aged 6-10

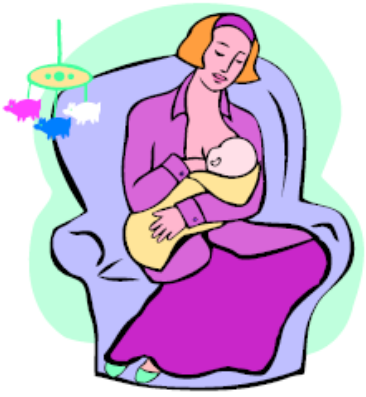
Exploring women's breastfeeding experiences using video diaries – 'Finding out about mums who breastfeed their babies'

Hello

My name is Alison. I am asking you to take part in research. Before you decide, please read or ask someone to read this leaflet to you. Do ask your Mum or Dad what it is about. You can ask them to phone me if you have any questions.

What is research? Why is this research being done?

Research is a way we try to find out answers to questions. I am trying to find out what it is like for a mum to breastfeed her new baby. I want to find out what is good and what is bad about breastfeeding. I want to find out what a mum likes about breastfeeding and what she doesn't like. I want to find out what her friends and family think about breastfeeding. I want to find out where she goes for help and how useful it is.



Why have I been asked to take part?

You have been invited because you are a friend or relative of ...mother's name.... and she is taking part in this research.

1

Do I have to take part?

No you don't. It is entirely your choice.

What will happen to me if I take part in the research?

Before you can take part in the research you will need to sign a 'Consent in Principle' form. Your Mum or Dad will also need to sign the form to say that they will allow you to take part.

You will be filmed with a video camera by them or someone else in the family. This is so that I can find out what it is like when you are with .....participant's name....and her baby.

After you have been filmed you can ask to see it and if you do not like any bits of the film, with you on it, you can ask for it to be cut out.

What happens when the research stops?

In order for me to use the film with you on it, I will need to speak with you and your Mum or Dad to make sure you are happy about how I will use it. I will ask you and your Mum or Dad to sign a special form, called 'Future use of the video diaries - consent'.

If you and your Mum or Dad sign this form, you are saying that I can use the video films in the research and to tell others about it afterwards.

I will use the film to find out what breastfeeding is like for mums.

I will use the film to tell other people what it is like to breastfeed a baby, in magazine articles, film shows and the internet.

I will use the film to teach people how to help other breastfeeding mums.

Will my taking part in this research be kept private?

Because you will be filmed by video camera, it will be very difficult to keep the images private. This means that someone may know who you are when they watch the film. This is a bit like if you were filmed on a TV programme.

If you want to be called something different in the video, you can choose a pretend name.

What if I don't want to take part in the research anymore?

You can ask for the video camera to be stopped at any time.
You can ask for you to be cut out of all or some of the film.

What are the bad things about taking part?

You may not like it if people know who you are when they watch the film.

What are the good things about taking part?

You will be able to watch yourself on the film.

You will help me find out about family life with a new baby. This will help people to look after breastfeeding women better.

Did anyone check to see if this research is OK to do?

Yes. Before any research is allowed to happen, it has to be checked by a group of people called a research ethics committee. They make sure that the research is fair. This research has been checked by the Southampton & South West Hampshire Research Ethics Committee and the Postgraduate Research Ethic Committee at Bournemouth University.

Working with children?

I have to have a special check called a Criminal Records Bureau check, to make sure I am safe to talk and work with children. I have passed that check

What do I do if I would like to take part?

Talk to your Mum or Dad first.
If they agree ask your Mum or Dad to fill out the 'Consent in Principle' form. You will need to sign this form too.
Once I have collected the film, I will phone your Mum or Dad so that I can meet with you to tell you what the research is about. I will ask if you are happy for me to use the video in my research and to tell people about it afterwards. If you are happy, I will ask your Mum or Dad to complete and sign a special form called 'Future use of the video diaries - consent' form. You will need to sign this too.

Contact for further information

I hope that this leaflet has told you what you need to know about this research study.

If you want to know more about this research your Mum or Dad can contact me or another person who knows about this research. We can then answer your questions. Our phone numbers are on the bottom of the page.

Thank you for reading this leaflet

Contact details

PhD Student:
Alison Taylor

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Dr Kath Ryan
Emerita Professor Jo Alexander
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Appendix 18 Participant Information sheet for children aged 11-16

REC Reference number: **10/H0502/64**
21 October 2010 – version 2

Bournemouth University

Participant Information sheet for children aged 11-16

Exploring women's breastfeeding experiences using video diaries – 'Finding out about mums who breastfeed their babies'

Hello

My name is Alison. I am asking you to take part in research. Before you decide, please read or ask someone to read this leaflet with you. Do ask your Mum or Dad what it is about. You can ask them to phone me or phone me yourself if you have any questions. Or you may prefer to email me. My contact details are on the back of this information leaflet.

What is research? Why is this research being done?

Research is a way we try to find out answers to questions. I am trying to find out what it is like for a mum to breastfeed her new baby. I want to find out what is good and what is bad about breastfeeding. I want to find out what a mum likes about breastfeeding and what she doesn't like. I want to find out what her friends and family think about breastfeeding. I want to find out where she goes for help and how useful it is.

Why have I been asked to take part?

You have been invited because you are a friend or relative of Anna and she is taking part in this research.

Do I have to take part?

No you don't. It is entirely your choice.

1

What will happen to me if I take part in the research?

Before you can take part in the research you will need to sign a 'consent in Principle' form. Your Mum or Dad will also need to sign the form to say that they will allow you to take part.

You will be filmed with a video camera by them or someone else in the family. This is so that I can find out what it is like when you are with Anna and her baby.

After you have been filmed you can ask to see it and if you do not like any bits of the film, with you on it, you can ask for it to be cut out.

What happens when the research stops?

In order for me to use the film with you on it, I will need to speak with you and your Mum or Dad to make sure you are happy how I will use it. I will ask you and your Mum and Dad to sign a special form, called 'Future use of the video diaries- consent '.

If you and your Mum or Dad sign this form, you are saying that I can use the video films in the research and to tell others about it afterwards.

I will use the film to find out what breastfeeding is like for mums.

I will use the film to tell other people what it is like to breastfeed a baby, in magazine articles, film shows and the internet.

I will use the film to teach people how to help other breastfeeding mums.

Will my taking part in this research be kept private?

Because you will be filmed by video camera, it will be very difficult to keep the images private. This means that someone may know who you are when they watch the film. This is a bit like if you were filmed on a TV programme.

If you want to be called something different in the video, you can choose a pretend name.

What if I don't want to take part in the research anymore?

You can ask for the video camera to be stopped at any time.
You can ask for you to be cut out of all or some of the film.

What are the bad things about taking part?

You may not like it if people know who you are when they watch the film.

What are the good things about taking part?

You will be able to watch yourself on the film.

You will help me find out about family life with a new baby. This will help people to look after breastfeeding women better.

Did anyone check to see if this research is OK to do?

Yes. Before any research is allowed to happen, it has to be checked by a group of people called a research ethics committee. They make sure that the research is fair. This research has been checked by the Southampton & South West Hampshire Research Ethics Committee and the Postgraduate Research Ethic Committee at Bournemouth University.

Working with children?

I have to have a special check called a Criminal Records Bureau check, to make sure I am safe to talk and work with children. I have passed that check.

What do I do if I would like to take part?

Talk to your Mum or Dad first.
If they agree ask your Mum or Dad to fill out the 'Consent and Contact form. You will need to sign this too.
Once I have collected the film, I will phone your Mum or Dad so that I can meet with you to explain what the research is about. I will ask if you are happy for me to use the video in my research and to tell people about it afterwards.
If you are happy, I will ask your Mum or Dad to complete and sign a special form called 'Future use of the video diaries - consent' form. You will need to sign this too.

If you are happy for me to use the film in my research and to tell people about it afterwards I will contact your Mum or Dad to make sure they are happy for me to use the video too. I will ask them to complete the form called 'Future use of the video diaries'.

Contact for further information

I hope that this leaflet has told you what you need to know about this research study. If you want to know more about this research your Mum or Dad can contact me or another person who knows about this research. We can then answer your questions. Our phone numbers are on the bottom of the page.

Thank you for reading this leaflet

Contact details

PhD Student:
Alison Taylor

School of Health and Social Care
Bournemouth University
Royal London House
Christchurch Road
Bournemouth
Dorset BH1 3LT
Phone: 01202 961548
ataylor@bournemouth.ac.uk

PhD Supervisors:
Edwin R. van Teijlingen
Dr Kath Ryan
Emerita Professor Jo Alexander
School of Health and Social Care
Bournemouth University
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Appendix 19 Parent's consent 'in Principle' form:

Child Assent in principle form: Child

REC Reference number: 10/H0502/64

13 February2011 – version 4

Bournemouth University

School of Health and Social Care

Parent's Consent 'in Principle' form: Child

Title of Project: Exploring women's breastfeeding experiences using video diaries 'Finding out about mums who breastfeed their babies'

Name of Researcher: Alison Taylor, PhD student at Bournemouth University

Bournemouth University Research Supervisors: Prof Edwin R. van Teijlingen

Other Research Supervisors: Dr Kath Ryan and Emerita Prof Jo Alexander

Parent/Guardian

Please initial box

1. I confirm that I have read and understood the information sheet called 'Participant Information sheet for families and friends' (dated 21 October 2010) for the above project. ☐
2. I confirm that I have also read the information sheet called 'Participant Information leaflet for children aged .....' for the above study with my child. I have had the opportunity to consider the information with him/her including answering any questions he/she may have. ☐
3. I have had the opportunity to consider the information, and am willing for my child to be filmed by mother's name..... or a member of her family. ☐
4. My child has had the opportunity to consider the information, and is willing to be filmed by mother's name ..... or a member of her family. ☐
5. I understand that **BEFORE the Researcher can use the film in her research project or publish the findings** she will need to contact us to explain the project in full, ensure we both understand my child's involvement in the project, to gain written consent from me and my child. ☐

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6. I understand that if the Researcher is unable to contact us to gain consent, or either of us are unwilling to give consent that she will delete any portions of the film featuring my child. ☐

7. I understand that my child's participation in the research is voluntary and that he/she can ask for filming to be stopped or deleted at any time without giving any reason. ☐

8. I understand that I can ask for filming to be stopped or deleted at any time without his/ her medical care or legal rights being affected. ☐

The personal data collected on this form will be held securely and will only be used for the management of the project by those persons with a strict need to know it as part of the project. It will not be kept longer than necessary for the carrying out of the project.

I will make no claim for any reason to the Researcher or the University in relation to the data contained in this release form, except as permitted by law.

Name of parent/ guardian

_____ Email address_____

Address _____ Tel /Mobile Number_____

_____

_____ Postcode _____

Signature _____ Date _____

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'Assent in Principle' form: Child

Title of Project: Finding out about mums who are breastfeeding

Name of Researcher: Alison Taylor, PhD student at Bournemouth University

Bournemouth University Research Supervisors: Prof Edwin R. van Teijlingen

Other Research Supervisors: Dr Kath Ryan and Emerita Prof Jo Alexander

To be completed by the child and their parent or guardian

1. Has someone explained this research to you? Yes/No
2. Do you understand what this research is about? Yes/No
3. Have you asked all the questions you want? Yes/No
4. Have you had your questions answered in a way you understand? Yes/No
5. Do you understand it's okay to stop filming at any time? Yes/No
6. Do you understand that you can ask for the film or part of the film to be deleted at any time Yes/No
7. Are you happy to be filmed? Yes/No

If <u>any</u> answers are 'no' or you don't want to take part, don't sign your name!

Your name_____

Date_____

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Christchurch Road
Bournemouth Dorset
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Appendix 20 Suggestions from Bournemouth University legal team for release of images

R&D reference number: 23887/175096/14/714

Future use of my images

Release Form for Mother and baby

Title of Research Project: Exploring women's breastfeeding experiences using video diaries

Name of Researcher: Alison Taylor, PhD Student at Bournemouth University Higher Education Corporation (the "University")

Name of Bournemouth University Research Supervisor: Prof Edwin R. van Teijlingen.

This release form relates to any and all audio-visual records which I and/or any person among my entourage has created as part of the Project ("video diaries"). It is intended that the content of the video diaries featuring me and/or my baby will be analysed for research purposes by the Researcher and the University and that a thesis will be produced based on the findings of this research. It is also intended that the edited video diaries will be used in publications, education, lectures, conferences, internet and broadcasting and will be primarily aimed at informing other people with an interest in breastfeeding including other breastfeeding mothers and their families, midwives, health workers and other breastfeeding supporters as well as researchers and students. Video clips from the video diaries will therefore be made available publicly. Knowing that anonymity and confidentiality cannot be maintained in the video diaries, I realise that anyone watching the video diaries may recognise me or my baby (as the case may be).

Please initial box

1. I understand the Project aims and that it is intended that the content of my video diaries will be analysed for research purposes. ☐

2. I understand that the video diaries will be stored securely in appropriate file formats on password protected computers prior to being made available publicly. ☐

3. I have edited out any video footage that I do not want to be made available publicly. ☐

4. I realise that anonymity and confidentiality cannot be maintained and I may be recognised by anybody who watches the video. I consent to the inclusion of my images within the following media: (tick all that apply)

- ☐ PhD thesis
- ☐ publications
- ☐ educational materials
- ☐ conferences
- ☐ the internet
- ☐ broadcasting

5. I realise that anonymity and confidentiality cannot be maintained and my baby may be recognised by anyone who watches the video. I consent to the inclusion of my baby's images within the following media: (tick all that apply)

- ☐ PhD thesis
- ☐ publications
- ☐ educational materials
- ☐ conferences
- ☐ the internet
- ☐ broadcasting

In consideration of the Researcher hereby agreeing to pay me the sum of £1 (if demanded), I irrevocably grant the University, its successors, licensees and assigns a perpetual non-exclusive licence, with a right to sublicense, throughout all territories of the world to copy and reproduce and make alterations to the video diaries, and to use the video diaries (and any such copies, reproductions and altered versions of the Material), alone or in connection with other works, in any and all media, for the University's research and educational purposes.

If at any stage I inform the Researcher or the University that I no longer want my images or images of my baby used in the agreed media, the Researcher or the University (as the case my be) will take reasonable steps to remove these from all media within the Researcher's or the University's control at the time of my

request. Although, I accept that it will not be possible to remove all existing copies from circulation once the images have been published.

The personal data collected on this form will be held securely and will only be used for the management of the Project by those persons with a strict need to know it as part of the Project. It will not be kept longer than necessary for the carrying out of the Project.

I will make no claim for any reason to the Researcher or the University in relation to the video diaries or the data contained in this release form, except as permitted by law.

Video Ref No_____

Name: (block capitals) _____

Date of Birth: _____

Address: _____

_____

Telephone: _____

Email: _____

Signature: _____

Date: _____

Appendix 21 Future use of my video diaries form: mother and baby

Bournemouth University

13 February 2011 – version 4
REC Reference number: 10/H0502/64

School of Health and Social Care

Future use of my video diaries: Mother and baby

Title of Research Project: Exploring women's breastfeeding experiences using video diaries

Name of Researcher: Alison Taylor, PhD student at Bournemouth University

Bournemouth University Research Supervisors: Prof Edwin R. van Teijlingen

Other Research Supervisors: Dr Kath Ryan and Emerita Prof Jo Alexander

This release form relates to audio-visual records which I and/or any person among my friends and family have created as part of the project ("video diaries"). It is intended that the content of my video diaries featuring me and/or my baby will be analysed for research purposes. It is also intended that the video diaries will be used to inform other people with an interest in breastfeeding including other breastfeeding mothers and their families, midwives, health workers and other breastfeeding supporters as well as researchers and students. Video clips from my video diaries will therefore be made available publicly for use in publications, education, lectures, conferences, internet and broadcasting by Bournemouth University Higher Education Corporation (the University). Knowing that anonymity and confidentiality cannot be maintained in the video diaries, I realise that anyone watching the video may recognise me or my baby.

Please initial box

1. I understand the project aims and that it is intended that the content of my video diaries will be analysed for research purposes. ☐
2. I understand that the video diaries will be stored securely in appropriate file formats on password protected computers prior to being made available publicly. ☐
3. I have edited out any video footage that I do not want used for research and made available publicly. ☐
4. I realise that anonymity and confidentiality cannot be maintained and I may be recognised by anybody who watches the video. I consent to the inclusion of my video diaries within the following media. (Tick all that apply)

   - ☐ PhD thesis
   - ☐ publications
   - ☐ educational materials that may be used or sold by BU
   - ☐ conferences
   - ☐ the internet
   - ☐ broadcasting

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www.bournemouth.ac.uk/hsc

5. I realise that anonymity and confidentiality cannot be maintained and my baby may be recognised by anyone who watches the video. I consent to the inclusion of my baby's images within the following media. (Tick all that apply)

   - ☐ PhD thesis
   - ☐ publications
   - ☐ educational materials that may be used or sold by BU
   - ☐ conferences
   - ☐ the internet
   - ☐ broadcasting

I grant the University, its successors and licensees a non-exclusive licence, with a right to sublicense to copy and edit the video diaries and to use the video diaries alone, or in connection with other works, for the University's research and educational purposes worldwide, in any or all of the media that I have agreed to, as I have indicated above.

If at any stage I inform the Researcher or the University that I no longer want my images or images of my baby used in the agreed media, they will take reasonable steps to remove these from all media within their control, although I accept that it may not be possible to remove all existing copies from circulation once the images have been published.

I will make no claim for any reason to the Researcher or the University in relation to the video diaries or the data contained in this release form, except as permitted by law.

Name: (block capitals) _____ Video Ref No_____

Signature:_____ Date:_____

Royal London House
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Appendix 22 Consent to participate and future use of video diaries: Friend and family

Bournemouth University

REC Reference number: 10/H0502/64

13 February 2011 – version 5

School of Health and Social Care

Consent to participate and future use of video diaries: Friend or family

Title of Research Project: Exploring women's breastfeeding experiences using video diaries

Name of Researcher: Alison Taylor, PhD student at Bournemouth University

Bournemouth University Research Supervisors: Prof Edwin R. van Teijlingen

Other Research Supervisors: Dr Kath Ryan and Emerita Prof Jo Alexander

This release form relates to audio-visual records which I and/or any person among my friends and family have created as part of the project ("video diaries"). It is intended that the content of ....Mother's name.... video diaries will be analysed for research purposes. It is also intended that the subsequent use of the video diaries will be used to inform other people with an interest in breastfeeding including other breastfeeding mothers and their families, midwives, health workers and other breastfeeding supporters as well as researchers and students. Video clips from these diaries will therefore be made available publicly for use in publications, education, lectures, conferences, internet and broadcasting by Bournemouth University Higher Education Corporation (Bournemouth University). Knowing that anonymity and confidentiality cannot be maintained in the video diaries, I realise that if I am recorded within the video footage, anyone watching the video may recognise me.

Please initial box

1. I have had the opportunity to discuss the research project with Alison Taylor (the researcher) and/or her research supervisors. I understand the project aims and that it is intended that the content of the video diaries featuring me will be analysed for research purposes. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my legal rights being affected. ☐

3. I agree that the video footage featuring me can be used in the above project. ☐

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4. I understand that the video diaries will be stored securely in appropriate file formats on password protected computers prior to being made available publicly. ☐

5. I realise that anonymity and confidentiality cannot be maintained and I may be recognised by anybody who watches the video. I consent to the inclusion of video clips of me within the following media. (Tick all that apply)

   - ☐ PhD thesis
   - ☐ publications
   - ☐ educational materials that may be used or sold by BU
   - ☐ conferences
   - ☐ the internet
   - ☐ broadcasting

I grant the University, its successors and licensees a non-exclusive licence, with a right to sublicense to copy and edit the video diaries featuring me and to use the video diaries alone, or in connection with other works, for the University's research and educational purposes worldwide, in any or all of the media that I have agreed to, as I have indicated above.

If at any stage I inform the Researcher or the University that I no longer want my images used in the agreed media, they will take reasonable steps to remove these from all media within their control, although I accept that it may not be possible to remove all existing copies already in circulation once images have been published.

I will make no claim for any reason to the Researcher or the University in relation to the video diaries or the data contained in this release form, except as permitted by law.

Name: (block capitals) _____ **Video Ref No**_____

Signature:_____ **Date:**_____

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Appendix 23 Parent's consent for child to participate and future use of video diaries

Bournemouth University

REC Reference number: **10/H0502/64**
13 February 2011 – version 4

School of Health and Social Care

Parent's consent for child to participate and future use of the video diaries

Title of Project: Exploring women's breastfeeding experiences using video diaries –

'Finding out about mums who breastfeed their babies'.

Name of Researcher: Alison Taylor, PhD student at Bournemouth University

Bournemouth University Research Supervisors: Prof Edwin R. van Teijlingen

Other Research Supervisors: Dr Kath Ryan and Emerita Prof Jo Alexander

This release form relates to audio-visual records which I and/or any person among my friends and family have created as part of the project ("video diaries"). It is intended that the content of ....Mother's name.... video diaries will be analysed for research purposes. It is also intended that the subsequent use of the video diaries will be used to inform other people with an interest in breastfeeding including other breastfeeding mothers and their families, midwives, health workers and other breastfeeding supporters as well as researchers and students. Video clips from these diaries will therefore be made available publicly for use in publications, education, lectures, conferences, internet and broadcasting by Bournemouth University Higher Education Corporation (Bournemouth University). Knowing that anonymity and confidentiality cannot be maintained in the video diaries, I realise that if my child is recorded within the video footage, anyone watching the video may recognise him or her.

Please initial box

1. I have had the opportunity to discuss the research project with Alison Taylor (the researcher) and/or her research supervisors. I understand the project aims and that it is intended that the content of the video diaries featuring my child will be analysed for research purposes. ☐

2. I understand that my child's participation is voluntary and that I am free to withdraw him/her at any time without giving any reason and without his/her legal rights being affected. ☐

3. I agree that the video footage featuring my child Name:..... can be used in the above project. ☐

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4. I understand that the video diaries will be stored securely in appropriate file formats on password protected computers prior being made available publicly. ☐

5. I realise that anonymity and confidentiality cannot be maintained and my child may be recognised by anybody who watches the video clips. I consent to the inclusion of these clips within the following media. (Tick all that apply)

   - ☐ PhD thesis
   - ☐ publications
   - ☐ educational materials that may be used or sold by BU
   - ☐ conferences
   - ☐ the internet
   - ☐ broadcasting

I grant the University, its successors and licensees a non-exclusive licence, with a right to sublicense to copy and edit the video diaries featuring my child and to use the video diaries alone, or in connection with other works, for the University's research and educational purposes worldwide, in any or all of the media that I have agreed to, as I have indicated above.

If at any stage I inform the Researcher or the University that I no longer want my child's images used in the agreed media, they will take reasonable steps to remove these from all media within their control, although, I accept that it will not be possible to remove all existing copies already in circulation once images have been published.

I will make no claim for any reason to the Researcher or the University in relation to the video diaries or the data contained in this release form, except as permitted by law.

Name: (block capitals) _____ **Video Ref No**_____

Signature:_____ **Date:**_____

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REC Reference number: **10/H0502/64**
13 February 2011 – version 4

Assent to participate and future use of the video diaries: Child's assent

Title of Project: Exploring women's breastfeeding experiences using video diaries –

'Finding out about mums who breastfeed their babies'.

Alison, the researcher, would like to look at the video film many times to find out what it is like for a mum to breastfeed a new baby. While she is looking at them she will keep them in a safe and private place on her computer. She will write a big report about this project which is called a thesis. She will use the film to teach people how to help other breastfeeding mums. She will also use the video film to tell other people understand what it is like to breastfeed a baby in magazine articles, film shows and the internet. When other people watch the video film, they may know who you are.

Please initial box

1. Alison has explained the project to me. I have been able to ask her questions and she has answered them. ☐
2. I understand why the project is being done and that Alison will look at the video films many times to find out what it is like for a mum to breastfeed a new baby ☐
3. I understand that the video film will be kept in a safe place until it is used to tell other people what it is like to breastfeed ☐

4. I understand that people who watch the video film may know who I am. I consent to the video clips being used for
   - ☐ a thesis
   - ☐ articles in magazines or journals
   - ☐ teaching materials
   - ☐ conferences
   - ☐ the internet
   - ☐ film making

Name of child_____

Date_____

Royal London House
Christchurch Road
Bournemouth Dorset
BH1 3LT
United Kingdom

hsc@bournemouth.ac.uk
www.bournemouth.ac.uk/hsc

Appendix 24 Example of video diary log

During Sarah's first week

Sarah1: 05.03.12 at 21.29 (11 mins) 1/2

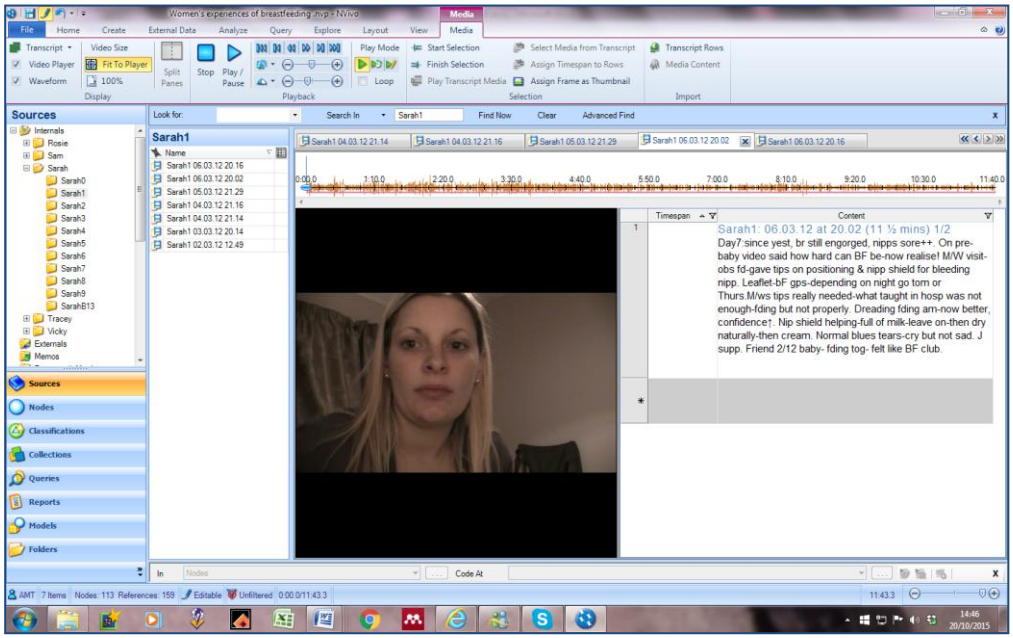
Day6: (J) skin to skin while shower. Last night, bit of a routine- slept in between feeds. Breasts engorged++, nipples sore++. Breasts too big for bras, so went to shops-spent £50 on new bras. This eve-nipples started to bleed-noticed when (S) was sick++ , blood stained-rang national breastfeeding helpline - nice lady not much help - advised re positioning, cabbage, warm compress before feeding, express to help attach, cold compress after, didn't answer question – should I rest breast overnight? Answer was fine for baby to drink blood! Have to ask m/w tomorrow – advice not helpful tonight. Spoke to NHS breastfeeding lady (support worker) this am -phoned me to offer support - advised re positioning & invited to group on Thurs to watch me feed - Mon today! Mixed feelings, good night but sore today. 'Struggling to work out what I'm doing wrong - but must be doing something'. When I went to shops -anxious re feeding out-plan car or Mothercare, feed before when home. Emotional today-no reason - hormones- crying++ - J supportive

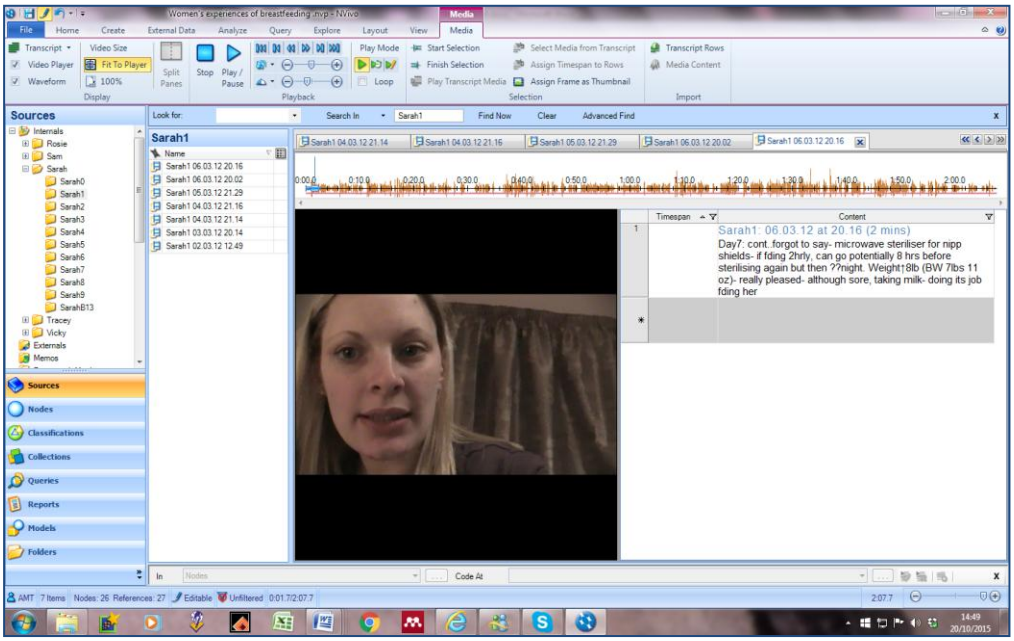
Sah1: 06.03.12 at 20.02 (11 ½ mins) 1/2

Day7: Since yesterday, breasts still engorged, nipples sore++. On practice video, pre baby, said how hard can breastfeeding be? Now realise! M/W visit –observe feed - gave tips on positioning & nipple shield for bleeding nipple. Looked at leaflet for breastfeeding groups-depending, might go tom or Thurs. I really needed m/w's tips - what taught in hosp was not enough-feeding, but not properly. Dreading feeding this am – bit better now, feeling more confident. Nipple shields helping -full of milk - leave milk on nipple - then dry naturally - then cream. Normal blues – tears - crying but not sad. (J) supportive. Friend 2 months old baby- feeding tog- felt like breastfeeding club.

Emily1: 06.03.12 at 20.16 (2 mins) 2/2

Day7: ..forgot to say- using microwave steriliser for nipple shields- if feeding 2hrly, can go potentially 8 hrs before sterilising again but then what about night. Weight up to 8lb (BW 7lbs 11 oz)- really pleased - although sore, taking milk- doing its job feeding her.


Sarah1: 06.03.12 at 20.02 (11 ½ mins) 1/2
Day7:since yest, br still engorged, nipps sore++. On pre-baby video said how hard can BF be-now realise! M/W visit-obs fd-gave tips on positioning & nipp shield for bleeding nipp. Leaflet-bF gps-depending on night go tom or Thurs.M/ws tips really needed-what taught in hosp was not enough-fding but not properly. Dreading fding am-now better, confidence↑. Nip shield helping-full of milk-leave on-then dry naturally-then cream. Normal blues tears-cry but not sad. J supp. Friend 2/12 baby- fding tog- felt like BF club.


Sarah1: 06.03.12 at 20.16 (2 mins)
Day7: cont. forgot to say- microwave steriliser for nipp shields- if fding 2hrly, can go potentially 8 hrs before sterilising again but then ??night. Weight↑8lb (BW 7lbs 11 oz)- really pleased- although sore, taking milk- doing its job fding her

During Tracey's fifth week

Tracey5 09.05.12 14.28 (3 mins) 2/4

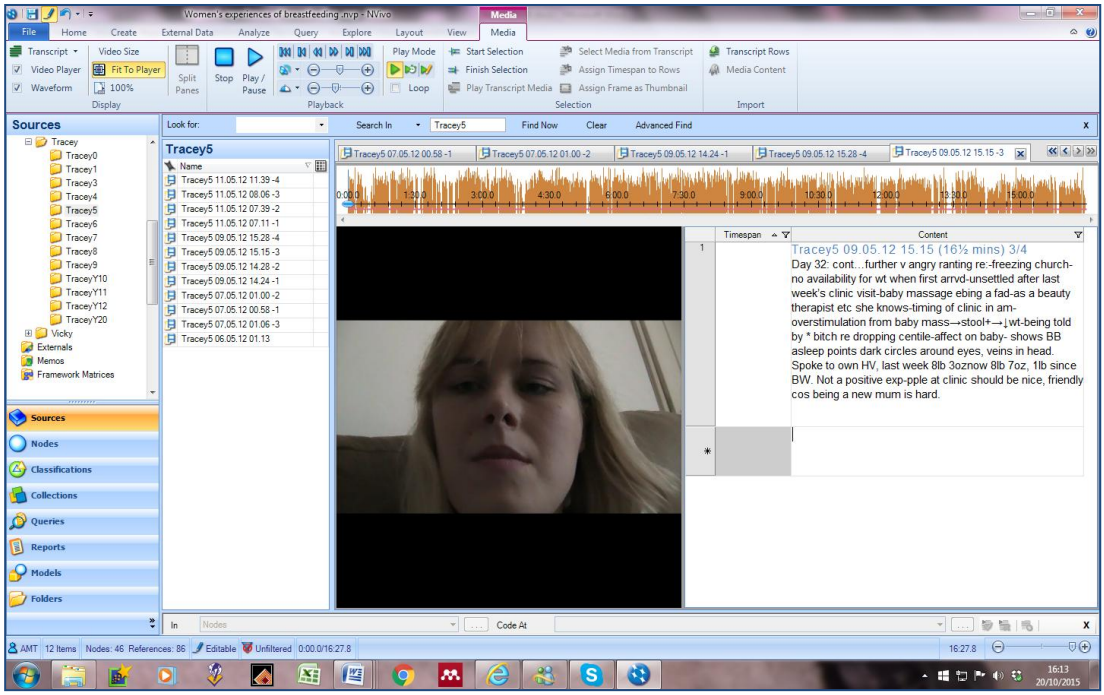
Day32: cont…Baby weighed up↑4oz- saw Nazi Health Visitor (HV) -not own- told not good enough weight-centile dipping. Friends of my mum's says charts are based on bottle fed babies. If hadn't known that I would have given up breastfeeding and put on formula by now. Told own HV who is lovely-I'm not going there anymore- you can come to house or I'll go to see her but not going to clinic. He's too young to go without being fed for 4-5 hrs. When told centile chart dipping- said to HV don't show me-that makes me feel like crap-it does. (T) unsettled - have been engorged –leaking. [Phone rings, switched camcorder off] ….

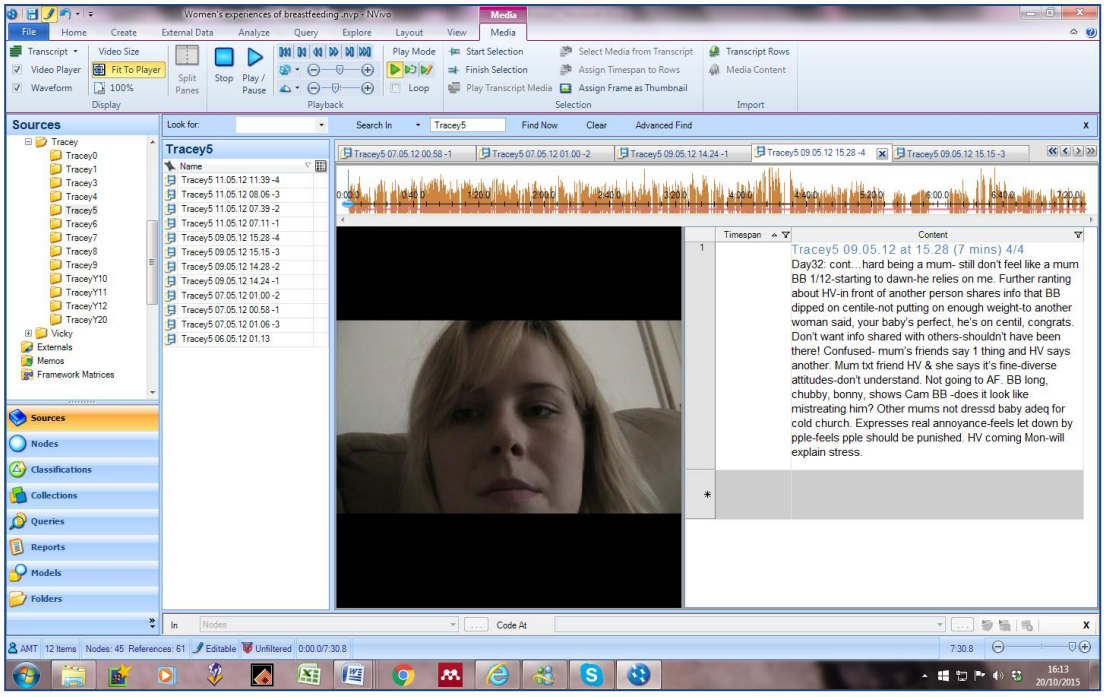
Tracey5 09.05.12 15.15 (16½ mins) 3/4

Day 32: further v angry ranting re:-freezing church- no availability of staff to do weight check when first arrived; unsettled after last week's clinic visit; baby massage being a fad-as a beauty therapist she knows; timing of clinic in am; overstimulation from baby massage causes excess stool which causes weight to drop; being told by [swearing] bitch re dropping centile; effect on baby - shows (T) asleep points dark circles around eyes, veins in head. Spoke to own HV, last week 8lb 3oz now 8lb 7oz, 1lb since birth weight. Not a positive experience too many people at clinic should be nice, friendly cos being a new mum is hard.

Tracey5 09.05.12 at 15.28 (7 mins) 4/4

Day32: …hard being a mum- still don't feel like a mum. (T) 1/12 - starting to dawn-he relies on me. Further ranting about HV, sharing personal information in front of another person; shares info that BB dipped on centile - not putting on enough weight. To another woman said, your baby's perfect, he's on centile, congrats. Don't want info shared with others-shouldn't have been there! Feel confused- mum's friends say 1 thing and HV says another. Mum txt friend HV & she says its fine -diverse attitudes - don't understand. Not going to formula feed. (T) long, chubby, bony, [shows (T) to camcorder] Other mums not dressed baby adequately for cold church. Real annoyed-feels let down by people who call themselves professionals-feels peopple should be punished. HV coming Mon - will explain stress.


Women's experiences of breastfeeding.nvp - NVivo
Media
Tracey5
Tracey5 09.05.12 15.15 (16½ mins) 3/4
Day 32: cont…further v angry ranting re:-freezing church-no availability for wt when first arrvd-unsettled after last week's clinic visit-baby massage ebing a fad-as a beauty therapist etc she knows-timing of clinic in am-overstimulation from baby mass→stool+→↓wt-being told by * bitch re dropping centile-affect on baby- shows BB asleep points dark circles around eyes, veins in head. Spoke to own HV, last week 8lb 3oznow 8lb 7oz, 1lb since BW. Not a positive exp-pple at clinic should be nice, friendly cos being a new mum is hard.


Women's experiences of breastfeeding.nvp - NVivo
Media
Tracey5
Tracey5 09.05.12 at 15.28 (7 mins) 4/4
Day32: cont…hard being a mum- still don't feel like a mum BB 1/12-starting to dawn-he relies on me. Further ranting about HV-in front of another person shares info that BB dipped on centile-not putting on enough weight-to another woman said, your baby's perfect, he's on centil, congrats. Don't want info shared with others-shouldn't have been there! Confused- mum's friends say 1 thing and HV says another. Mum txt friend HV & she says it's fine-diverse attitudes-don't understand. Not going to AF. BB long, chubby, bonny, shows Cam BB -does it look like mistreating him? Other mums not dressd baby adeq for cold church. Expresses real annoyance-feels let down by pple-feels pple should be punished. HV coming Mon-will explain stress.

Appendix 25 Initial impressions plotted on mind map

Appendix 26 Participant narratives

Rosie

Lily was born in the water at home. Rosie's first recording shows Lily rooting for her breast within 3 hours of birth. Throughout Rosie's data collection, Lily remained close by her and she continually chatted to her, stroking her in natural conversation at the same time as chatting to the camcorder.

Initially Rosie had difficulty waking Lily to feed. She held her in skin-to-skin contact and followed her mother's advice to hand express which gave her the reassurance that Lily was getting something just by licking some colostrum off her nipple. Her nipples were sore for the first two weeks and breastfeeding was not relaxing, easy and joyful. She used lanolin cream for the soreness. Lily slept in the crook of Rosie's arm for the first few nights. Rosie was frequently challenged by the frequency of night feeding so she continued co-sleeping after that. She acknowledged that exhaustion made it difficult for her to always find the 'loving patience' that was required.

Tom was practical supporting Rosie in the home. Rosie's mother and a close friend had breastfed their children and their advice was invaluable and reassuring. She was surrounded by breastfeeding mothers in her workplace. Rosie acknowledged that she was nervous of midwives but felt more comfortable with the support worker.

Nobody had warned Rosie how much her body had to do in labour and birth and postnatally with healing, hormones, afterpains and breastfeeding. On day 5 she declared trust in her own body to work for breastfeeding and was reassured with Lily's weight gain on day 7, Lily having lost 10% of birth weight previously. Little signs helped to reassure her that Lily was growing, such as her 'friendship' bracelet that became tight. She regularly expressed her faith in breastfeeding, highlighting the benefits for them as a family, as well as the benefits for the wider community and globally.

Initially, Rosie breastfed in a special chair with cushions because she developed a really painful shoulder from holding her while breastfeeding but this resolved by 16 days and both she and Lily became more relaxed. She felt the first few days passed by in a daze, with no routine and the excessive number of visitors was exhausting. By week 2, she was aiming for more structure for herself in the day. By day 11, Rosie realised that breastfeeding did not work so well when she was trying to fit it in to her own schedule and that it went better if she focused on Lily's needs. Around 4 weeks, Lily became very unsettled in the evening and at night and Rosie filmed herself rocking in the dark. Other strategies included bouncing on a 'space hopper', walking out in the evening, and '*rambling*' to her video diary.

Excessive leaking of breastmilk was reassuring but was frequently mentioned as annoying right up to the end of data collection. She struggled with layers of clothes. She was keen to follow her eco-friendly approach to parenting, using washable wipes and nappies and wearing woolly jumpers to soak up excessive leaking. A changing relationship with her body caused her to talk about breasts, bras and clothes like she had never done before and she ordered nursing bras and breastfeeding tops via the internet at 10 days.

By day 5 she was using a sling to carry Lily close to her and changed the style of carrying her to a more upright position in week 5. Small jobs were considered massive achievements. For the first few days she was always sitting feeding or cuddling Lily but after that if she wasn't breastfeeding, she was seen doing other household activities, usually with Lily in the sling. Rosie enjoyed the closeness with Lily and while she enjoyed a short break for a little freedom, she hated it if she was out of her sight.

At 3 weeks Rosie and Tom visited an antenatal class to share their experience of birth, parenthood and breastfeeding. Rosie was frank but encouraging. She enjoyed sharing experiences at her own class reunion too.

By day 7, Rosie was working out the logistics to visit her work place. By day 12, while outside doing gentle gardening, she started asking existential questions

which continued over many diary entries as she worked out how she could do meaningful work with Lily by her side. Not wanting to pollute the world, Rosie did not drive, but starting walking with Lily by day 14, walking to her work place regularly by week 5. She ‘tried out’ practical arrangements for working and breastfeeding many times, reporting back on the results.

Sam

Sam gave birth in hospital to Zac,. She was not shown how to breastfeed before discharge the next day. During the first few days she had difficulty attaching Zac to her breasts and her nipples became very sore for the first two weeks. Her midwife suggested cream for sore nipples. She attended a peer support group once but found it a ‘daunting’ experience because she felt judged when someone watched her breastfeeding, so she did not return.

Ryan, Sam’s partner was ambiguous about breastfeeding but supportive, helping out with calming Zac.

Feeding in public on her second postnatal day was a ‘horrible’ experience: she felt uncomfortable and out of place. Subsequently, she rarely breastfed when she went out, instead taking expressed breastmilk (EBM) in a bottle.

Sam was expressing breastmilk by day 6. She left her baby with her own mother to attend a social party on day 8 and then overnight for a social event when Zac was a month old, where she enjoyed drinking some alcohol again. At 13 days, she started to plan going back to college and returned for the first time on day 22, with her own mother providing baby care. She also undertook voluntary work for her course which involved Zac. She found it difficult to complete her assignments when Zac was unsettled.

On day 14, Sam started giving Zac infacol for ‘wind’ following her own mother’s advice. Believing Zac to be thirsty, she gave cooled boiled water on week 5

following a friend's advice. She was wary of asking her health visitor (HV) questions as she was not supportive of introducing a bottle of EBM.

She bought a range of paraphernalia including a monitor, special teats and bottles, sterilizer, 3 breast pumps (2 electric and 1 hand pump). She expressed regularly, often breastfeeding one side and expressing the other both day and night. By week 7 she contacted her local breastmilk bank to donate her excess EBM.

Sam found breastfeeding exhausting and admitted it was not all that it was 'cracked up to be'. She bed-shared for one night because she was desperate for some sleep, but she did not do it again for fear of suffocating Zac.

Sam attended a selection of groups with Zac including 'baby sensory', swimming, under one's group and baby massage. By week 8, Sam felt breastfeeding was a bit of a burden and was very pleased she had introduced a bottle of EBM early. She felt that breastfeeding had provided the opportunity for a special 'bond' with her baby. She gave 5oz of EBM in a bottle at 10pm before 'bedtime' which she felt helped him to stay settled for 4 hours. She planned to breastfeed/express breastmilk until Zac had teeth.

Sarah

Sarah gave birth in hospital to Sophie who was slow to initiate breastfeeding. Sarah felt that support in hospital was inadequate. She was shown how to hand express but received 'hands on' breastfeeding support so that she did not understand how to breastfeed once home.

Sarah's nipples were sore by day 3 and started bleeding by day 6 when she sought advice from the Breastfeeding Network helpline. Her husband, Jason was supportive, e.g. having skin-to-skin time with Sophie in the evenings to give Sarah a break. Sarah sought her midwife's advice when Sophie started vomiting on day

4. Breast engorgement on day 4 resulted in new bras on day 6. Face-to-face support from her midwife for positioning and attachment and advice to use nipple shields was given on day 7. Telephone support from NHS breastfeeding support service occurred on day 9. Sarah recognised thrush in Sophie's mouth and treatment commenced on day 9. Jason suggested using bottles on day 11 because of increasing nipple pain. Sarah declined but stopped breastfeeding on her right side, expressing only. On day 12, she was advised to stop feeding on both breasts by an 'out-of-hours' GP because both nipples had become infected. Antibiotics were prescribed and she started expressing and giving Sophie EBM in a bottle. On day 13, she was distraught because she could not express enough breastmilk for Sophie and introduced supplements of formula. She attended a local breastfeeding peer support group where Sophie's tongue tie was diagnosed. Frenulotomy was performed on day 13 and she started breastfeeding immediately afterwards with continued supplements of formula. Sarah started drinking fennel tea to boost her milk supply and her thrush treatment was changed. She noticed Sophie was more settled after breastfeeding than receiving formula milk and felt closer to her when breastfeeding. Sarah continued using nipple shields but her right nipple became very painful again on day 19. Sarah found it difficult to remain discreet when breastfeeding using nipple shields in the company of others. Breastfeeding in front of close friends was acceptable but she felt embarrassed in front of male family members and is some public places. Throughout this time she continued to top up with formula but gradually her milk supply increased and she gave less formula. Towards the end of her fourth week, her left nipple had healed but her right nipple remained cracked.

At 6 weeks, she was on the cusp of stopping formula feeding when she went to a friend's house for 5 hours and mainly used formula milk. She felt this caused a sudden drop in her milk supply. She spent the next few days building up her milk supply again. She didn't return to the peer support group for fear of using a bottle of formula if Sophie remained hungry after a breastfeed. By week 7, Sarah started to put herself under a lot of pressure to stop bottle feeding but each time she got

near to achieving her goal she ended up giving bottles again believing Sophie to be hungry. Stressing about giving bottles of formula milk took up much of her diary entries.

By 9 weeks breastfeeding was a lot easier. Sarah was enjoying a busy social life attending various groups with Sophie and once a week she left Sophie with Jason to attend the gym. At 13 weeks, Sarah was giving one formula feed at night to help Sophie sleep for longer and felt pressure from various people to stop breastfeeding because Sophie was still waking in the night for feeds. Feeling stubborn, she decided to stop formula feeding altogether and to fully breastfeed with nipple shields until she weaned Sophie onto solids. She acknowledged that breastfeeding had been very hard but that she had got there in the end. She felt strongly that if tongue tie had been diagnosed earlier she would not have experienced the same problems and wondered if anatomically she was able to breastfeed without nipple shields.

Tracey

Theo was delivered by forceps in hospital after an induced labour. Tracey thought the midwives on the postnatal ward were only interested in breastfeeding and not in her own wellbeing. She was not prepared for the relentless breastfeeding and felt intimidated by midwives who insisted on observing her breastfeed and provided conflicting opinions. She experienced sore nipples before discharge and was advised to use nipple cream.

Scott, her partner was ambiguous about breastfeeding and felt there was too much pressure put on mothers to do it. He helped her practically in the first few days but then worked long hours meaning Tracey felt lonely and unsupported. Tracey received lots of support from her mother who lived locally. Scott's mother suggested formula feeding on a number of occasions which she felt was undermining.

Tracey was not impressed when she contacted the breastfeeding support service for advice on day 5 and found that it operated for only four hours a day. A visit from the breastfeeding support worker felt more like a visit from a friend than a specialist and she did not feel the information offered was useful.

By day 8, Theo had regained his birth weight. Tracey was not prepared for the frequency of feeding including the exhaustion she felt, lack of routine and opportunity to clean her flat, which she fretted about on a regular basis. On day 12, she gave Theo water in a bottle believing him to be thirsty because of the hot weather but stopped giving it by week 5. Tracey accepted Theo waking up once at night and thought more than this was excessive. By day 16, the frequency of feeding was making her feel negative about breastfeeding and she wished she could get some professional support and not have to ask her own mother for advice. From this point she started continually worrying about Theo's weight. During week 4, Theo's weight dropped to the 50th centile and a week later she felt humiliated by health care staff in front of other mothers at the clinic because her baby had not put on enough weight. She observed staff praising mothers who were bottle feeding babies because they were putting on weight. She spoke angrily about this experience repeatedly in her diary entries feeling that she was being victimised but also failing as a mother. She felt emotionally and physically drained. During the 5th week she started expressing milk with a hand pump because her breasts felt uncomfortable. She sought urgent support during the 5th week from an A&E department because she felt panicked when Theo started vomiting. She was reassured by a paediatrician. During the same week, Scott brought formula milk home but Tracey refused to use it. He also bought a bouncy chair for Theo to encourage him to remain settled for longer.

On day 34 and 40, Theo received treatment from a chiropractor for tension in his back and neck.

Her health visitor saw her at home during week 6. Theo had gained weight and she felt mildly reassured. She also attended a peer support group but came away

crying as she was expected to breastfeed in front of the counsellor. In addition, there was confusion between the weight chart in her child development record and the WHO growth chart at the group. This caused considerable angst over repeated diary entries because it seemed no-one knew the correct information.

She did not want to breastfeed in front of anyone other than her partner. This restricted her going out and put pressure on feeding times. She felt lonely and isolated and had no friends who were breastfeeding at the time to support her. By week 8, she started to go to two mother and baby groups and enjoyed the company. Theo gained more weight but she seemed uncertain whether this was adequate and weight gain continually preyed on her mind. Tracey was finding it more difficult to cope with the relentless feeding. Theo often passed green stools and over the next three weeks Tracey appeared exhausted and agitated. She craved time and space away from Theo for herself.

Tracey regularly offloaded her concerns on camcorder including those about her changing relationships. She felt that breastfeeding and the worry of not being a good enough mother put tension on her relationship with her partner. She fluctuated between determination to breastfeed and feeling despondent. By week 10 she re-introduced bottles of water and considered introducing solids preferring it to formula milk. Over the next two weeks, Theo became more unsettled and despite attending an emergency drop in clinic and being reassured by a different health visitor, Tracey remained anxious, stressed and agitated in her diary entries believing her milk was inadequate and weak. During week 12, she made a series of five recordings, four on one day when Theo was particularly unsettled and she was exhausted feeling physically and emotionally drained. She did not record again until 20 weeks when she recalled that during the 12th week she introduced solids using baby rice and rusks. By week 13, Theo's weight had dropped to the 9th centile and she was strongly advised to start introducing formula milk. Tracey stopped breastfeeding and started Theo on 9oz bottles of formula and she continued to increase solids. At the same time she started taking international students as lodgers to gain financial income.

Vicky

Vicky gave birth to Benjamin in hospital. She did not hold him in close skin-to-skin contact at birth. Her midwife used a ‘hands on’ approach to attach him to the breast and he fed for about 40 minutes on the labour ward. She went home on the same day.

In the early days, Vicky enjoyed holding Benjamin in skin-to-skin contact. She was unprepared for the frequency of feeding especially in the evening when Benjamin became more unsettled and that made her question what she was doing wrong. Tiredness was sometimes overwhelming and that made her feel emotional and on day 24, Peter suggested using formula milk but Vicky declined this idea. On day 26, she realised she had to stop fighting the frequency of feeds, relax and feed more responsively.

Her breasts were sore when her milk came in on day 3. She experienced leaking of breastmilk which she found annoying and used breast shells to catch the milk from week 2. During week 3 her nipples were cracked and bleeding and she focused her attention on attaching Benjamin better to the breast. During week 4 she developed mastitis, which she worked out was due to a tight strap on her bra. She was prescribed antibiotics by her GP. During week 11, also had diarrhoea and vomiting for 48 hours.

On day 12, Vicky went to her grandmother’s funeral and managed to fit breastfeeding around the main events of the day. Juggling breastfeeding around daytime activities was a challenge so that she set targets for each day. Doing small jobs was considered great achievements. Initially she felt trapped and her sense of freedom had gone but within a few weeks she enjoyed going to various activities with Benjamin. Once she had gained confidence in breastfeeding, she was not afraid to breastfeed anywhere.

Peter, Vicky’s husband was on leave for the first two weeks and was supportive of breastfeeding helping her in practical and encouraging ways. He was also keen to

get involved with feeding and so Vicky spent time finding a specialised teat that would not disturb breastfeeding. He was then very happy to give Benjamin his first bottle of EBM during the fifth week and they recorded this as an important milestone in Benjamin's development. Her parents-in-law lived locally and had mixed feelings about breastfeeding. Vicky's parents lived some distance away but provided practical support staying with them for a few days when Peter went back to work. She received cooked meals for two weeks from her local church.

Vicky received lots of support from friends via text 24/7. She also received many conflicting opinions from friends and family which she discussed in her diaries because she found them confusing, such as introducing a bottle before it is too late, introducing a formula feed at 10pm, scheduling feeding to get into a routine and 'going with the flow'. She read lots of books which also provided conflicting opinions which were not always encouraging and sometimes the ideas were daunting. She discussed these suggestions repeatedly on her video diaries, with 'routine verses demand feeding' and 'introducing a bottle' being her primary concerns. She was wary of sharing these concerns with her HV in case she was judged but sought reassurance from her HV by getting Benjamin weighed frequently. She attended the peer support group on a few occasions although found it difficult to fit it in around other activities.

Most diary entries included some discussion about the timings of feeds especially the frequency at night and she longed for a full night of sleep. This occurred for the first time on day 51, when she worried because she had not fed in the night. This was short-lived, and night feeds resumed again. Some of the time she bed-shared with Benjamin to help cope with night-feeding.

During week 8, Vicky filmed while staying away with wider family. She discussed varying views with interest and found that it was a very emotive subject.

At 4 months, Vicky was still exclusively breastfeeding but was confused after reading a book that appeared to her to be promoting formula feeding.

Appendix 27 Video statistics taken from NVivo

19/05/2015 22:19

Media Duration

Source Type	Name	Date	Time	Duration	
Video					
	Rosie1	14.2.12	01:55:12	00:00:11	00:00:11
	Rosie1	14.2.12	14:09:36	00:00:50	00:00:50
	Rosie1	16.2.12	01:26:24	00:25:35	00:25:35
	Rosie1	17.02.12	04:48:00	00:15:10	00:15:10
	Rosie1	18.02.12	11:45:36	00:02:41	00:02:41
	Rosie1	19.02.12	00:00:00	00:01:19	00:01:19
	Rosie1	20.02.12	12:14:24	00:09:54	00:09:54
	Rosie1	20.02.12	00:43:12	00:29:47	00:29:47
	Rosie1	20.02.12	09:36:00	00:02:29	00:02:29
	Rosie2	22.02.12	05:45:36	00:19:01	00:19:01
	Rosie2	23.02.12	12:14:24	00:20:58	00:20:58
	Rosie2	24.02.12	00:14:24	00:25:16	00:25:16
	Rosie2	25.02.12	13:55:12	00:05:57	00:05:57
	Rosie2	26.02.12	03:36:00	00:25:25	00:25:25
	Rosie2	27.02.12	04:48:00	00:22:26	00:22:26
	Rosie3	01.03.12	09:50:24	00:17:53	00:17:53
	Rosie3	02.03.12	00:14:24	00:02:02	00:02:02
	Rosie3	02.03.12	13:40:48	00:24:08	00:24:08
	Rosie3	04.03.12	10:48:00	00:09:36	00:09:36
	Rosie3	05.03.12	10:19:12	00:08:57	00:08:57
	Rosie3	05.03.12	08:38:24	00:29:12	00:29:12
	Rosie3	28.02.12	08:52:48	00:26:43	00:26:43
	Rosie3	29.02.12	12:14:24	00:30:15	00:30:15
	Rosie4	06.03.12	02:09:36	00:14:39	00:14:39
	Rosie4	06.03.12	04:48:00	00:01:58	00:01:58
	Rosie4	07.03.12	00:57:36	00:14:01	00:14:01
	Rosie4	08.03.12	04:33:36	00:29:32	00:29:32
	Rosie4	09.03.12	01:40:48	00:22:20	00:22:20
	Rosie4	11.03.12	13:55:12	00:38:40	00:38:40
	Rosie4	12.03.12	02:52:48	00:13:03	00:13:03
	Rosie5	14.03.12	08:24:00	00:24:01	00:24:01
	Rosie5	14.03.12	00:57:36	00:08:00	00:08:00
	Rosie5	15.03.12	10:04:48	00:32:08	00:32:08
	Rosie5	16.03.12	11:31:12	00:20:04	00:20:04
	Rosie5	17.03.12	05:02:24	00:22:00	00:22:00
	Rosie5	19.03.12	07:12:00	00:36:58	00:36:58
	Rosie6	21.03.12	05:31:12	00:01:14	00:01:14
	Rosie6	21.03.12	12:14:24	00:25:47	00:25:47
	Rosie6	21.03.12	00:14:24	00:09:24	00:09:24
	Rosie6	23.03.12	03:36:00	00:21:01	00:21:01
	Rosie6	23.03.12	11:02:24	00:01:58	00:01:58
	Rosie6	25.03.12	08:24:00	00:22:02	00:22:02
	Rosie7	1.4.12	04:19:12	00:27:57	00:27:57
	Rosie7	2.4.12	02:38:24	00:03:33	00:03:33
	Rosie7	28.03.12	05:02:24	00:33:27	00:33:27
	Rosie7	28.03.12	07:40:48	00:03:11	00:03:11
	Rosie7	30.3.12	02:52:48	00:27:07	00:27:07
	Rosie8	6.4.12	04:33:36	00:21:13	00:21:13
	Rosie8	9.4.12	12:14:24	00:25:12	00:25:12
	Rosie9	12.4.12	13:40:48	00:43:20	00:43:20
	Rosie10	17.4.12	06:14:24	00:43:01	00:43:01

Rosie recorded over 63 days from: 14.02.12 -17.04.12 | Max recording in any one day = 3 | Rosie Total: 14:59:35 | Rosie Average: 00:18:00 | Shortest Recording 9 Seconds - Longest Recording - 43 minutes and 20 seconds

19/05/2015 22:19

Media Duration

Source Type	Name	Date	Time	Duration	
	Sam1 28.12.11 20.46			00:07:20	00:07:20
	Sam1 29.12.11 19.31			00:03:53	00:03:53
	Sam2 01.01.12 20.16			00:04:26	00:04:26
	Sam2 03.01.12 20.04			00:03:51	00:03:51
	Sam2 04.01.12 21.08			00:02:17	00:02:17
	Sam2 05.01.12 21.18			00:03:31	00:03:31
	Sam2 06.01.12 21.10			00:04:22	00:04:22
	Sam3 08.01.12 17.19			00:08:11	00:08:11
	Sam3 11.01.12 16.33			00:03:15	00:03:15
	Sam4 14.01.12 17.38			00:03:44	00:03:44
	Sam4 16.01.12 11.45			00:05:29	00:05:29
	Sam4 19.01.12 18.07			00:02:20	00:02:20
	Sam5 23.01.1218.10			00:03:09	00:03:09
	Sam5 27.01.12 20.40			00:02:09	00:02:09
	Sam6 02.02.12 18.38			00:02:48	00:02:48
	Sam6 31.01.12 18.52			00:03:25	00:03:25
	Sam7 6.02.12 16.47			00:01:49	00:01:49
	Sam8 13.02.12 18.31			00:20:33	00:20:33

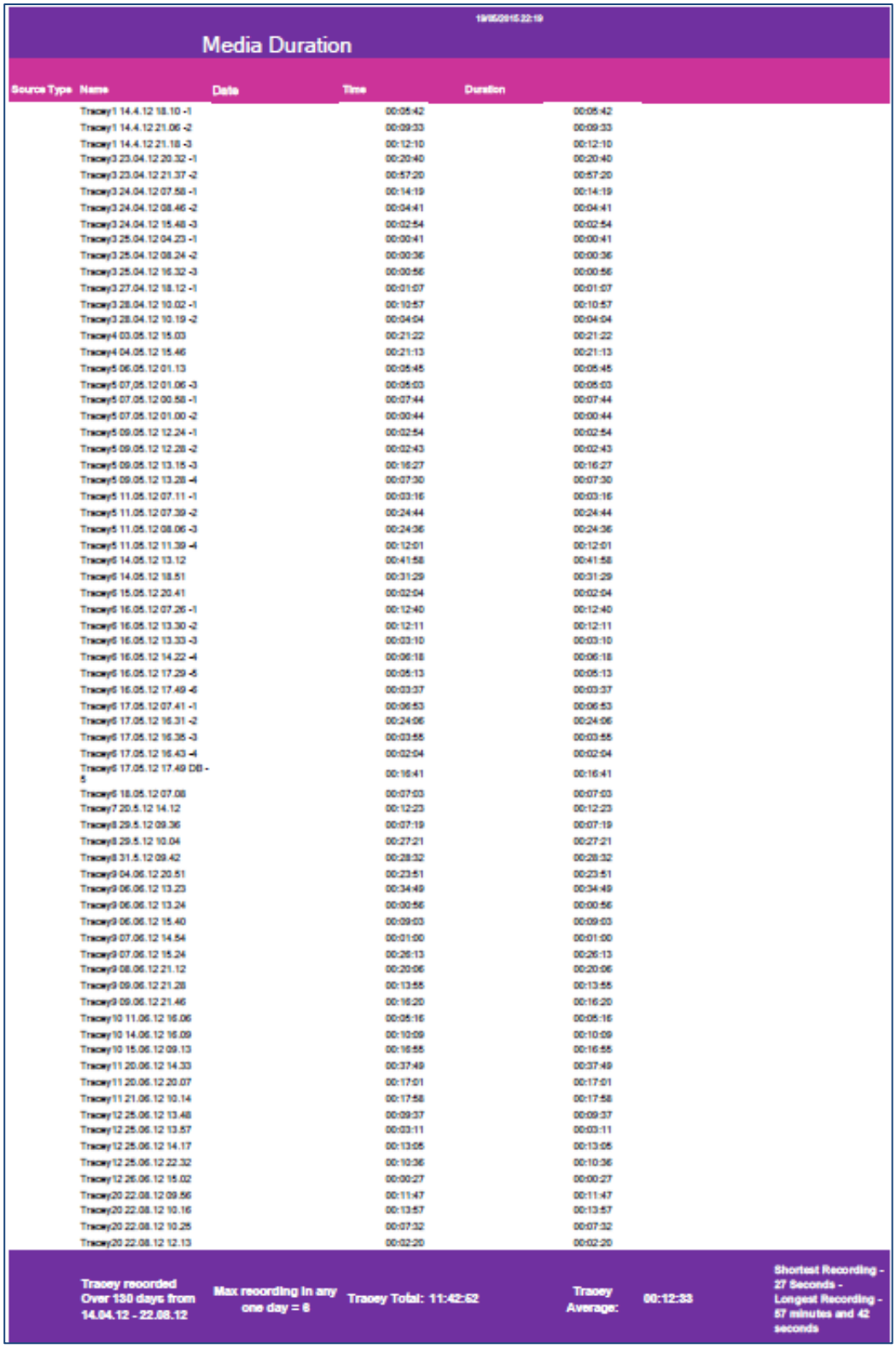
Sam recorded over 48 days from: 28.12.11 - 13.02.12 | **Max recording in any one day = 2** | **SamTotal: 01:26:32** | **Sam Average: 00:04:48** | **Shortest Recording - 1 minute 49 Seconds - Longest Recording - 20 minutes and 33 seconds**

19/05/2015 22:19

Media Duration

Source Type	Name	Date	Time	Duration	
	Sarah1 02.03.12 12.49		00:13:32		00:13:32
	Sarah1 03.03.12 20.14		00:10:51		00:10:51
	Sarah1 04.03.12 21.14		00:09:36		00:09:36
	Sarah1 04.03.12 21.16		00:01:23		00:01:23
	Sarah1 05.03.12 21.29		00:11:16		00:11:16
	Sarah1 06.03.12 20.02		00:11:43		00:11:43
	Sarah1 06.03.12 20.16		00:02:07		00:02:07
	Sarah2 08.03.12 17.38		00:09:13		00:09:13
	Sarah2 10.03.12 23.05		00:04:51		00:04:51
	Sarah2 12.03.12 21.45		00:11:11		00:11:11
	Sarah3 15.03.12 14.28		00:11:18		00:11:18
	Sarah3 16.03.12 14.48		00:07:46		00:07:46
	Sarah3 17.03.12 14.10		00:11:15		00:11:15
	Sarah3 17.03.12 14.23		00:01:26		00:01:26
	Sarah3 18.03.12 19.40		00:09:00		00:09:00
	Sarah3 19.03.12 15.33		00:08:13		00:08:13
	Sarah4 21.03.12 19.49		00:07:55		00:07:55
	Sarah4 23.03.12 14.35		00:09:52		00:09:52
	Sarah4 23.03.12 19.52		00:01:10		00:01:10
	Sarah4 26.03.12 13.29		00:11:52		00:11:52
	Sarah5 29.03.12 03.16		00:03:45		00:03:45
	Sarah5 29.03.12 10.20		00:01:39		00:01:39
	Sarah5 3.4.12 11.28		00:06:23		00:06:23
	Sarah6 08.4.12 8.30		00:07:28		00:07:28
	Sarah6 10.4.12 12.30		00:10:11		00:10:11
	Sarah7 14.4.12 20.26		00:11:15		00:11:15
	Sarah7 15.4.12 13.37		00:05:03		00:05:03
	Sarah7 17.4.12 11.03		00:07:15		00:07:15
	Sarah8 18.4.12 11.43		00:06:39		00:06:39
	Sarah8 18.4.12 11.46		00:01:40		00:01:40
	Sarah9 01.05.12 11.24		00:32:48		00:32:48
	Sarah13 28.05.12 13.32		00:04:14		00:04:14
	Sarah13 28.05.12 14.06		00:02:25		00:02:25

Sarah recorded over 87 days from 2.03.12-28.05.12 | **Max recording in any one day = 2** | **SarahTotal: 04:19:36** | **Sarah Average: 00:08:22** | **Shortest Recording - 1 minute 10 Seconds - Longest Recording - 32 minutes and 48 seconds**



19/05/2015 22:19

Media Duration

Source Type	Name	Data	Time	Duration
	Tracey1 14.4.12 18.10 -1		00:05:42	00:05:42
	Tracey1 14.4.12 21.06 -2		00:09:33	00:09:33
	Tracey1 14.4.12 21.18 -3		00:12:10	00:12:10
	Tracey3 23.04.12 20.32 -1		00:20:40	00:20:40
	Tracey3 23.04.12 21.37 -2		00:57:20	00:57:20
	Tracey3 24.04.12 07.58 -1		00:14:19	00:14:19
	Tracey3 24.04.12 08.46 -2		00:04:41	00:04:41
	Tracey3 24.04.12 15.48 -3		00:02:54	00:02:54
	Tracey3 25.04.12 04.23 -1		00:00:41	00:00:41
	Tracey3 25.04.12 08.24 -2		00:00:36	00:00:36
	Tracey3 25.04.12 16.32 -3		00:00:56	00:00:56
	Tracey3 27.04.12 18.12 -1		00:01:07	00:01:07
	Tracey3 28.04.12 10.02 -1		00:10:57	00:10:57
	Tracey3 28.04.12 10.19 -2		00:04:04	00:04:04
	Tracey4 03.05.12 15.03		00:21:22	00:21:22
	Tracey4 04.05.12 15.46		00:21:13	00:21:13
	Tracey5 06.05.12 01.13		00:05:45	00:05:45
	Tracey5 07.05.12 01.06 -3		00:05:03	00:05:03
	Tracey5 07.05.12 00.58 -1		00:07:44	00:07:44
	Tracey5 07.05.12 01.00 -2		00:00:44	00:00:44
	Tracey5 09.05.12 12.24 -1		00:02:54	00:02:54
	Tracey5 09.05.12 12.28 -2		00:02:43	00:02:43
	Tracey5 09.05.12 13.15 -3		00:16:27	00:16:27
	Tracey5 09.05.12 13.28 -4		00:07:30	00:07:30
	Tracey5 11.05.12 07.11 -1		00:03:16	00:03:16
	Tracey5 11.05.12 07.39 -2		00:24:44	00:24:44
	Tracey5 11.05.12 08.06 -3		00:24:36	00:24:36
	Tracey5 11.05.12 11.39 -4		00:12:01	00:12:01
	Tracey6 14.05.12 13.12		00:41:58	00:41:58
	Tracey6 14.05.12 18.51		00:31:29	00:31:29
	Tracey6 15.05.12 20.41		00:02:04	00:02:04
	Tracey6 16.05.12 07.26 -1		00:12:40	00:12:40
	Tracey6 16.05.12 13.30 -2		00:12:11	00:12:11
	Tracey6 16.05.12 13.33 -3		00:03:10	00:03:10
	Tracey6 16.05.12 14.22 -4		00:06:18	00:06:18
	Tracey6 16.05.12 17.29 -5		00:05:13	00:05:13
	Tracey6 16.05.12 17.49 -6		00:03:37	00:03:37
	Tracey6 17.05.12 07.41 -1		00:06:53	00:06:53
	Tracey6 17.05.12 16.31 -2		00:24:06	00:24:06
	Tracey6 17.05.12 16.35 -3		00:03:55	00:03:55
	Tracey6 17.05.12 16.43 -4		00:02:04	00:02:04
	Tracey6 17.05.12 17.49 DB - 5		00:16:41	00:16:41
	Tracey6 18.05.12 07.08		00:07:03	00:07:03
	Tracey7 20.5.12 14.12		00:12:23	00:12:23
	Tracey8 29.5.12 09.36		00:07:19	00:07:19
	Tracey8 29.5.12 10.04		00:27:21	00:27:21
	Tracey8 31.5.12 09.42		00:28:32	00:28:32
	Tracey9 04.06.12 20.51		00:23:51	00:23:51
	Tracey9 06.06.12 13.23		00:34:49	00:34:49
	Tracey9 06.06.12 13.24		00:00:56	00:00:56
	Tracey9 06.06.12 15.40		00:09:03	00:09:03
	Tracey9 07.06.12 14.54		00:01:00	00:01:00
	Tracey9 07.06.12 15.24		00:26:13	00:26:13
	Tracey9 08.06.12 21.12		00:20:06	00:20:06
	Tracey9 09.06.12 21.28		00:13:55	00:13:55
	Tracey9 09.06.12 21.46		00:16:20	00:16:20
	Tracey10 11.06.12 16.06		00:05:16	00:05:16
	Tracey10 14.06.12 16.09		00:10:09	00:10:09
	Tracey10 15.06.12 09.13		00:16:55	00:16:55
	Tracey11 20.06.12 14.33		00:37:49	00:37:49
	Tracey11 20.06.12 20.07		00:17:01	00:17:01
	Tracey11 21.06.12 10.14		00:17:58	00:17:58
	Tracey12 25.06.12 13.48		00:09:37	00:09:37
	Tracey12 25.06.12 13.57		00:03:11	00:03:11
	Tracey12 25.06.12 14.17		00:13:05	00:13:05
	Tracey12 25.06.12 22.32		00:10:36	00:10:36
	Tracey12 26.06.12 15.02		00:00:27	00:00:27
	Tracey20 22.08.12 09.56		00:11:47	00:11:47
	Tracey20 22.08.12 10.16		00:13:57	00:13:57
	Tracey20 22.08.12 10.25		00:07:32	00:07:32
	Tracey20 22.08.12 12.13		00:02:20	00:02:20

Tracey recorded Over 130 days from 14.04.12 - 22.08.12

Max recording in any one day = 6

Tracey Total: 11:42:52

Tracey Average: 00:12:33

Shortest Recording - 27 Seconds - Longest Recording - 57 minutes and 42 seconds

19/05/2015 22:19

Media Duration

Source Type	Name	Date	Time	Duration
	Vicky2 13.1.11 16.59		00:00:36	00:00:36
	Vicky2 14.1.11 19.23		00:00:51	00:00:51
	Vicky2 14.1.11 19.25		00:01:07	00:01:07
	Vicky2 14.1.11 19.27		00:01:18	00:01:18
	Vicky2 15.1.11 20.36		00:01:25	00:01:25
	Vicky3 16.1.11 13.24		00:14:42	00:14:42
	Vicky3 17.1.11 11.25		00:01:16	00:01:16
	Vicky3 17.1.11 13.57		00:03:24	00:03:24
	Vicky3 18.1.11 21.31		00:05:10	00:05:10
	Vicky3 19.1.11 21.47		00:03:17	00:03:17
	Vicky3 20.1.11 14.37		00:17:07	00:17:07
	Vicky3 21.1.11 21.51		00:04:15	00:04:15
	Vicky4 23.1.11 20.45		00:06:42	00:06:42
	Vicky4 24.1.11 10.16		00:02:05	00:02:05
	Vicky4 24.1.11 10.18		00:02:22	00:02:22
	Vicky4 24.1.11 21.30		00:05:41	00:05:41
	Vicky4 26.1.11 11.44		00:05:17	00:05:17
	Vicky4 28.1.11 18.36		00:17:18	00:17:18
	Vicky4 29.1.11 16.16a		00:00:35	00:00:35
	Vicky4 29.1.11 16.16b		00:00:22	00:00:22
	Vicky4 29.1.11 16.22		00:00:34	00:00:34
	Vicky5 1.2.11 9.20		00:04:03	00:04:03
	Vicky5 2.2.11 10.09		00:08:15	00:08:15
	Vicky5 3.2.11 12.33		00:06:45	00:06:45
	Vicky5 30.1.11 11.15 -1		00:09:42	00:09:42
	Vicky5 30.1.11 12.23		00:00:51	00:00:51
	Vicky5 31.1.11 09.19		00:11:10	00:11:10
	Vicky5 4.2.11 10.23 -1		00:05:44	00:05:44
	Vicky5 4.2.11 14.23 -2		00:00:40	00:00:40
	Vicky5 4.2.11 19.18 -3		00:01:23	00:01:23
	Vicky5 4.2.11 19.36 -4		00:01:26	00:01:26
	Vicky5 5.2.11 09.26 -1		00:01:47	00:01:47
	Vicky5 5.2.11 11.25 -2		00:03:43	00:03:43
	Vicky6 10.2.11 09.50 -1		00:05:26	00:05:26
	Vicky6 10.2.11 22.14 -2		00:01:13	00:01:13
	Vicky6 11.2.11 14.25 friends experience -1		00:14:59	00:14:59
	Vicky6 11.2.11 21.49 -2		00:02:41	00:02:41
	Vicky6 12.2.11 09.52 -1		01:12:45	01:12:45
	Vicky6 12.2.11 10.03 -2		00:09:58	00:09:58
	Vicky6 6.2.11 20.34		00:06:49	00:06:49
	Vicky6 7.2.11 15.50 -1		00:07:03	00:07:03
	Vicky6 7.2.11 15.51 -2		00:01:01	00:01:01
	Vicky6 8.2.11 09.37 -1		00:04:07	00:04:07
	Vicky6 8.2.11 10.02 -2		00:00:29	00:00:29
	Vicky6 9.2.11 11.18-1		00:32:00	00:32:00
	Vicky6 9.2.11 14.23 -2		00:09:49	00:09:49
	Vicky6 9.2.11 14.57 -3		00:01:50	00:01:50
	Vicky6 9.2.11 21.57 -4		00:00:43	00:00:43
	Vicky7 13.2.11 13.17		00:01:52	00:01:52
	Vicky7 13.2.11 13.21		00:00:24	00:00:24
	Vicky7 14.2.11 9.46		00:03:29	00:03:29
	Vicky7 15.2.11 11.16		00:01:58	00:01:58
	Vicky7 15.2.11 11.36		00:00:17	00:00:17
	Vicky7 16.2.11 11.12		00:18:24	00:18:24
	Vicky7 17.2.11 10.14		00:05:32	00:05:32
	Vicky7 18.2.11 14.31		00:09:21	00:09:21
	Vicky7 19.2.11 10.28		00:03:12	00:03:12
	Vicky8 20.2.11 10.12		00:00:26	00:00:26
	Vicky8 20.2.11 10.17		00:05:15	00:05:15
	Vicky8 21.2.11 07.36		00:07:26	00:07:26
	Vicky8 22.2.11 09.30		00:15:27	00:15:27
	Vicky8 22.2.11 15.19		00:04:50	00:04:50
	Vicky8 23.2.11 16.14		00:04:11	00:04:11
	Vicky8 23.2.11 16.46		00:00:18	00:00:18
	Vicky8 23.2.11 20.02		00:01:12	00:01:12
	Vicky8 23.2.11 20.04		00:01:07	00:01:07
	Vicky8 23.2.11 20.08		00:04:03	00:04:03
	Vicky8 23.2.11 20.10		00:01:37	00:01:37
	Vicky8 23.2.11 20.11		00:00:45	00:00:45
	Vicky8 23.2.11 20.14		00:01:51	00:01:51
	Vicky8 24.02.11 09.11		00:02:19	00:02:19
	Vicky8 24.02.11 11.25		00:09:31	00:09:31
	Vicky8 24.02.11 13.01		00:22:16	00:22:16
	Vicky8 25.02.11 12.52		00:08:49	00:08:49
	Vicky8 25.02.11 23.04		00:05:37	00:05:37
	Vicky8 26.02 11 08.36		00:02:02	00:02:02
	Vicky8 26.02 11 20.17		00:00:45	00:00:45

19/05/2015 22:19

Media Duration

Source Type	Name	Date	Time	Duration
	Vicky9 01.03.11 10.03		00:07:16	00:07:16
	Vicky9 02.03.11 10.25		00:05:33	00:05:33
	Vicky9 02.03.11 10.32		00:00:37	00:00:37
	Vicky9 03.03.11 12.26		00:01:03	00:01:03
	Vicky9 03.03.11 15.04		00:00:10	00:00:10
	Vicky9 03.03.11 15.08		00:03:41	00:03:41
	Vicky9 04.03.11 22.33		00:12:55	00:12:55
	Vicky9 05.03.11 21.25		00:03:41	00:03:41
	Vicky9 27.02.11 19.20		00:03:38	00:03:38
	Vicky9 28.02.11 08.43		00:02:37	00:02:37
	Vicky10 06.03.11 09.53		00:02:10	00:02:10
	Vicky10 06.03.11 23.19		00:03:34	00:03:34
	Vicky10 07.03.11 08.03		00:02:05	00:02:05
	Vicky10 07.03.11 08.22		00:03:05	00:03:05
	Vicky10 07.03.11 10.08		00:04:08	00:04:08
	Vicky10 08.03.11 14.06		00:16:15	00:16:15
	Vicky10 08.03.11 16.50		00:09:36	00:09:36
	Vicky10 09.03.11 20.30		00:11:24	00:11:24
	Vicky10 10.03.11 22.36		00:07:59	00:07:59
	Vicky10 11.03.11 08.07		00:02:49	00:02:49
	Vicky10 11.03.11 17.35		00:01:50	00:01:50
	Vicky10 12.03.11 09.15		00:02:48	00:02:48
	Vicky11 13.03.11 22.08		00:04:28	00:04:28
	Vicky11 13.03.11 22.10		00:00:58	00:00:58
	Vicky11 14.03.11 09.07		00:05:20	00:05:20
	Vicky11 15.03.11 22.23		00:01:47	00:01:47
	Vicky11 16.03.11 13.24		00:02:24	00:02:24
	Vicky11 16.03.11 19.58		00:01:37	00:01:37
	Vicky11 17.03.11 09.58		00:01:06	00:01:06
	Vicky11 17.03.11 10.03		00:04:31	00:04:31
	Vicky11 18.03 11 09.45		00:02:28	00:02:28
	Vicky11 18.03.11 15.45		00:04:25	00:04:25
	Vicky11 18.03.11 18.05		00:01:41	00:01:41
	Vicky12 20.03.11 20.15		00:02:47	00:02:47
	Vicky12 22.03.11 07.01		00:07:46	00:07:46
	Vicky12 24.03.11 09.14		00:28:43	00:28:43
	Vicky12 26.03.11 19.18		00:05:07	00:05:07
	Vicky18 4.5.11 15.51		00:10:43	00:10:43
	Vicky18 4.5.11 18.41		00:01:11	00:01:11
	Vicky18 6.5.11 13.30		00:04:17	00:04:17
	Vicky18 6.5.11 17.29		00:02:15	00:02:15
	Vicky18 6.5.11 17.45		00:01:50	00:01:50
	Vicky20 16.5.11 12.06		00:04:35	00:04:35
	Vicky20 16.5.11 12.19		00:08:08	00:08:08

Vicky recorded Over 113 days from 13.01.11-.05.05.11 | **Max recording in any one day = 8** | **Vicky Total: 11:23:03** | **Vicky Average: 00:08:08** | **Shortest Recording - 17 Seconds - Longest Recording 1 Hour, 12 minutes and 45 seconds**

Total Time Camera Held	48:14:38

Appendix 28 Published Paper

Ryan K, Brown S, Wilkins C, Taylor A, Arnold R, Angell C, van Teijlingen E. (2010) Which hat am I wearing today? Practising midwives doing research. *Evidence Based Midwifery* 9(1): 4-8

Which hat am I wearing today? Practising midwives doing research

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Abstract

Doing research and practising as a midwife at the same time can lead to ethical conflicts as the ethical codes for midwifery practice and those for conducting research are subtly different. We use five narrative case studies of midwife-researchers, who have struggled with ethical considerations doing research as a practising midwife, to distil some of the key conflict areas. The key issue was around multiple and conflicting roles including the ethical issues of confidentiality and trust. Potential ethical dilemmas seemed to be related to the amount of control the midwife-researcher had over the research process, especially data collection. We conclude that it is time to discuss the issues and consider how best to support midwife-researchers; we must trust the researcher to make the best possible ethical decisions as we trust the health professional to in practice; and ultimately ethics governing practice must be given priority.

Key words: Research ethics, code of conduct, principles of research, evidence-based midwifery

Introduction

Practising midwives are governed by a professional code of ethics (NMC, 2008) and midwife-researchers like all health researchers are governed by the Helsinki Declaration (see: www.wma.net/en/30publications/10policies/b3/index.html). Midwife-researchers, however, often find themselves positioned between these two behavioural guides with the need to be very clear themselves and to make explicit to others the purpose of their activity at any particular time (Rogers, 2008; Soteriou et al, 2005). Hence the question, which hat am I wearing today? In this paper we ask how midwifery practitioners engaged in research deal with the ethical dilemmas that arise. As midwifery practitioners and educators who are also involved in research we draw upon our collective experience and doctoral work.

Background

All health professionals' codes of practice are based on the four principles of biomedical ethics: respect for autonomy (the right to choose); beneficence (do good); non-maleficence (do no harm); and justice (fairness and equality) (Beauchamp and Childress, 2001). When applied to research with human participants in health and social care settings, these basic principles are translated into many tenets, including but not limited to informed consent, mutual respect, confidentiality, anonymity, trust, truthfulness, sensitivity, protection of vulnerable research participants, debriefing and the safety of researchers. When the roles of research scientist and clinical practitioner are integrated conflict and ethical dilemmas that challenge traditional roles, core tasks, goals, values and professional identities become an issue for all professions (Taylor, 1992; Greenberg, 1997; Morin et al, 2002). In general, these issues revolve around 1) the nature of the relationship between the researcher-practitioner and the participant where boundaries may become blurred and false perceptions and expectations develop 2) confidentiality where anonymity cannot be maintained and 3) the dual roles of the researcher-practitioner where a duty of care and maintenance of the integrity of the research may conflict (Houghton et al, 2010). Recognition of these issues has resulted in suggestions for an ethical protocol for researcher-practitioners providing guidance for when a researcher will intervene in the care of a patient (Houghton et al, 2010) and the development of guidelines for research-practitioners (Soteriou, 2005).

For UK midwives the principles of ethical practice are articulated in *The code: standards of conduct, performance and ethics for nurses and midwives*, so people within the care of a midwife can trust her with their health and wellbeing (NMC, 2008). Midwives often find themselves in multiple roles, for example, clinical practice, midwifery education and research. Ethical dilemmas can arise for midwife-researchers when their code of practice conflicts with the principles of research ethics. Such dilemmas often come to the fore when formulating one's research protocol or application for scrutiny to a research

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ethics committee. Preparing such documents requires prior consideration of possible ethical dilemmas and is aimed at raising awareness of situations as well as helping to avoid or pre-empt problems. Conflict arises in these multiple roles when a participant does not distinguish a midwife-practitioner from a midwife-researcher or when a midwife is placed in a position of needing to breach confidentially. We present five case studies of midwifery research to highlight ethical conflicts between 'doing midwifery' and 'doing midwifery research' and how these conflicts were dealt with. These cases also touch upon other ethical dilemmas not specifically confined to midwifery research, including working with vulnerable people (for example, babies and young children), possible identification of participants when anonymity cannot be offered and working in other countries and cultures (for example, Parker et al, 2010; van Teijlingen et al, 2010).

Methods

We use a case study approach (analysing five personal reflective narratives) to give an impression of the range and scope of the work of midwife-researchers, thus providing insight into the similarities and differences that they face around ethical decision-making. Mitchell (1979: 24) defines the case study method as 'a holistic treatment of a subject whereby through the detailed examination of one instance information about a class of entities... may be obtained'. In general, we recognise that the case study 'allows an investigation to retain the holistic and meaningful characteristics of real-life events' (Yin 1989: 14) at the expense of generalisability while possibly demonstrating overriding principles that can be extrapolated to other similar situations. Each of the contributing midwife-researchers wrote approximately two pages in which they reflected on their study particularly on ethical issues they faced and how they dealt with them. These writings were then analysed by all authors to identify overriding issues.

The cases

1. Interviewing lactation consultants by Sarah Brown

As a midwife and an International Board Certified Lactation Consultant (IBCLC) I was always aware of the rewards and stressors of the joint roles. In 2007 I discovered that other IBCLCs working in the National Health Service (NHS) were describing similar experiences and some considered themselves 'burnt out'. Therefore I started a qualitative study to understand the experiences of IBCLCs in England, which included two in-depth interviews set six months apart with 12 practitioners, six of whom were midwives.

The participants changed my ethical practice from being woman-centred to practitioner-centred as my role changed. The collection of personal narratives, through in-depth interviews, encouraged practitioners to experience a similar exploration, which provided a powerful moral idea of authenticity within such accounts (Frank, 2002). The study reflected practical experience in the broad Aristotelian sense as wisdom not only concerning the technical knowledge of practice but as a holistic development of self (MacIntyre, 2007).

The collection of personal narratives was bound up with the participant's identity as a practitioner. Viewed in this way, a narrative could have the potential to become a transformational experience for the practitioner or provide a risk that the process may open participants to issues that could make them vulnerable (for example, Patton, 2002; Holloway and Freshwater, 2007). Elliott (2005) suggested that a researcher entered a personal and moral relationship with participants during the research process. The aspect of hearing practitioner's accounts contained an 'emotional heat' (Holloway and Freshwater, 2007, p.45) that sometimes closely reflected my experiences in practice. Such accounts were traumatic to listen to as well as for the practitioner to narrate (Brown, 2009). Sikes (2010) reflected a similar stance when she considered that ethical review procedures and codes do not always address what may occur during the research process when the researcher may have to return to the essence of personal practice. Maintaining a reflective research log throughout the study enabled me to navigate an ethical pathway within the study.

2. Emotional processing in childbirth (EPIC) study by Carol Wilkins

My research explores the relationship between the way women process their emotions during the major life-changing events of pregnancy and birth and the emergence of perinatal psychological problems. A cohort of 973 women completed three questionnaires between early pregnancy and six weeks postpartum. Participants were assured of anonymity and confidentiality and a structured feedback system was established to ensure that no participants who subsequently suffered pregnancy loss or neonatal death were emotionally disturbed by the receipt of further questionnaires. A number of specific ethical issues arose, however, from completion of the questionnaires, which sought information about women's emotions, mental health, self-esteem and general health. Certain questions might cause distress by raising personal awareness of emotional or psychological vulnerability. However, such probing questions were deemed ethically admissible as they are recommended in normal midwifery care (NICE, 2007). To assist any participants identifying difficulties the information sheet contained advice to contact a midwife or other health professional if they felt anxious. In addition a list of national and local support groups and advice lines was included. This action ensured that the researcher used professional guidance in managing potential risk contemporaneously whilst respecting the confidentiality required of the research study (NMC, 2008).

The questionnaires each included the Edinburgh Postnatal Depression Scale (EPDS) (Cox et al. 1987). Completion of question ten on that scale ('The thought of harming myself has occurred to me') raised a number of ethical issues in relation to confidentiality and duty of care. A response revealing thoughts of self-harm might raise an ethical dilemma for me, a registered midwife bound by professional regulation. Failure to exercise my professional duty of care as a midwife and seek appropriate professional support for women at risk might be deemed negligent and in breach of my professional code of conduct (NMC, 2008). Yet as a researcher I promised confidentiality to participants.

It was decided that in the case of a positive answer to this question research ethics are overruled and the midwife's clinical

judgment must prevail. *The code* (NMC, 2008) expects a midwife to work (which includes 'research') to protect the health and wellbeing of those in her care. Thus responses identified contemporaneously in antenatal clinic would be managed, with the woman's permission, in the same way as other vulnerable women, or else the issue would be addressed in the same way as postal questionnaires, which was to provide advice about contacting their midwife or GP if there were concerns. In this way I managed potential risk, while respecting the confidentiality required of the research study.

3. Midwifery research in Afghanistan by Rachel Arnold

This ethnographic study of Kabul public maternity hospitals explores the culture of care predominantly from the perspective of the healthcare providers. An initial glance at my Afghan ethics application form shows that anonymity, confidentiality, informed consent, risks and benefits have all been duly discussed. Behind the application however lies the complex, multifaceted world of culture. To represent another culture with its underlying meanings, values, perspectives and beliefs, and to delve beyond what is seen will depend not on ethical approval but on my ongoing commitment to perpetual learning, questioning and reflection on this world of 'others,' and equally on my own internal world of values, prejudices, assumptions and the requirements of conduct in professional practice. Challenges include cultural understandings of 'confidentiality' and the translation of information sheets and consent forms. Simply translating words from English to Dari or Pashto does not equate to communicating the same meaning. 'Confidentiality' in Afghanistan appears to mean that you do not tell the patient 'bad' news, but can discuss it with everyone else. Explaining the principle of confidentiality did not involve the Farsi/Pashto word for confidentiality but required words and concepts that can be understood by illiterate and literate alike. As a qualified midwife who has worked in the Afghan health system for some years, my new role as a participant observer with its promise of confidentiality could pose a dilemma. It is possible that during the course of observation I might witness care that is sub-optimal or potentially dangerous. Despite my desire not to jeopardise the study or the trust and acceptance I hope to achieve as an outsider, my most likely course of action would be to inform the ward supervisor immediately. Regardless of the consequences, it is clear that in accordance with the code of practice (NMC, 2008) my first duty of care would be to 'act without delay if a colleague was putting the safety of a mother or child at risk.'

4. Midwifery research with children by Catherine Angell

A PhD study of 56 schoolchildren aged between nine and 11 in Southern England explored children's infant-feeding awareness (Angell, 2010). Children were shown a series of drawings, and a story was read to them about a hungry newborn infant. They were asked to finish the story, showing how they thought the baby was fed using 'Draw, write and tell', a creative method developed for this study. The children produced pictures, often with text, and were offered the opportunity to talk about their own work. This child-led approach to the research was complemented by a range of measures put in place to support and protect children, parents and teaching staff. Parental permission (Koocher and Keith-Spiegel, 1990) was a prerequisite to seeking children's consent to participate. Parents were provided with information about the research as well as contact details of the researchers, and the option to withdraw their child from the research. Careful classroom organisation ensured that the children's contributions to the research were anonymous, especially to the teacher.

Ethical issues related to the perceived vulnerability of the participants (Thomas and O'Kane, 1998), permission and consent (Wiles et al, 2006), gate-keeping (Murray 2005), and research around a 'sensitive' subject in a non-health-related setting. A well-recognised concern when involving children in research is the risk of exposing them to ideas or situations, which they have not previously encountered, which potentially may be harmful or distressing (Freedman et al, 1993).The use of a storytelling technique meant that the children could only respond from their existing knowledge and were not introduced to new ideas. Equally, when the children discussed their creative work with the researcher (a midwife engaged in breastfeeding education) no comment was made about the choices they had suggested. While this was ethically sound it clearly did not provide an opportunity for individual participants to expand their knowledge around infant feeding. As a midwife it was regrettable to lose this opportunity for health education that may have benefitted individual participants in the future, and this epitomized the dichotomy between the role of the midwife and that of the researcher.

5. Exploring women's breastfeeding experiences using video diaries by Alison Taylor

My prospective qualitative study will ask eight women to keep personal daily video diaries for the first two to eight weeks of their baby's life until their feeding method is established. Participants will film anything and everything that reveals their breastfeeding experiences, including interactions with the baby, friends and family and may involve others using the camera.

Informed consent using participant information sheets and a pre-birth meeting with participants will ensure that both the woman and her family have the opportunity to raise questions and have them answered. Since video recording may involve infants, 'parental consent' will also cover the baby or any toddlers (Allmark, 2002). Thereafter, the responsibility and decision rests with the parents as to what images they record.

Further inherent complexity appears initially to contravene the ethical principles of both researcher and midwife alike. Unlike most other research, confidentially and anonymity cannot be maintained when collecting visual data. Obscuring images using computer software to blur facial or other identifiable features was considered but was viewed as 'objectifying people' and a mark of disrespect that might provoke criticism about the integrity of the data or cause offence to participants (Wiles et al, 2008). To explain the loss of anonymity, participation was compared to appearing on television. Evidence suggests that participants who engage in this type of research often want to be identified and have a voice (Tenney and MacCubbin, 2008). To increase safety and security, participants will be advised not to record identifiable features such as road names and

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house numbers. Also, they may choose to use a pseudonym. Furthermore, participants will be encouraged to edit their own tapes before releasing them to me, to ensure that only video footage that they are comfortable about sharing is used (Tenney and MacCubbin, 2008). It is argued that recording and editing research material in this way can empower participants to create videos that represent their views, voices and experiences in a meaningful way (Banks, 2001).

According to UK law, copyright of moving images such as video footage belongs to the person actually recording the images (Wiles et al, 2008). In this study that means the copyright of the video diaries will rest with the participants. Before the video data can be used for research purposes, copyright will need to be signed over to the organisation hosting the research. This provides added protection to the participant. Arguably, recording the challenges of breastfeeding on a daily basis could be emotionally draining. When visiting the family to collect the tapes (as a midwife-researcher), I will look carefully for any signs of psychological stress (as a midwife-practitioner) caused by recording and/or editing the video diary and, if necessary, I will suggest stopping data collection and offer referral for specialist support. Reporting the findings without causing any psychological harm will be essential. Participants will be reassured that all data will be sensitively reported and that particular care will be taken not to make any judgements or assertions about their actions or decisions. A reflexive approach will thus be adopted in all stages of the research.

Multiple and conflicting roles

Our five cases raise several ethical issues common to all health and social care research, such as informed consent, confidentiality, anonymity, and cultural and personal sensitivity (Parker et al, 2010; van Teijlingen et al, 2008). The one unique theme that links all is that of the 'multiple and potentially conflicting roles' of the midwife-researcher, especially around confidentiality and trust. The latter is central in the woman-centred philosophy underpinning midwifery, which promotes a close bond between a woman and her midwife during pregnancy and childbirth. In contrast, research ethics guidelines are very clear about the need for a researcher to maintain a role discrete from their professional role. In reality, it might be difficult for a midwife (or a mother) to make this distinction. For example, what does a midwife-researcher do if she suspects or becomes aware that her participant is in a life-threatening situation, such as experiencing domestic abuse or receiving substandard care from a professional colleague? Her code of practice says that she has a duty of care to give assistance or to report the situation to the appropriate authority, while standard research ethics call for maintenance of confidentiality and participant anonymity within the role of researcher. Many ethics committees recognise this dilemma, recommending pre-emptive transparency and information for staff that observed malpractice may be referred to supervisors/managers. In some of the cases above it seemed easier to anticipate ethical dilemmas and attempt to avoid them, for example in the cases of the schoolchildren and that of emotional processing. In others, though, such as the cases of video diaries and conducting research in Afghanistan the potential dilemmas seemed less predictable, largely because the midwife-researcher had less control over the actual research process and data collection environment.

Discussion

From the cases above, we would argue that the midwife's role, governed by her professional code of conduct (NMC, 2008), must override her role as a researcher and her duty of care must come to the fore (Rogers, 2008; Hegney and Chan, 2010). Pragmatics say that when life is threatened a midwife-researcher is morally obliged to exchange her research hat for her professional one and act accordingly. Research-practice dilemmas may possibly be rationalised by ensuring a thorough understanding and adherence to professional codes but this does not stop the midwife from feeling conflicted at times. Thompson (2002), however, looked critically at professional codes of practice and ethics in general and the then current midwifery codes of practice (UK and Australia) in particular and concluded that codes offer very little guidance to enable practitioners to transform principles into the practice of ethical engagement with others. She argued that they were inadequate 'to address context, historical changes, culture, character and relationship' (2002: p531) and called for ethical behaviour based on the sincerity and veracity of human engagement in relationships. Ethical protocols and open discussion may help to reduce the tension between the research and practice roles (Houghton, 2010). Research ethics guidance for nurses was recently updated by the Royal College of Nursing (Haigh, 2009) and by An Bord Altranais (2007) for Irish nurses and midwives but both of these documents are principles-based and very prescriptive. Perhaps it is time to look at NMC guidance for midwife-researchers that is constructed from the experiences of the researcher's themselves. These researchers may be defining a new clinical research discipline (Taylor, 1992).

Along similar lines to Thompson, Holloway and Wheeler (1995) encouraged midwives and nurses to ask questions about the utility of their research, their obligations to the participants and to construct a complex ethical framework for their research. They argued that the researcher-practitioner must be clear about their own identity and their duty to their 'patient' first, responding to distress and need and involving colleagues when appropriate. Our cases show that there is no substitute for good research design, including reflexive practice and the keeping of a research journal and accurate records, design that clearly outlines role boundaries and includes consideration of the possible ethical dilemmas and a means of dealing with them. Moreover, these cases also highlight that 'the researcher is central to ethical research practice' (van Teijlingen et al, 2008). In the same way that the midwife is responsible for their own decisions surrounding the care they provide they are also responsible for the way they conduct their research. In a similar conclusion, regarding doctors doing research, Holmes (2004: 309) suggested: 'We must trust researchers – as we do physicians and surgeons 'to do the right thing'.' We trust the midwife to make the right ethical decisions in their practice; similarly we must trust the midwife-researcher to conduct their research to the highest ethical standard.

Conclusion

However much detail we cram into research proposals, research ethics applications, ethical protocols and codes of practice we

must remember that it is always the midwife-researcher in the field who has to decide what is the best action to take when there is tension between their professional ethics and their research ethics. Moreover we must trust the midwife-researcher to do what is ethically sound, in the same way that we trust them to make the best ethical decisions in practice and education.

Finally, we conclude that ethical considerations governing practice must come first and that there needs to be discussion about the best way to support midwife-researchers. It is very important to conduct research ethically, but it is ultimately more important to save the life of a mother or baby than to study its passing!

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Glossary

Altruism	Selfless behaviour for the good of others (Ryan et al 2010)
Axiology	The philosophy of values
Bed sharing	'Adults and infants sharing the same surface for sleep' - sleeping for at least some of the night in the same bed as a parent or parents (ISIS 2014).
BFHI	Baby Friendly Hospital Initiation is a global programme supported by UNICEF and WHO. It has worked in UK with public services to promote and support breastfeeding and were underpinned by the ten steps to successful breastfeeding and the International Code of Marketing of Breastmilk Substitutes
Biological Nurturing	Laid back position for breastfeeding which promotes innate reflexes in baby to self-attach (Colson 2012)
Biomedical approach	An approach to illness that excludes psychological and social factors and includes only biological factors
Biophysical approach	Biological and physical approach
CASP	Critical Appraisal Skills Programme

Centile line	The lines of on the growth chart. The centile number predicts the percentage of children who are below that measurement at a given age e.g. the 25th centile means that 25% of the population of children of the same age and sex will be smaller and 75% will be bigger
Corporal	Bodily
DOH	Department of Health
Duration of breastfeeding	“Length of time that mothers who breastfed initially continued to breastfeed for (including giving expressed breastmilk), even if they were also giving their baby other milk and solid foods” (McAndrew et al. 2012)
Dysphoria	State of unease or dissatisfaction
EBM	Expressed breastmilk
Emic	The participant’s perspectives of their own experiences (Cluett and Bluff 2006)
EPDS	Edinburgh Postnatal Depression Score is a 10-item self-report scale to screen for Postnatal Depression. Scores ≥13 suggest probably postnatal depression (Cox et al. 1987)
Ethnography	Research that explores a culture or group of people (Cluett and Bluff 2006)

Etic perspective	The researcher's interpretations of participant's experiences (Cluett and Bluff 2006)
Exclusive breastfeeding	The infant receives only breastmilk, and no other liquids or solids, with the exception of medicine, vitamins, or mineral supplements (WHO 1991)
Expressing	The process by which a mother expels breastmilk from her breast by hand or breast pump
Extra-uterine	Outside of the uterus
Formula feeding	Feeding a baby on a breastmilk substitute
Frenulotomy	The procedure in which a tongue tie (frenulum) is cut. It is done when the tongue seems unusually short or tight and impedes effective feeding
Hands on support	When the practitioner actively touches the mother's breast and/or the baby's head, neck or back with his/her hands to get the baby to the breast
Hawthorne effect	A change that results from the research process and not the interventions in the research Cluett and Bluff 2006)
Hermeneutics	The theory and practice of interpretation (Braun and Clarke 2013)

Incidence of breastfeeding:	"The percentage of babies who were breastfed initially, including all babies who were put to the breast at all, even if it was only once. It includes giving babies expressed breastmilk." (McAndrew et al. 2012)
Initiation of breastfeeding	**"**Percentage of mothers breastfeeding or partially breastfeeding or giving breastmilk" (McAndrew et al. 2012)
Intra-uterine	Inside the uterus
Let down	An involuntary reflex which causes milk to flow freely during breastfeeding or expressing
Maternities	**"**Women who give birth to one or more live or stillborn babies of at least 24 weeks gestation where the baby is delivered by either midwife or a doctor and the place of delivery is either at home or in an NHS hospital or birthing centre (including GP units). It excludes all maternities that occur in either psychiatric or private beds / hospitals. It counts the number of mothers (maternities), not the number of babies (deliveries)" (NHS England 2014)
Medicalisation	The process by which human conditions such as labour, birth and breastfeeding are treated as medical conditions, and thus become the subject of medical study, diagnosis, prevention, or treatment
Mixed feeding	Combining formula feeding with breastfeeding
NMC	Nursing Midwifery Council

Ontological	The study of being
Partial breastfeeding	Infant receives some breastfeeds but is also given other foods such as supplements of formula milk or solids
Participant observer	Researchers enters into social life of a participant sometimes assume an insider's role and observing for purpose of research
PND	Postnatal depression
Postpartum period	Period immediately after birth until six weeks later
Praxeological	The study of human action or conduct
Premature	Baby born before 37 weeks gestation
Prevalence of breastfeeding:	"Percentage of all babies who are being breastfed (including being given expressed breastmilk) at specific ages, even if they are also receiving infant formula, solid food or other liquids." (McAndrew et al. 2012)
Primary Care Trust (PCT)	Mainly administrative bodies within NHS, responsible for commissioning primary, community and secondary health services from providers
RCM	Royal College of Midwives is a trade union orientated organisation run by midwives.
REC	Research Ethics Committee

SIDS	Sudden Infant Death Syndrome, the sudden, unexpected and unexplained death of an apparently healthy infant
Skin-to-skin contact	Mother holds infant with skin of infant in direct contact with her own skin
Social semiotics	A communication approach that aims to understand how people communicate by various ways to suit specific social contexts
Temporal	Related to time
Visual anthropology	The study of ethnographic film, photography and new types of media
WMA	World Medical Association
WHO	World Health Organisation