

**Exploring the Impact of a Difficult Breastfeeding Experience on Maternal
Identity: A Narrative Analysis**

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**A thesis submitted in partial fulfilment of the requirements of the
University of East London for the degree of Professional Doctorate degree
in Counselling Psychology**

June 2015

34, 491 words

Abstract

Introduction: Due to the implied health benefits for mother and baby, breastfeeding has become a key public health issue. Literature reviewed highlighted the 'medical' and 'natural' mother discourse which surrounds motherhood and impacts on women's decisions to breastfeed. Whilst the emotional and physical strains of a difficult experience have been explored, it is unclear how these experiences impact on women's identities as mothers and in what ways women are able to narrate and share their embodied experiences.

Methods: Seven first time mothers who described themselves as having had a difficult breastfeeding experience were interviewed to gather data pertaining to how mothers construct narratives of breastfeeding and the impact of these narratives on their identity as mothers. An interest in both socio-political discourse and embodiment theory derived from the literature review led to the use of visual methods in eliciting narratives and the employment of a critical narrative analysis in exploring the data gathered.

Findings: The participants' narratives drew from 'medical' and 'natural' mother discourses and were found to constrain subjective experience and leave participants with feelings of guilt, frustration and loss. A prevailing assumption that unruly, excessive bodies must be controlled by a rational 'mind' led to the body becoming a site for control and resistance for participants as they attempted to conform to norms of motherhood and breastfeeding.

Discussion: Results identified the ways in which women as mothers can see their subjective experiences diminished and their voices silenced due to a lack of available discourse and entrenched ideologies surrounding the 'good' mother. It is suggested that adopting a social justice agenda within therapeutic practice might prevent the internalisation of oppressive discourse which can lead to mothers' psychological distress. Moreover, it is suggested that exploring the body in therapy might resist a mind/body dualism and lead to increasingly compassionate and accepting relationships with our bodies; in turn increasing awareness of subjective experience.

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Acknowledgements

Many people have supported me in the writing of this thesis – to them all heartfelt thanks. I would like especially to thank the following people.

Those mothers who were interviewed for their honesty, openness and trust in sharing their stories; each one of you made this research possible, thank you. Also to the many other women, friends, clients and strangers, unnamed in this research, for talking with me about their experiences as mothers; every story shared formally and informally has been invaluable for me both personally and professionally- thank you all.

Sincere thanks to my first supervisor Dr Laura McGrath for your consistent and constructive feedback and your steady, calm and encouraging approach which has kept me grounded and feeling confident. Without your patience and commitment I would not have reached the end of this project.

Thanks to my second supervisor Dr Pippa Dell for sharing your knowledge and experience which has introduced me to new and challenging concepts, ones which have influenced not just this thesis but my world view.

To my friends and peers in training – thank you for sharing this journey with me.

Mr and Ms Griffin (aka Dan and Katja) - thank you for proof reading and remaining interested and supportive in all my endeavours during training.

Mum and Dad, thank you for your unwavering encouragements in all my undertakings growing up and for bearing with me as I have found the path that I am now on. Without your support in its numerous ways I would not have completed my training.

To my wonderful and always encouraging husband, a big thank you. It has been a long journey, involving many sacrifices and compromises. I have been overwhelmed by your hard work in supporting our family. I love the story we are writing together.

To my gorgeous bump – your companionship and wriggling has kept me focused in the final months. To my beautiful boy, my motivation throughout; at just four (and a half!) years old you are a huge inspiration to your Mummy. Thank you for all you have taught me. I love you.

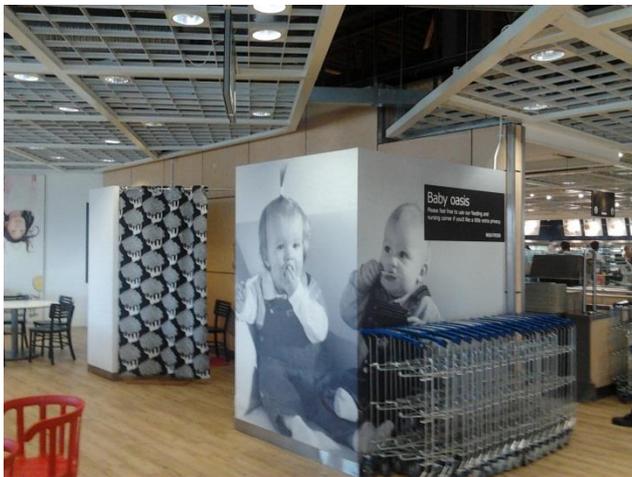
Dedication

I dedicate this thesis to my Nain, a true matriarch who not only survived incredible events as a woman, mother and grandmother, but did so with humour, warmth and non-judgemental affection for others. From studying in her dining room, chats about psychiatry, religion and local goings on, to fish and chips on my respites in North Wales, she never failed to be there for me. Nain, all the stories you shared and the ones we created together will be retold many times and will continue to shape the woman I become.

Exploring the Mother-Infant Dyad following a Difficult Breastfeeding Experience:

A Narrative Analysis

Introduction



Ikea: 'Baby Oasis'

Area behind a curtain for mothers to breastfeed. Promotes breastfeeding by providing the space but could be interpreted as a 'hidden,' 'isolated' or 'private' act.

The name 'Baby Oasis' implies a natural, calm and secluded place. The image accompanying these words is of children self-feeding – not a breast in sight.

How do these words and images come together to construct value and meaning around breastfeeding?

Ikea: sign to area designated for breastfeeding.

The word 'nursing' sounds medicalised and dated. There is an implication of the mother as nurturer. The implication is that 'nursing' is a more palatable word than breastfeeding – it is loaded with moral and natural values. Furthermore, it ensures that in all signage no breasts are visible, not even the word.

The word 'corner' implies a small, discrete space. It is also reminiscent of naughty, shamed children being placed in the corner.

The pictures above¹ illustrate the foundations of this research: society's response to breastfeeding and how discourse activities shape the meaning and values placed on breastfeeding. Furthermore, interest lies in how these meanings and values influence stories of women's difficult breastfeeding experiences.

Breastfeeding is of interest as a part of the transitional experience of women to first time motherhood. The way in which people narrate these events can be understood as "*an interpretative process of self-making*" (Pals, 2006, p.176) and contributes to the ways in which life experiences are recalled and how future events are understood. This is of particular interest to Counselling Psychology as such narratives may teach us more about the nature of motherhood and can be linked to therapy and the relationship between life story and personal transformation (McLean et al., 2007).

In particular this research explores discourse and embodiment and considers how a mother's body figures as both the "*demarcation and dissolution of identity*" (Russo, 1997, p.329). Furthermore, it argues for the vital role of people's bodies in gaining a perceptual sense of being-in-the-world, drawing on understandings of both the lived and inscribed body (Heidegger, 1996; Merleau-Ponty, 1968; Crossley, 2007). Crucially relevant to Counselling Psychology is the impact this has on subjective experience as it is argued that a lack of available discourse and oppressive constructions of the body lead to the pathologising of women's experiences (Bordo, 1997, 2003; Eyer, 1992; Henwood, 1998; Okado, 2011), their isolation (Blum, 1999; Okado, 2011; Wall, 2001) and psychological distress including feelings of guilt, loss, shame and

¹Photos taken by author, August 2012, Ikea, Edmonton

frustration (Hoddinott et al., 2012; Ryan, Todres & Alexander, 2011; Schmied et al., 1999; Williams et al., 2012).

Furthermore, this study is interested in the role of Critical Psychology and social justice, both of concern to the discipline of Counselling Psychology (Kagan, Tindall & Robinson, 2009). It highlights the ways in which oppression can be seen to be internalised, with women absorbing the prejudice of the dominant culture, losing their self-worth, confidence and connection with their feelings (Henwood et al., 1998). Counselling Psychologists are challenged to consider their roles as social justice agents who both within and out of the therapeutic encounter are encouraged to stay vigilant to discrimination and work to empower people (Goodman et al., 2004). It is argued that by being aware of issues of oppression and marginalisation Counselling Psychologists are able to hear more clearly the often silenced voices of women, remaining aware of the impact of context on a person's experiences.

Embracing not bracketing: Personal reflections on my position as mother-researcher

I have chosen to write these reflections on my personal story to acknowledge the position I hold within the thesis. In conducting the research I am aware of my own position of mother-researcher. My reflections and analysis will be informed by this dual role. Using the same approach I asked the participants to use in their stories, I pre-selected four images to elicit these reflections.



Image one: 'Domestic Bliss'

My story is one of a mother and researcher. As I write this I am sat at the kitchen table of my brother's house. My nephew is making ginger bread men with his Dad (my brother) and my other nephew is sat beside me eating a water cracker (no sugar, low salt). *The Beatles* play in the background. My typing is interrupted as my younger nephew, the one eating the cracker, starts crying, startled by the mixer which is being used by the older nephew to make the ginger bread men. The scene is 'idyllically' middle class; everyone is 'as they should be.' The fact that it is my brother at home defies some conventions but fits the 'modern man' discourse (interesting research – Dads' traditional roles, new expectations – how to be the bread winner and the bread maker – or something like that)? My mind is flitting between the family scene and the discourses surrounding/imprisoning/defining it. This is an increasingly common experience – I am liberated and also imprisoned by my new dual identity as mother and researcher. I feel at once, happy, content, proud and guilty. Guilt is a new pervasive emotion which seemed to hit me from nowhere the moment my son emerged out of me into the birth pool (natural birth, another expectation met). Today's guilt is that my son is absent from this domestic scene. Will his absence instil in him an internal dynamic of rejection and abandonment? This is one of the privileges and pains of training as a Psychologist whilst 'training' as a mother; I am able to see first-hand the child development so integral to

understanding our clients and yet this same understanding can make you all the more concerned (and guilty) about your own parenting.

Image two: 'Silent scream'

I wanted to research this area following my own difficult breastfeeding experience which involved five bouts of mastitis, for one of which I was hospitalised. The inflammation, cracked nipples, blood in my breast milk, ultrasounds, antibiotics, midwives, GPs, health visitors, lactation consultants all punctuate my external experience.

The screams of desperation and pain, the tears, the exhaustion, the guilt, resentment, fear,

loneliness and anger punctuate my internal experience. The internal and external aspects of my experience were inextricably linked. As time passed I began to make sense of these experiences and became interested in how they affected my new identity as a mother. I cannot deny this woman in the undertaking of this research, but I am also mindful of keeping my personal transition running parallel to and not enmeshed with this thesis. I felt silenced in those initial months and this research is motivated to hear the voices of women with whom I unapologetically identify. However, I must be careful not to reinforce the silence by allowing my 'mother' role to overtake my 'researcher' role.



Image three: 'Finding a voice'

I am unable to shift this image from my mind when I think about my research. It speaks to me of my motivation to research and to work as a Psychologist. My interpretation of the sculpture is that it encapsulates struggle and silencing. The open mouth and seeming forward movement suggest a desire to express something. I notice the woman's mouth open but throat held – symbolically this can be read as silencing. The

absence of any limbs suggests amputation and can serve to symbolise loss of power and resistance.

The hands at the breast make me think of the fragile, physical connection between mother and child. However, it can also be seen as invasive and restraining. It is not the traditional image of mother and child in an embrace but rather the child seems to cling to the breast. At times I recall feeling overwhelmed by my son's need for milk which seemed to have nothing to do with bonding or closeness and made me feel so distant from him and my body as I struggled to satisfy his hunger through the pain.

Furthermore, it could be argued that it is the breasts in this sculpture which serve as the identifying feature of its gender. It is the breasts which provide the sculpture with the identity of 'woman.' This relationship between the woman and her breasts is not exclusive. The breasts also have a relationship with a child, with a partner and more broadly with society. It speaks to me of how I felt my body had become the property of others and disconnected from my 'self.'

The sculptor has constructed the body as fragmented and marked with scratches. This makes me think of the emotional experience and memory, the story, held by the body. It brings to mind my own physical and emotional wounds inflicted by a difficult breastfeeding experience. Holding onto these embodied experiences whilst living up to the expectations of motherhood and the needs of my son was a challenge to me and I believe in order to meet these expectations I disavowed my body and my story.

Image four: 'Newness'

This is my son, Isaac, aged only a few days. This image reminds me of his fragility, his, to my eyes, utter beauty and wonder. I cannot see this image without being flooded by the huge love I



felt at first seeing him. He has just finished a feed – the small spots in the image make me wonder if they are breast milk that splattered the image at some later date; it was everywhere in those first few weeks! The nail varnish on my nails reminds me of how, a week before I was due to give birth, I went to have a

manicure and have my eye lashes dyed as I knew I would not be able to apply mascara as a tired busy Mum. I am embarrassed by this naivety and ashamed that this was a priority, guilty that my focus on my own needs diminished the preparations for his arrival. Yet I am more compassionate now at my attempt to hold onto my identity and the innocence with which I approached this transition – in this picture my newness meets his.

This image does not show the pain, anger, desperation and fear which only moments before I was experiencing as I tried to feed him. Though I can share this with other women and have begun to reconcile all the negative feelings, I am not sure I could share them as honestly and openly with a researcher as the women in this project. I have found it far easier to sit on the other side of the project and reflect privately on my own experiences. Despite my efforts the lure of academic conventions has kept my story constrained and protected and I openly acknowledge how this creates an inevitable power imbalance between myself and the participants. This can also be seen in the therapeutic relationship and creates questions about positioning in narratives and how to hear stories in a therapeutic encounter, some of which I hope to address in my discussion.

Reflections on the Constructs of 'Woman' and 'Mother'

Modern Western Society is saturated with images of mothers and through the process of my research I have come to realise how readily I have accepted the assumptions and constructions created by these images. I would like to share some stories of discussions with and about women and mothers I have had during my training.

The first comes on a Saturday night with my husband at home. We are watching a performance on T.V. by some singer or other and their backing dancers. The singer is male, the dancers female. It is a common scene; the women are scantily clad and are moving in a highly sexualised way and often seemingly for the pleasure of the main act. I comment on how I dislike women dancers being made to dance in this way, to which my husband replies: "*it's their choice; they are empowered by their sexuality*". His comment irritates. It is not easy to understand how the women ended up dancing in that way and how they feel about it, but the mere fact that it was happening without question or debate on a Saturday night for a family audience upsets me. The fact that in popular magazines I have seen celebrities claim they no longer need the word 'feminism' upsets me. The nuanced meaning of feminism, of women's behaviour and position seems to be eroded in popular Western culture, and this upsets me. Roberts and Waters (2004) suggest that women are transforming their bodies to be increasingly idealised and sexualised in order to distance themselves from the corporeal body and its 'messy' functioning associated with its historically inferior status. Perhaps then my husband is right in a way, as suggested the objectified and sexualised body becomes a way to achieve "*civilised status and social acceptance*" (p.10).

The next story comes from my work with a client. The mother of two small children, she was going through a divorce and struggling to maintain her family home and finances. During our time working together she said to me “*I have no identity anymore, that’s what happens when you are a mother.*” She expressed feelings of loss, confusion, sadness and resentment alongside feelings of love, pride and protection for her children. I wondered with her how her identity had been lost and what it had become. She seemed to mourn her previous self before children and felt uncertain as to how to reconstruct her identity. As she had lost herself, I lost her too as she prematurely terminated our contract, without explanation. I felt huge guilt, anger and shame that I had not found a way to hear her story.

Finally, another client I have worked with lived by the belief that she proved her worth through the success and happiness of her children. In my client’s eyes any blame for her children’s struggles lay firmly at her door and she had become subsumed by critical thoughts and assumptions about not being a good enough mother. She described her continued self-sacrifice, physically, emotionally and financially for the needs of her children. Exploring ways to reframe and challenge some of her assumptions was difficult as her belief that mothers ‘should know’ was deep rooted.

These stories illustrate the power that a label of ‘woman’ and ‘mother’ can have on a person, defining their identity and position in society. It also speaks of the ways in which women interpret and respond to their positions be it through ‘empowering’ sexualised use of their bodies or through subjugating their needs to those of their children. My confusion and frustration inspired me to want to understand further the gendered assumptions I have faced. In the literature review I offer a sketch of women as mothers. I refine this sketch to

create a more complete image of women as breast feeders, critically evaluating research in this area and the debates which arise from women's experiences of feeding their children. In doing so I am left wondering about how mother's come to be positioned as they are.

Analysis of discourse and themes within the participants' narratives are used to build an argument which sees a woman's embodied experience as central to the meaning making process involved in their developing identities as mothers. Furthermore, it is argued, in line with previous research, that the breastfeeding experience can be difficult to reconcile with previous identities which value autonomy, independence and control (Schmied & Lupton, 2001).

Clinical implications to these findings are discussed, namely that effective therapeutic treatment requires us to acknowledge that certain psychopathologies have their roots in culture more than in the individual (Roberts & Waters, 2004). Furthermore, ways of introducing the body into clinical interventions, increasing acceptance and awareness of bodily symptoms and oppressions, are discussed.

To conclude and before presenting my literature review I will outline my researcher position. As shared in my own narrative, I came to the research having had a difficult breastfeeding experience. Furthermore, as the project comes to an end I am pregnant and anticipating difficult decisions about feeding my next child and the anxiety which accompanies these thoughts. This research was never intended to be pro or anti breastfeeding but rather an exploration of how women talk about and make sense of their individual experiences. However, having had my own experience I came to the project expecting, hoping perhaps for my own validation, to hear certain stories. What I have

heard, learned and read has reinforced my belief that mother's stories are not always easily told.

Understanding this I became interested in how mothers' stories are told. Two broad research questions were arrived at (as discussed further in the methodology) and shall be explored in the thesis which follows:

- What can women's stories tell us about the influence of social processes on their meaning making/understanding of a difficult breastfeeding experience?
- What can women's stories of difficult breastfeeding experiences tell us about their understanding of their identity as a mother?

Literature review

Why a multidisciplinary approach to the literature review?

A multidisciplinary approach to the literature review was adopted to reflect the complex and diverse constructs involved in breastfeeding and maternal identity. Furthermore, reviewing literature across disciplines acknowledges the need for a biopsychosocial (Engel, 1980) understanding of the act of breastfeeding and achieves a comprehensive and nuanced exploration of the subject area.

Motherhood is widely researched and has been understood and interpreted in multiple ways. The literature review which follows creates a sketch for the reader on how women are positioned as mothers – who says what about them and how. In undertaking this task it became apparent that a vast amount of the research into breastfeeding is carried out by medical professionals. Furthermore, being a public health concern, much of the literature is orientated around the economic and political ‘breast is best’ agenda (Wolf, 2011). Joan Wolf has highlighted the shortcomings of such medical research, arguing that medical journals minimise the significance of methodological shortcomings which coupled with the vast body of research in the area of breastfeeding leads to physicians relying on ‘conventional wisdom’ to interpret studies and reproduce assumptions uncritically (2011, p.37). Sarah Nettleton argues that the functioning of the body can have profound psychological, social and political consequences (1995); therefore, to avoid presenting a polarised view, which the dichotomy of health and illness can present, it was necessary to examine literature derived from the medical establishment critically and furthermore to look beyond this body of research to understand breastfeeding (Wolf, 2011). This drew me to examine feminist,

psychological and sociological literature. Feminist sociologists are often credited with being the first to recognise the explicit significance of the body for social theory. They argue that women's bodies can reveal the extent to which medical and scientific descriptions of biological functioning are socially constructed (Shilling, 1993, Nettleton, 1995). This complex interplay of the material and the social is no more vital than in the exploration of breastfeeding practices.

In the following literature review, I start by outlining the key discourses utilised within mothering literature – namely the 'medical' and the 'natural' mother. I will then summarise theoretical explorations of motherhood which I draw on in this research, feminist and psychodynamic. Next, I outline breastfeeding literature, focusing on biological aspects, theories of bonding and introducing the literature on 'difficult experiences.' Finally, I will bring this literature together by summarising embodiment theory and its implications for understanding breastfeeding and maternal identity.

1.1 Who Says What about Mothers and How? Discursive

Constructions and Theory

Becoming a mother is a life-changing event which involves a huge emotional transition period (Marshall, Godfrey & Renfrew, 2007; Miller, 2005). Rich (1995) suggests motherhood propels women into a domain of cultural, political, social and economic discourses. These discourses are value-laden and leave women open to multiple judgments. Research often assumes that mothering is either an "*instinctual ability or a skill unleashed by hormones*" (Baumslag & Michels, 1995, p. 3). The concept of mothering as an innate ability is reinforced by the 'natural' discourse which aligns mother to nature, femininity

and morality (De Beauvoir 1953; Eyer, 1992; Ussher, 1997; Ussher, 2006). The concept of a mothering as “*unleashed by hormones*” draws from the ‘medical’ discourse which sees mother-as-machine aligned to progress, production and medicalisation (Carter, 1995; Crossley, 2007; Nicholson, Fox & Hefernan, 2010). Both of these discourses are utilised to position the ‘good’ mother and I will argue that both oppress the subjective, embodied experience of women.

1.1.2 Discursive Constructions of Motherhood

I shall define discourse as referring to specific structures, meanings, categories and beliefs often expressed in bodies of knowledge e.g. medicine (Carter, 1995). How people come to identify with particular discourses is explored in the work of Rom Harre who suggests that the process can be understood as ‘positioning’ and is more dynamic than thinking about individuals assuming static roles (Harre & Van Langenhove, 1991). Through certain discursive practices Harre describes people becoming ‘positioned’ and their subjectivity generated (Davis & Harre, 1990; Malson & Swann, 2003).

1.1.2.1 ‘Natural’ mother discourse. One key discourse of motherhood is that of the ‘natural’ mother (Eyer, 1992; Ussher, 2006). Banks (1990) traces feminist activities over the centuries and outlines the origins of what she refers to as the “*domestic prison*” and “*moral identity*”. Banks describes the “*cult of true motherhood*” (p.86) and the opinion that women’s role in the home during the late nineteenth century was to succour her husband and children; the position of women to support and nourish is evident. Banks describes how women’s attempts to emancipate themselves from the domestic role were seen to be in conflict with their roles as mothers. The assumption was that the pursuit of independence and education would corrupt the moral purity required of women

as mothers. This moral imperative is argued to be aligned to the inherent moral authority of nature and can lead to substantial pressure on mothers (Wall, 2011). False expectations of women's abilities resulting from this association with nature is argued to induce feelings of failure (Hoddinott et al., 2012; Ryan, Todres & Alexander, 2011; Wall, 2001; Williams et al., 2012).

Society tells us that motherhood is natural and blissful. Depictions of Madonna and child and soft focus images of women kissing their children in advertisements all reinforce a discourse which sees motherhood as the central and most gratifying role in women's lives (Jackson & Mannix, 2004; Ussher, 2006). Motherhood as described in such imagery and fantasy is constructed as 'natural,' of the body rather than of the mind. De Beauvoir (1953) makes links between nature and the sexualised female body. She suggests that breast and buttocks become sexualised through their "*gratuitous blooming*", mirroring the reproductivity of nature (p.190). This construction includes an idealised and sanitised view of the 'natural' body (Basow, 1991; Bordo, 1997) and sees women manage their bodies according to a feminine ideal as described by De Beauvoir in her discussions of bodily adornments - fashions and make up. This is further exemplified by women's changing body appearance as they move into the public sphere. An example offered by Ewen (1976) sees women during the 1920's encouraged to remove their body hair to "*secure [her mates] fidelity in particular and her homes security in general*" (p. 177 cited in Basow, 1991, p. 84).

This construction continues today as the sanitised body becomes increasingly deodorised and perfected in Western societies, with women concerned to mask the bodies functioning (Roberts & Waters, 2004). Basow (1991) claims that women's bodies become unacceptable and unattractive in

their natural state and it is argued that discursive practices concerned with modesty and appropriate privacy contribute to oppressive management of corporeal functioning which alienate women from their subjective experience (Carter, 1995).

1.1.2.2 'Medical' Discourse. A second major construction of motherhood is medical. "*Medicalisation*" sees behaviours and conditions given medical meaning and framed in terms of health and illness. It allows medical practice to become the vehicle for eliminating and controlling problematic experiences (Carter, 1995, p.175). Van Estrick (1989) argues that the medical community redefines certain events, behaviours and problems as divergent from what is 'normal' and therefore in need of control. Michele Crossley's (1997) review of pregnancy and childbirth highlighted what feminists have termed the '*maternal gaze*', the scrutiny which the medical model uses to undermine and alienate women from their own bodies. This concept was developed by Foucault in his writings on surveillance medicine (1979) which sees that which is normal become problematic and reinforces the development of risks around behaviours. In pregnancy this can be seen increased advice on women's diet and lifestyles (Nicholson, Fox & Hefernan, 2010). Furthermore, biomedical models provide the language and terminology with which to express such deviations from the norm and thus privilege the expert over the subject of experience; this both limits agency but also the possible ways of expressing experience (Carter, 1995). Individualising human problems within the medical model is argued to remove experience from its social and economic context, resulting in isolation and feelings of guilt and fear described in many studies of breastfeeding (Okado, 2011).

The positivist paradigms within which much breastfeeding research is undertaken reinforces medical 'truths' and obscures alternative interpretations which may underpin feeding practices. The focus on the biological aspects of breastfeeding excludes insights into women's sense of self and embodiment (Schmied & Lupton, 2001). Within a medical context infant feeding becomes reduced to 'facts' which women can be taught, this objective and reductionist approach limits a constructionist understanding of women's experiences and limits insight into women's subjectivity (Ussher, 2006; Young, 1990). Furthermore, positivist paradigms serve to mask power dynamics and ideological underpinnings which contribute to marginalisation and discrimination (Prilleltensky & Nelson, 2009).

Sustaining both of these discourses are the assumptions surrounding a mind/body dualism. The body as autonomous to the mind was a principle of Enlightenment and forms the basis of much of Western medicine, assuming that patients are individual entities outside of cultural and social contexts (Ussher, 1997). This principle will be further developed and explored later in the chapter when introducing embodiment literature. The discourses examined have been seen to oppress women and essentialise their roles as mothers; therefore it is important to consider the work of feminist theory for a critical perspective on the positioning of women and mothers.

1.1.2 The feminist mother. 'Reproduction' is often constructed as the ultimate feminine endeavor, making gender and discourses of the feminine particularly relevant to consider (Eyer, 1992; Malson & Swann, 2003). Feminist authors have written much about women and motherhood. The following section shall briefly introduce some overarching ideas relevant to this thesis.

Glick & Fiske (2001) have argued that two forms of sexism exist, benevolent and hostile. Benevolent sexism sees women in particular roles, such as mothering, receive protection and affection, whilst hostile sexism is encountered where women subvert conventional roles and are viewed as usurping men's power. They argue that benevolent sexism is "*disarming*" as women are positioned to receive positive reinforcement only when oppressed (p.111). Feminists have challenged the notion that being a mother is the only legitimate role for women suggesting this essentialises women's functions within patriarchal social structures; reinforcing notions which define motherhood as central to femininity and childlessness as abnormal (D'Arcy et al., 2011; Letherby & Williams, 1999; Malson & Swann, 2003). Despite the aforementioned concerns regarding women's roles as mothers, many contemporary feminists aim to support mothering so that it might become an empowering rather than oppressive practice (Kinser, 2010).

The assumption that mothering is 'natural', 'pure' and belonging in the private sphere has led to what Brown et al., (1994) have described as the "*invisibility*" of motherhood (p.161). The unseen emotional and physical work of mothers has been argued to be idealised and go largely unrecognised (Dyck, 2005, Eyer, 1992). Such assumptions are argued to lead to undue responsibility on mothers for the care of children and the home and consequently increased levels of scrutiny and "*mother blaming*" (Jackson & Mannix, 2004, p.150). I

would suggest that the associated feelings of guilt and failure which accompany this blame lead to further oppression and isolation for mothers as they struggle to meet the demands of the 'good' mother (Miller, 2005; Wall, 2001).

Furthermore, it is suggested that a reluctance to discuss the difficult emotional impact of mothering, may result from a belief that such responses are stigmatising (Brown et al., 1994).

The arguments presented in feminist literature suggest that mothers are positioned as holding undue responsibility for child rearing and that their subjectivity is constructed through historic and cultural patriarchal discourses (Eyer, 1992). Billings (1995) suggests these constructions are compounded by psychological theory and an exploration of psychoanalytic literature will follow to demonstrate this.

1.1.3 The Psychodynamic mother. As well as linked to 'natural' discourses, expectations of mothers' behaviour can be seen to have been established in many psychological child rearing theories including Freudian theory and attachment theory. It is argued that these theories have become overstated and burdensome on the mother and do not extend the same responsibility to the father (Billings, 1995; Phares, 1992).

Central to the development of the idea of attachment and 'good enough' mothering were John Bowlby and Donald Winnicott. Winnicott's assertions around 'good enough' mothering whether intentional or not have been argued to create a dualism which saw certain care giving as falling short of suggested ideals and therefore becoming 'not good enough' (Brown et al., 1994). Winnicott (1973) emphasised the crucial nature of what happens between mother and baby; though food was only one aspect of this he did utilise the term 'breast' to encompass techniques of mothering (Brazelton &

Cramer, 1990), an association which has become problematic for the 'good' mother discourse as feeding and bonding have become synonymous.

Bowlby (1958) had enormous influence in the study of attachment, suggesting that early interactions between mother and baby lead to a particular attachment style in infants which goes on to underpin all human relationships and interactions (Brazelton & Cramer, 1990). Bowlby's assertions that infant attachment is an instinctually guided behavioural system which has functioned throughout human development (Lemma, 2003), links attachment to evolution and can be seen to have contributed to the 'natural' mother discourse. There is evidence supporting Bowlby's research that sees babies sustain attachment to those who can provide regulation of behavioural, neural and affective systems (Slade, 2000). However, crucially argued is that there is more to mother-infant interaction than the fulfillment of physiological needs (Bowlby, 1958). Whilst this might usefully remind us that parenting goes beyond feeding, especially pertinent to this study, none the less the work of Bowlby and Winnicott does lay the foundations of responsibility for mothers to relate to her baby in a way which meets its psychological needs.

Schmied & Lupton (2001) have argued that Psychodynamic literature assumes that women automatically develop a sense of self that is able to "*desire and tolerate connectedness and interdependency*" (p.244) and whilst the infant focus of attachment theory might reinforce this idea authors such as Daniel Stern and Dinora Pines acknowledge the upheavals of motherhood. It has been suggested that pregnancy and first time motherhood can lead to an increase in maturity and increase self-esteem; conversely it is possible that women are left with potentially guilt-laden mother-child relationships (Pines, 2010). Stern (1998) calls the transition for women to motherhood "*a unique*

psychic organisation...the motherhood constellation". This reorganisation may evoke drives and defenses related to early attachment, requiring "*the greatest amount of mental work and mental reworking*" (p. 172). These internal conflicts provide useful explorations of the developing identity of mothers and being aware of them might introduce a different way of hearing women's stories of this transition.

1.2 Breastfeeding: Issues and Key Debates

In the following section I will introduce the focus of this study, breastfeeding, focusing on its political, medical and social positioning. I am concerned to avoid focusing too closely on the individual over society, therefore, I will utilise cross disciplinary literature to respond to criticisms that Psychology encourages identity to be seen through individualistic and competitive rather than collaborative endeavours (Fox, Prilleltensky & Austin, 2009). Breastfeeding is here framed within a broader context which might foster mutuality and connectedness (Fox, 1985).

Breastfeeding has become a key public health issue in Western society (Wall, 2001) and much of the literature confers significant benefits to mothers and babies (Graffy & Taylor, 2005; Sloan et al., 2006). As a consequence breastfeeding is heavily promoted in NHS literature, stating the health benefits to babies and its apparent ease and convenience. It is claimed that breastfeeding impacts on the mother-child relationship, for example the NHS website states "*it can build a strong physical and emotional bond between mother and baby*" and "*it can give a great sense of achievement*" (NHS, 2015). Whilst the website does identify problems mothers may encounter including sore or cracked nipples and blocked ducts the psychological impact on the

mother when breastfeeding problems arise is not fully addressed. These difficulties are often characterised as small concerns dealt with with ease (Wall, 2001).

It is clear from statistics that mothers are being motivated to find alternatives to feed their babies. The Department of Health identify that in England on average 73.6% of women initiate breastfeeding with this figure falling to 46.6% by six to eight weeks (DoH, 2013). The La Leche League (2015), a support network for breastfeeding mothers, suggests this has fallen to 25% by six months, despite the public health recommendation of exclusive breastfeeding for six months. Most women can be seen not to be adhering to the recommendations to fully breastfeed for the first six months (Wilkinson and Scherl, 2006), with possible reasons for stopping being described by Sloan et al., (2006) as difficulties in establishing feeding including: a poor latch resulting in painful nipples and a low milk supply; second children; and a return to work.

Despite these figures, breastfeeding has been revealed to be central to women's experiences of motherhood, especially in the first few weeks (Schmied & Lupton, 2001). Most writing about breastfeeding presents it in positive biomedical and public health terms (Schmied & Lupton, 2001, Wall, 2001) and as such is often framed as a matter of individual and rational decision making (Ryan, Bissel and Alexander, 2010). There is, however, a growing body of literature which illustrates the difficulties faced by breastfeeding women (Crossley, 2007; Kelleher, 2006; Mausharts, 2000; Wolf, 2007). Such literature reveals breastfeeding narratives as sites of "*construction and reconstruction of the self*" and exposes tensions created by prevailing discourses as women attempt to make sense of their experiences (Ryan, Bissel & Alexander, 2010, p. 951, see also Marshall, Godfrey & Renfrew, 2007).

Furthermore, recent research into the clinical implications for women who have difficulties in breastfeeding have found links to depression and anxiety (Feldman, 2007). Borra, Iacovou and Sevilla (2014) in their study looking at links between breastfeeding and postpartum depression found diverse effects of breastfeeding on depression but conclude that these effects seem to be mediated by women's intentions during pregnancy. The emotional disturbance seems to result from a mismatch between expectation and reality (Hoddinott, et al., 2012; Miller, 2005).

The intentions alluded to above by Borra, Iacovou & Sevilla (2014) can be seen to be formed as a result of constructions surrounding breastfeeding (Leeming et al., 2013) which are argued to embed the act within socio-cultural ideologies, beyond the individual mother (Van Estrick, 1995). It is argued that similarly to other eating practices, breastfeeding is socially and culturally regulated (Schmeid & Lupton, 2001; Schulze & Carlisle, 2010; Quandt, 1995). Sloane et al., (2006) found that the slogan used in much promotional literature, 'breast is best,' was quoted spontaneously by participants in their study, indicating the impact of health and political discourses over women's choices. These messages influence women and Price (1998) argues that consequently mothers decision making and actions are altered to "*fit the fashion*" (p.63).

There has been reluctance historically for feminist researchers to enter into the debate surrounding the imperative to breastfeed due to concerns around exploitations of third world women by formula companies and a loss of control and confidence in women which followed the medicalisation of reproduction, child birth and child care (Palmer et al., 2012; Wall, 2001). Repeatedly in the feminist literature fears around the essentialising of women's

roles are muted, as concerns about linking the concept of 'woman' too closely to 'reproduction' and biology are seen to be reductionist and oppressive (Bordo, 2003; Carter, 1995; Crowley & Himmelweit, 1994; Malson & Swann, 2003).

Therefore exploration of the topic of breastfeeding – a biological and reproductive act, seems to have been neglected. However, Crowley & Himmelweit(1994) argue that neglecting issues of biology and reproduction can lead to "*somatophobia*" (p.64), a hostility and disregard for the body, in feminist literature (see also Jaggar, 1993).

According to Van Estrick (1989) breastfeeding is an important feminine issue as it encourages woman's self-reliance and confirms women's power and control over their bodies. Furthermore, it challenges models of commodification and sexualisation and requires society to reinterpret what is defined as women's work. This is to my mind a somewhat optimistic view of the simplicity with which breastfeeding can determine change. I agree that all these opportunities arise but as Van Estrick herself points out such change requires self- esteem and is influenced by socio-economic status. Many constructs, norms and discourses limit the opportunity to achieve these conditions. I have introduced some of the discourses in the exploration of 'mother' and revisit these in the following overview of breastfeeding.

1.2.1 Medical Breastfeeding: Objectifying and Erasing Women's Experiences.

Breastfeeding research to date has been criticised for being held within the medical domain (Andrews & Knaak, 2013; Crossely, 2007; Spencer, 2008) and, as will be established in the upcoming section, the mother's voice may become lost in this. The biomedical model dominates our understanding of breastfeeding with benefits focusing on hormonal changes in the mother and

subsequent responses including decreased stress and calmness (Gerhardt, 2004; Mezzacappa & Katkin, 2002; Ryan, Tordes & Alexander, 2011; Schulze & Carlisle, 2010).

Physiological changes have been linked to operant conditioning (Mezzacappa & Katkin, 2002), the hormonal 'reward' for the mother, resulting from the release of oxytocin during breastfeeding, assists in the promotion of maternal 'attunement' (Gerhardt, 2004). Defined as "*mutual adjustment of emotional and attentive states*", this sounds like an innate process (Jansen, Weerth & Riksen-Walraven, 2008, p. 504). Unclear are the possible negative consequences if breastfeeding is difficult. Strathearn (2007) in a study of 'stress reactivity' explains that the infant provides somatosensory cues (breastfeeding being one), which the mother responds to with the ambiguously described 'maternal behaviour.' Regardless of the experience, breastfeeding as presented here in terms of hormonal change or somatosensory exchange, is constructed as gratifying and innate (Brown et al., 1994; Jackson & Mannix, 2004; Ussher, 2006).

Much of the breastfeeding research reviewed is concerned with the health of the baby (Carter, 1995; Field et al., 2010; Schulze & Carlisle, 2010; Silberstein et al., 2009). Field et al.'s (2006) paper supposedly examines the benefits of breastfeeding for depressed mothers, however, all the results indicate how maternal behaviour during breastfeeding is of benefit to the baby: growth, development, optimal levels of stimulation and where the mother is reported as more relaxed this is described as beneficial as it leads to the baby being able to better focus on feeding. In this vein, Blum (1999) has suggested that breastfeeding advice is preoccupied with maximising and perfecting children. In Henderson, Kitzinger and Green's (2000) study of the media's

portrayal of breastfeeding, they describe how breastfeeding confers crucial benefits on the mother and baby, referencing papers related to sudden infant death, urinary tract infections in infants and reduced risk of insulin dependent diabetes in breastfed babies. This both reinforces the absence of the mother in any inferred benefits and also assumes that a mother's sole intention is motivated by making the right moral decision for her baby's health, not feeding becomes a near fatal decision for her baby's future health. This message is clearly powerful as Sloan et al., (2006) found that 'best for baby' was the most common reason cited for breastfeeding in their study exploring mothers decision to breastfeed.

This decision making is argued to be largely influenced by research into breast milk. Schmied et al., (2001) describe how the vast majority of research relates to the physiological and immunological benefits of breast milk, and becomes central to the arguments for women to breastfeed their babies. In her research examining the La Leche League, Bobel (2001) describes how women talk of the objectification of breasts not as sexual objects but rather as a source of nutrition, she quotes one woman as describing her baby saying "*she goes for the breast like a Big Mac*"(p.136). Here we see links between commodification, production and the body: as the Big Mac is a mass manufactured commodity so too the breast becomes an industrialised object, devoid of subjectivity.

Also reinforced are constructions of nature which surround breastfeeding, for example in the health care literature examined by Wall (2001) it claims that "*nature has given women a wonderful way for every new woman to care for her baby*"(p. 596). Milk is described as changing in composition daily according to the baby's needs, containing antibodies both protecting the baby

and meeting all its nutritional needs (Schulze & Carlisle, 2010). The natural discourse used here sees women's bodies becoming an "ecosystem" for a child's optimum food source (Wall, 2001, p.603). This idea is further reinforced by the medical model as women are urged to manage their bodies to ensure quality production for example by being told to eat well and avoid alcohol (Blum, 1999; Ussher, 2006).

In the medical literature, breastfeeding is hence emphasised as good for the baby, nutritionally beneficial and hormonally regulated. This overemphasis on the baby coupled with the oppressive positioning of women's bodies as objectified producers of milk, likely contributes to what some authors have described as many mothers' "loss of and disruption to the self" (Ryan, Bissel & Alexander; 2010, p.292, see also Palmer et al., 2012; Schmied & Lupton).

1.2.2 Bonding and Breastfeeding: Feeding as the Conduit to Building a Maternal Bond.

During the first years of life, relational exchanges between mothers and infants revolve around care giving. Feeding a life-sustaining function that is critical for growth and survival, provides a central context for the development of the dyadic relationship (Silberstein et al., 2009, p.502).

This quotation taken from Silberstein et al.'s paper on feeding relationships and the development of feeding difficulties in low-risk premature infants highlights the strong correlation often drawn between breastfeeding and bonding and the pathological implications for deviations from this practice (Eyer, 1992).

Eyer (1992) suggests that the enthusiasm with which bonding as a concept was accepted can in part be explained by the fact that it fits with deeply embedded ideologies surrounding the role of women. It is argued that post Freudian psychology saw a shift within child rearing from assisting with the socialisation of the child to the psychological functioning of the child (Heffner, 1980). Furthermore, Brown et al., (1994) argue that authors of childcare manuals imply meeting her child's needs is synonymous with a mother's sense of purpose and self (Brown et al., 1994). Such assumptions bind a mother's identity to that of her child's 'progress' and functioning and ignore realistic difficulties accompanying parenting. In this context, any lack of gratification is regarded as unnatural and resulting from individual shortcomings (Wall, 2001).

Bonding is often examined within the quantitative paradigm, despite the subjectivity of such a term (Eyer, 1992). In this literature a union between mother and infant is often assumed, referred to as the 'maternal bond', defined as an "*emotional connection of the mother to her infant*" (Else-Quest et al., 2003, p.496). However, a review of the literature by Jansen, Weerth & Riksen-Walraven (2008) suggests that the evidence of endocrine effects of breastfeeding and the positive implications for health derived from breast milk should be the sole message of promotional literature. They conclude there is no conclusive empirical evidence supporting the relationship between feeding and bonding.

However, it is argued that the touch and gaze which accompanies breastfeeding are central components to bonding (Silberstein et al., 2009). These non-nutritive aspects of breastfeeding are argued to allow for better 'attunement,' as the infant is exposed to different interactive experiences not possible outside of breastfeeding (Else-Quest et al., 2003; Jansen, Weerth &

Riksen-Walraven, 2008). Understated in such literature is how sensory feedback may be disrupted when a mother experiences difficulty breastfeeding such as pain, physical vulnerability and discomfort (Schulze & Carlisle; 2010). Furthermore, closer examination of quantitative studies show bias in the literature reviews towards physiological aspects of feeding leaving subjective experience is often overlooked. This coupled with the positive methods employed and derogatory descriptive terms such as "*failure to thrive*" (Silberstein et al., 2009, p. 503), all serve to further silence or vilify the mother.

Breastfeeding as described in this review of biology and bonding has become intimately linked with 'medical' and 'natural' mother discourses, creating a moral imperative that contributes to a woman's sense of self and the potential for "*lifelong feelings of personal failure and grief*" (Ryan, Tordes, & Alexander, 2011, p. 73, see also Wall, 2001). Bobel (2001) describes the push and pull created by such discourses in which women are pulled into attempts to reclaim their decisions as breastfeeding mothers, but in so doing are pushed into prescribed, restrictive and often biologically determined roles. The following section reviews the consequence of this push and pull for women who experience a difficult breastfeeding experience and will specifically explore the bodies of women as central to this tug of war.

1.2.3 Expectation vs. Reality in Difficult Breastfeeding Experiences.

Breastfeeding is not without complications (Schmied & Lupton, 2001, Wilkinson & Scherl, 2006). Research has identified that difficult experiences result in mothers lacking confidence in their bodies and their babies (Burns et al., 2009; Larsen, 2008; Regan & Ball; 2013). Studies have shown women often feel unprepared for the realities of breastfeeding, and highlight a conflict between the idealised views of breastfeeding versus the more challenging reality

when difficulties arise (Graffy & Taylor, 2005, Hoddinott et al., 2012). The idealism discussed in such studies could be a consequence of the discourses and ideology I have outlined previously. The reality for some women who encounter difficult experiences is far from this (Palmer et al., 2012). Schmied and colleagues (1999, 2001) explain women express a desire to breastfeed, reporting it as important to their identity; however those who find it difficult express feelings of guilt and disappointment. Interpreting these findings, Wilkinson & Scherl (2006) conclude that it is early weaning that leads to these feelings in women, however I would argue that is the idealised image of the 'natural' mother, coupled with the scrutiny of the medical gaze which leads to women's distress.

The literature highlights difficulties faced by mothers during painful and exhausting breastfeeding experiences (Palmer et al., 2012). Mausharts (2000) describes the pain involved in breastfeeding, explaining the "*force of baby's gums in action is astoundingly disproportionate to its size and putative helplessness*" (p.157), highlighting the conflict between the somatic experience and the perception of the infant. Responses to their babies during difficult experiences see women associating their child with pain and fear: "*it is hard to want to feed your baby when you know they are going to hurt you*" and "*I was afraid basically to feed her*" (Kelleher, 2006, p.2732). Women have also described their experiences of feeling like a 'cow,' implying feelings of exploitation and disconnection from the body as it is personified as a farmed animal (Sloan et al., 2006). Finally, a dichotomy in women's emotional response to the continuation of feeding has been identified: pride vs. guilt. Such emotional responses indicate the cultural value attributed to breastfeeding (Hegney, Fallon & O'Brien, 2008).

In the aforementioned studies the political drive for women to feed and a bias towards teaching women to fulfill their role as productive and nurturing can be seen. Hegney, Fallon & O'Brien frame their research with the question "*why is it that some women continue to breastfeed successfully to their goals in the face of significant adversity while others with similar problems do not reach these goals?*"(p.1183). Their question highlights the medical bias in the research towards promotion of breastfeeding. Whilst Kelleher concludes from her findings that "*pain and discomfort may detract from women's care giving capacities and intentions*" (p. 2737), reminding us of the bias towards the baby and towards a woman's role of fulfilling her duties. Once more, the embodied subjective experience of women is overlooked.

Skitolsky (2012) argues that suffering has been normalised by the cultural expectation that mothers should put their baby's needs ahead of their own. She explains that often pain is perceived as a natural part of pregnancy, birth and breastfeeding, an expectation in part resulting from attachment theorists and development psychologists (Phoenix & Woollett, 1991), and suggests a correlation between nurturing and suffering (see also, Ussher, 2006). Discussing pain and breastfeeding Skitolsky (2012) describes the conflict mothers face to endure pain for the health of her child or remove the pain and be seen to deny the child? The Le Leche League website (2012) states "*mothers have breastfed their babies through a variety of illnesses, from colds and infections to chronic conditions...these mothers found creative solutions to enable them to continue breastfeeding while caring for their health.*"The suggestion here seems to be that mothers' suffering never supersedes the value of breastfeeding. The medicalisation of reproductive experience has contributed to this view of the mother and her body; women become the

regulated container of the foetus (Bordo, 2006; Nicholson, Fox & Hefernan, 2010; Ussher, 2006). The social construction of the self-sacrificing mother influences women to interpret this struggle as a personal failing as a mother (Benson & Wolf, 2012). This literature highlights the often punishing discourses which shape women's experiences and the need for continued research into the 'moral work' of women as mothers and the implications of this on their embodied experience (Ryan, Bissel & Alexander, 2010).

Despite the many emotional responses to breastfeeding which have been documented in research (Burns et al., 2009; Hoddinott et al., 2012; Larsen et al., 2007; Marshal et al., 2007; Wilkinson & Scherl; 2006), little research has been done into the themes of embodiment and emotion in breastfeeding experiences (Regan & Ball, 2013; Ryan, Tordes & Alexander, 2011). It therefore seems important to consider how embodiment theory may assist in our understanding of difficult breastfeeding experiences. In the following section I will outline the embodied turn, critique Rene Descartes' mind/body dualism and consider the implications of this for women and breastfeeding mothers.

1.3 The Embodied Turn: Bringing Together the Mother and her Body

Our body is our way of being-in-the-world, of experiencing and belonging to the world. It is our first point of view on the world
(Crossley, 1995, p.48).

This quote highlights the centrality of the body to experience and yet it is argued to be overlooked within breastfeeding research (Regan & Ball, 2013; Crowley & Himmelweit, 1994). Bartlett (2002) suggests that breastfeeding

is often reduced to universal claims relating to the observable, homogenous body, disregarding lived experience as embodied. Authors have argued that in de-subjectifying the body we lose the ability to connect to the world (Connolly, 2013). This suggestion is in line with the argument central to Merleau-Ponty's (1965) writing. He explains that the "*body is our general medium for having a world*" (p.146), therefore removing subjectivity from the body risks minimising our connection to the world around us. This has many clinical repercussions, impacting on our identity, emotional experience and meaning making.

Brown et al., (2011) describe the 'embodied turn' outlining four key areas of research, the first being social theories of the body as described in the works of Foucault, Bourdieu and Elias. The second concerns the body as historically and culturally mediated, the third analyses body techniques e.g. modification and dysmorphia and finally the fourth examines embodied experience. The turn to embodiment in research has not been without its difficulties as it involves reconsidering epistemological foundations. The humanities have tended towards idealism, natural sciences have aspired for materialism, whilst social sciences have increasingly examined discourse - all are argued to be responsible for the prevailing mind/body dualism (Grosz, 1994, McNamara, 2011).

1.3.1 Cartesian Dualism and the Construction of Women's Irrational Bodies

The disembodied mind belongs to the ontological tradition of Rene Descartes and his belief that subjectivity and meaning come only from the mind (Connolly, 2013). Separation of the mind and body has seen the mind become responsible for thought and free will and the body relegated to the position of a machine (Burkitt, 1999). Dualism positions the mind as essential and the body

as an arbitrary physical form (Crowley & Himmelweit, 1994). This hierarchy also delegates women to an inferior status where mind and reason, rationality and control become synonymous with men, whereas nature and body, irrationality and loss of control become synonymous with women (Crowley & Himmelweit, 1994, Gear, 2001).

The consequences of such dualisms can be observed in Sampson's (1998) argument that social psychology trains "*spectators*" (p.22) who visit and observe, creating an objective position and reinforcing a subject/object dualism. This dualism implies that reality can only be attained by a subject/mind inferring, deducing or projecting for the object/body. The subject holds hierarchical superiority over the object, the body becomes passive and in turn embodied experience denied (Grosz, 1994). This is especially problematic during breastfeeding experiences in which Bartlett (2001) argues women are disempowered when their "*corporeality is most active and symbolically significant*" (p.376, see also Russo, 1997; Young, 1990). Pregnancy and the early post-natal period are said to provide an opportunity for exploring embodiment and subjectivity as the bodily changes subvert the usual mind/body relationship with breastfeeding the most "*tangibly embodied act a mother performs*" (Bobel, 2001, p.133, see also Nicholson, Fox & Hefernan, 2010).

1.3.2 The Body as Scrutinised and Controlled

The body is central to the medical models developing control over pregnancy, childbirth and feeding. As technology advances the body becomes less mysterious as Foucault describes in *The Birth of the Clinic*, the body once invisible and subject to fantasy becomes visible "*offered to the brightness of gaze*" (1979, p.241). This gaze has been greatly discussed and it is argued that the surveillance of women's bodies leads to oppressive and controlling

practices (Bordo, 2003; Diprose 1995; Shildrick, 1997). Such scrutiny reinforces social distance between the person and their body, with the need to present a disciplined body superseding a person's ability to represent the self (Ryan, Bissel & Alexander, 2010). For breastfeeding women this may result in the rendering of responsibility for their bodies to medical professionals and knowledge (Crossley, 2007, Van Estrick, 1989).

Bodily presentations are argued to be manipulated in order to communicate (Sampson, 1998), created through a set of discursive practices which reinforce modesty and apparent privacy (Carter, 1995). Wall (2001) has suggested that women are expected to manage the scrutiny of their breasts by maintaining an appropriate balance between attractiveness and respectability – breastfeeding therefore presents a precarious site of boundary transgressions (Schmied & Lupton, 2001, Ussher, 2006). In their discussions around menstruation, Roberts & Waters (2004, p.9) describe a “*hygiene crisis*” in which women are concerned with being discovered through their bodily functions. So too the laboring and breastfeeding body leaks, divulging its biological truths. Women, they argue, attempt to distance themselves from these truths by distancing themselves from their bodies. At an individual level women utilise a “*looking glass*” view of themselves and at a societal level norms of concealment, for example reproductive products and nipple pads, keep the corporeal body from public view (p.11).

Bringing together embodiment theory as presented in the literature review I conclude that the body is a crucial site for exploration in women's experiences of breastfeeding. Tordes (2007) emphasises that embodiment cannot be considered separately from knowing and that we must engage in understanding people's lived experiences in all its complexity. Finding ways for

women to challenge social relations and reclaim their bodies has great potential for women's transformed relationships with their bodies (Carter, 1995). It is suggested that embracing the body is an act of resistance in a society which seduces women with sanitised and scientific constructions of breastfeeding (Bobel, 2001).

Expression of embodied experiences presents an opportunity for discursive change, creating new discursive spaces beyond the deterministic positions of success or failure (Bailey, 2001, Ryan, Bissel & Alexander, 2010). However, to subvert such discourses women must find ways to articulate their embodied experiences beyond the 'medical' and 'natural' discourse and accept an 'inside out' relationship to their bodies (Roberts & Waters, 2004). It is hence argued in the subsequent chapters that the embodied nature of breastfeeding creates a crucial site for the development of emerging maternal identities.

1.4 Conclusions

A common theme which runs through 'medical' and 'natural' mother discourses is the invisibility of women and their needs as they become subject to public scrutiny and moral authority; consequently mothers are often set up to fail (Ryan, Bissel & Alexander, 2010, Wall, 2001). Carter states "*women's needs in relation to the costs of infant care have barely been addressed*" (1995, p.239), in this research through exploring stories of difficult breastfeeding experiences such costs will be examined and brought to the forefront of new understandings of motherhood.

Jung suggested that disembodiment lies at the heart of the "*malaise of modernity*," if our bodies are reduced to material objects, so too our world becomes empty and meaningless (Connolly, 2013 p. 638). Malone (1998)

argues that in the exploration of subjectivity the body is central and suggests that social constructionism can limit understanding of the body to an “*adaptive perceptual apparatus*” (p.66). By keeping embodiment theory central in this research it is hoped that both the lived and inscribed body can be explored (Crossley, 1996). Embodied discourse as examined in this thesis highlights both the control and disempowerment accompanying disembodiment and the resistance created by embracing embodied experience (Regan & Ball, 2012, Williams et al., 2012). For Counselling Psychologists’ such research provides an opportunity to better understand the lived experience of mothers and develop ways both to hear their stories within the therapeutic encounter and challenge pathologising discourse which may lead women to counselling (Henwood, et al., 1998).

Methodology

2. Philosophical Approach to the Topic

This section outlines my philosophical approach to the research topic. My primary concerns are of the discourses surrounding the positions of breastfeeding women and the impact of these on subjective experience. Therefore, when developing my research method consideration was given to social justice and empowerment, challenging oppression and to hearing the voice of those who have been silenced.

2.1 Counselling Psychology: Aims and Values of the Profession

As well as being a scientist, philosopher and researcher, the counselling psychology practitioner needs also to be an artist in order to be creative and innovative (Woolfe, Dryden & Strawbridge, 2002, p. 638).

This quotation drew me to Counselling Psychology, and continues to underpin my approach to both clinical work and research. However, Counselling Psychologists are encouraged to use the scientist-practitioner model to approach our work (Lane & Corrie, 2006). This model assumes that the practitioner can apply psychological theory to practice and that the practitioner is able to reflect through the use of hypothesis testing and re-formulation of ideas (Blair, 2010). Whilst maintaining that theory underpins our work, I agree with the suggestion that Psychology needs to embrace its “*artistic and dialogic dimensions*” (Fillery -Travis & Lane, 2008 p. 177) over too narrow a focus on scientific principles.

In our clinical work we acknowledge that within the therapeutic relationship meaning is co-constructed through process and moderated by context (Lane & Corrie, 2006). Research should mirror the stance we take with our clients, in this way reflecting the division's practice guidelines:

[Counselling Psychology] *continues to develop models of practice and research which marry the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship...to engage with subjectivity and intersubjectivity, values and beliefs...to recognise social contexts and discrimination and to work always in ways that empower rather than control* (Division of Counselling Psychology Professional Practice Guidelines, 2005).

In response to the emphasis on creativity and to avoid too reductionist an approach to individual experience, it is necessary to consider which research methodology to apply. Furthermore, the literature review pointed to a need to hear women's voices, including their experiences of embodied subjectivity, to embrace and remain critical to context, ideology and discourse. In doing so, my research can also support Counselling Psychology in its social justice agenda (Goodman et al., 2004).

These concerns all call for a qualitative response to the research. According to Sciarra (1999) qualitative research assumes that the researcher and participant interact subject to subject, not subject to object, the relationship is one "*of intersubjectivity involving the values, emotions, perceptions and cultural contexts of both parties*" (p.39). Therefore there is no assumption of a bracketed researcher; rather knowledge is generated through an interpersonal

exchange. In this way the encounter mirrors that of the therapist and client; the 'expert-by-education' is removed and it is through interactional process that knowledge is generated; truths are constructed in the exchange rather than 'found' (Josselson, 1999).

2.2 Critical Psychology

Critical psychology was developed in response to concerns that the way in which psychology understood how we determined our view of the world was defined too much in terms of cognitive processes and of the individual (Billig, 2008). A critical perspective would argue that it is through our interaction with historical, social and political processes that we construct our subjectivity.

Critical psychology seeks to break disciplinary boundaries which have seen sociology, history and other social sciences at the forefront of societal analysis and positioned individual human behaviour, the domain of psychology, as outside of such exploration (Fox, Prilleltensky & Austin, 2009). A critical perspective would argue that an individual cannot be demarcated from social processes (Billig, 2008). Rose (1996) has argued that through practices of subjectification psychology reinforces an ideal which sees people aspire to become regulated, autonomous and freely choosing beings. In this way psychology individualises and pathologises societal problems, ignoring the role of systemic unjust practices.

It has been argued that psychology overemphasises scientific objectivity creating social constructs which often ignores common sense and ideological underpinnings (Mausharts, 2000, Phoenix & Woollett, 1995). By aligning itself with the 'scientific' model and attempting to be apolitical, psychology is argued to sustain oppressive practices through what Fox, Prilleltensky & Austin (2009) refer to as "*institutionalised allegiances*" (p. 5) that

unduly harm marginalised people by enabling inequality. Broadly, Critical and Counselling psychology critiques the principle of 'objectivity' suggesting it is neither neutral nor the best route to knowledge.

2.3 Who's voice? Expert by Experience vs. Expert-by-Education

A critique of 'objective' and scientific knowledge production is particularly pertinent for the study of breastfeeding due to the emphasis on medical and biological knowledge, outlined in the literature review. It is argued that the 'external,' as the authority for the promotion of breastfeeding, is the wrong approach for understanding the needs of breastfeeding mothers and suggests that listening to the 'intuitive' voice of mothers may provide better means by which to support breastfeeding (Williams, et al., 2012). This 'intuitive' voice can be found in many semi-autobiographical 'mothering manuals' (Baumslag & Michels, 1995; Heffner, 1980 and Mausharts, 2000) which highlight the gap between the individual experience and the broader promotional literature. Kinser (2010, p. 5) talks of the increasing use of the "*mamasphere*" which is the name she gives to the online community of mothers, bloggers and forum users, who are utilising their personal experience in an attempt to share knowledge and resist or reject the 'all knowing' position of the external experts.

The terms 'external' and 'intuitive' allude to the types of knowledge to which we have access and where authority in generating this knowledge lies. To accept uncritically these terms might reinforce the 'medical' and 'natural' mother discourses and silence women who do not ascribe to such narratives of motherhood. Therefore, it seems more appropriate to conceptualise voice in terms of expert positions and how and who might be positioned as expert. Borrowing from the mental health service user/survivor movement (Beresford,

2010, Dillon, 2011), I would like to draw attention to the critical perspective on who holds authority and power over experience.

Jacqui Dillon (2010) who describes herself as a writer, campaigner and voice hearer argues that experience and meaning making are central to understanding an individual and that we should privilege their unique position, holding them as the expert. Expert-by-experience movements reject traditional knowledge generated through objective research and promote the use of lived experience in research (Beresford, 2010). The “*mamasphere*” can be understood in these terms, women both in and out of the academic domain are using their expert-by-experience voice to narrate and share their maternal positions, also seen in the growth of ‘mothering manuals’ and the increase in auto-ethnographic studies (Amsterdam, 2014, Crossley, 2009). Here, it is evident that women are attempting to find new ways to distribute knowledge. Such knowledge has been argued to be a powerful tool in promoting the agency of women (Kinser, 2005). Emphasising the expert-by-experience voice, I am concerned with improving people’s lives as well as generating knowledge (Beresford, 2010).

To conclude this section I will borrow the words of Jacqui Dillon with whom I whole heartedly agree about who is expert and how we should hear them:

A key part of our role is to magnify the voices of the people who are normally not listened to, by emphasising the belief that each person has a deep wisdom and expertise (2011, p. 155).

2.4 Research Questions and Design

Having outlined my philosophical positions I will now explain how my research questions were formulated, and outline how these philosophical positions were realised in terms of the research design and analysis.

2.4.1 Constructing the Research Questions

Reviewing the literature raised many questions that could usefully be addressed in a qualitative study. Much of the recent research is being produced for and by medical professionals, often focusing on the promotion of breastfeeding which colludes with the prevailing 'medical' discourses (Larsen et al., 2008). Mothers' lived experience has been identified as important (Burns et al., 2009; Hegney, Fallon & O'Brien, 2008; Kelleher, 2006), yet notably absent has been the impact of a difficult breastfeeding experiences on a woman's views of herself as a mother and how these views are being constructed and shared. The research questions were designed to understand the meaning making processes involved in women's transitions to motherhood, remaining critical and alert to sociopolitical discourse. There were two main research questions:

- What can women's stories tell us about the influence of social processes on their meaning making/understanding of a difficult breastfeeding experience?
- What can women's stories of difficult breastfeeding experiences tell us about their understanding of their identity as a mother?

2.5 The Lived Body and the Inscribed Body: Ontological and Epistemological Position

Whilst a broadly narrative approach was taken to the research, the focus on embodied experiences outlined in the literature review required some reconsiderations of the traditional narrative method. Having outlined the position of the research and myself as a researcher, what follows is a discussion of the ontology, epistemology and methodology arrived at for this study.

2.5.1 Ontological Position

During the course of training I have become increasingly interested in the interconnectedness of the world and our place in it as people. I am intrigued by the invisible, meaningful world around us and how it can be articulated (Burkitt, 2003). For this reason I was struck by Maurice Merleau-Ponty's reflections on his interaction with a group of cypress trees. He describes looking at the trees reflected in the water and how in that moment the water, trees and himself shared an "*active and living essence*" all connected to each other through perceptual reality (1968, p. xlvi). It was from these reflections on our relationship to the world that I began to understand my ontological position.

Merleau-Ponty offers a radical departure from traditional Psychology which sees perception as a phenomenon primarily located within the individual, the brain or the mind (Billig, 2008). He argues that perception exists in the space between the person and the world (Sanz & Burkitt, 2001). In summarising the ontological position of Merleau-Ponty, Burkitt (2003) states that light can be shed on reality by the body a "*sensible-sentient*" which moves through the world perceiving of its "*depths and dimensions*" (p. 338). However, that reality is transformed and articulated through language, culture and history.

Here we can see the assertion that it is our body and our subjective experience of it which connects us to the world (Connolly, 2013). Our certainty of existence comes as a result of our bodies moving through that world. However, also evident is the view that all knowledge is constructed through language and transformed by context (Sanz & Burkitt, 2001). Social constructionism can here be seen to be a way to interrogate the world or “*read it like a text*” but it does not author reality (Burkitt, 2003, p. 320).

Whilst discourse theory has contributed greatly to our understanding of the body and its role in society it creates a dilemma when not wanting to adopt an ontology which sees discourse as everything (Tucker, 2010). Where Merleau-Ponty takes a significant move away from constructionism is in his concept of “*perceptual faith*” (Sanz & Burkitt, 2001, p. 330). Here he suggests a fundamental belief that all things exist and can be perceived through our embodied relationship with the world.

Discursive considerations of the generation of knowledge reinforce an artificial division between talk as ‘constructed’ and ‘materiality’ as simply given – meaningful only through what is said about it (Tucker, 2010). As I have stated in the literature review a purely linguistically orientated approach to understanding breastfeeding experiences runs the risk of reinforcing dualistic accounts of ‘mind’ and ‘body’ which has been critiqued as oppressive and reductionist (Burkitt, 1999; De Beauvoir, 1953; Gillies et al., 2005; Grosz, 1994; McNamara, 2011). Merleau-Ponty (1968) asserts that we can operate in the world guided by our “*perceptual faith*” however we come to question and doubt this faith through reflective thought. This turns on its head Cartesian principles that state it is our intellectual doubt of our senses which enables us to operate freely in the world. Burkitt (1998) argues that we cannot be reduced to either

mind or body but that the mind can reflect, wonder and explore a world brought into being by our animate bodies; prior to the “*I think*” there is an “*I can*” (p. 67).

2.6.2 Epistemological Position

In agreement with Crossley (1996) I am adopting the position that we do not need to choose between the lived body and the inscribed body as they are “*mutually informing*” (p. 99). I agree that people are “*hybrids*”, with bodies which belong to time and space but also identities constructed by values of a given culture (Burkitt, 1998, p. 78). Adopting theory drawn from the work of Merleau-Ponty and Michel Foucault allows an exploration of embodiment, power and subjectivity. Both identify the neglect of the body in traditional philosophy and oppose dominant Western conceptions of the body as a contained, physiological object. The tension of the two writers assertions which sees the body as both active (Merleau-Ponty) and acted upon (Foucault) is precisely the conflict I wish to highlight (Crossley, 1996). I would argue that it is this tension which leads to the negative feelings described by researchers in difficult breastfeeding experiences (Hegney, Fallon & O’Brien, 2008; Kelleher, 2006; Mausharts, 2000; Sloan et al., 2006).

The inscribed body exists in relation to context and its perceptual presence can be seen to be interpreted by language, therefore a narrative methodology was employed. However, in acknowledging that language can produce normative representations of feelings and experience I undertook a critical narrative approach, exploring discourse.

Narrative work is undertaken in a postmodern frame which assumes knowledge to be constructed rather than discovered (Wertz et al., 2011). For my research to achieve its aims of understanding how people narrate their subjective experience and the impact of discourse on their narratives and

embodied experience, I took the epistemological position described by Harper (2012) as a critical realist social constructionist, which assumes that both the detailed analysis of the qualitative data and the interpretation of context are important to arrive at the generation of knowledge. Furthermore, I am drawing on what Ponterotto (2005) calls the critical-ideological paradigm whereby research is explicitly influenced by the researcher's values and is driven by an emancipatory agenda. Finally, I am utilising embodiment theory and visual methods to explore the lived body and examine experience beyond language (Gillies et al., 2005).

2.6 Methodological Foundations: Combining Narratives and Embodiment

2.6.1 The narrative approach: Hearing women's stories of breastfeeding. Narrative Psychology is based on the premise that in everyday life people organise and interpret events by creating narratives (Esin, 2011; Murray & Sargeant, 2011). It assumes that humans are essentially interpretative beings, constantly reflecting on the world around us and engaging in language as a process of creating 'selves' (Crossley, 2000). Bruner (1990) emphasises the *meaning* of stories over their ability to directly reflect reality. Likewise, I hope to understand the way in which participants use narratives to represent their experience; not as a mirror to their experience but a re-telling, rich with interpretation and meaning making.

As well as allowing a better understanding of contextual issues Narrative Analysis can be used to explore a person's "*internalised and evolving sense of self*" (McAdams, 2012, p.16). In this regard it can be linked to therapy and the relationship between life story and personal transformation (McLean et al., 2007).

2.6.2 Embodiment. Bartlett (2001, p.380) describes the need to remake narrative through a sense of “*corporeal literacy*.” I believe that privileging language can remove people’s bodily experience and negate its relevance in exploring meaning and experience. As outlined in the literature review, the impact of this on breastfeeding research could be profound. Literature reviewed previously has indicated the ways in which women’s bodies change in response to breastfeeding (Gerhardt, 2004, Schulze & Carlisle, 2010). These physical responses happen without conscious control, the body is communicating to the mother and the child. This is not to suggest that these bodily experiences are without the mind but rather that they cannot be excluded from discussions of women’s experiences.

However, as argued in the literature review, the body is more than a machine of biological processes and is subjected to changing social relations (Bordo, 1997, Burkitt, 1999). The ‘practice’ of breastfeeding is argued to be continually constructed in response to discourses about women’s bodies, sexualities, medical understandings, economies and many more (Carter, 1995). The impact being that a woman’s body might become either excluded from her narrative or constructed by discourse whereby the ownership of her own bodily experience is stolen.

2.6.3 Visual methods. An interest in embodiment necessitates a consideration of more creative methods than verbal methods alone. In this study, visual methods were employed to stimulate stories beyond words, explore embodied experience and further the research aim to empower participants. The following section details how this was intended to be achieved.

Social sciences are often considered the “*discipline of words*” (Mead, 1995). However, researchers are becoming increasingly interested in the impact

of our visual experience with many arguing that the visual is central to “*cultural construction of social life in contemporary Western societies*” (Rose, 2007, p.2). Whilst I acknowledge that discourses prevail as much in image as language (Rose, 2007), bringing the verbal and visual accounts of an individual’s experience together allows for a more comprehensive understanding of the participant’s subjective experience (Reavey, 2012). An image is argued to disrupt the verbal and allow access to a more visceral response, thus increasing access to the embodied and emotional world of participants which might escape the spoken word (Ortega-Alcazar & Dyck, 2011, Reavey, 2012).

Qualitative research aims to make the participant the focus of meaning making and the active agent in the research; pre-selecting images further empowers the participants by removing the researcher from these initial processes (Reavey, 2011). Furthermore, despite having an interview schedule the intention was that the images would enable the participants to narrate freely, limiting inhibition and biasing (Ortega-Alcazar & Dyck, 2011).

In the previous sections I have outlined the methodology I employed in this research. I have described how narrative psychology has been used to meet the aims of generating knowledge by hearing the voices of experts-by-experience, in this instance mothers’, whilst also allowing consideration of constructions of identity through social and political discourse. Furthermore, I have explained my commitment to explore embodied experience and described how visual methods were introduced to enhance both empowerment of participants and the depth of data collected. In the rest of the chapter I shall describe in more detail the research procedures and analysis.

2.7 Method

2.7.1 Sample. The inclusion criteria were first time mothers, aged between 25 and 35, who described themselves as having had a difficult experience of breastfeeding. I left the interpretation of 'difficult experience' open to the participants so as not to assume or narrow participant's narrative. Furthermore, the assumption that first time mothers have no comparable experience was of importance as the initial transition to motherhood has been seen in the literature to propel women into a sphere of unknown discourses and experiences, yet to be assumed into identity (Rich, 1995). Therefore, limiting the sample allowed access to less processed narratives which was expected to provide richer data.

2.7.2 Participants. Data was collected from seven women, one a woman I knew personally who asked to take part; the other six were all recruited via the internet. I checked the administrator rules of potential sites carefully, either through emailing or reading the rules stated on the websites. These rules are various, and some count research as 'media advertising' whilst others do not. The final advert was placed on the membership boards of 'Netmums', in an allocated area for research requests. This satisfied the administrator rules of the site. Respondents were provided with a comprehensive letter explaining the nature of the study and the expectations of involvement (see Appendices 3 and 4). Full demographics of the participants recruited can be seen in table 1 below.

Participant	Ethnicity	Age	Age of child at interview	Difficulty reported
Alessandra	White British/Sicilian	29	6 months	Pain during feeds, engorged breasts and mastitis
Sarah	White British	25	18 months	Pain during latching, reflux, tongue tie
Bethan	White British	30	2 years	Exhaustion, isolation
Hannah	White British	34	1 year	Pain during feeds
Esther	White British	31	1 year	Milk supply, own and babies ill health
Maria	White British/Eastern European/Italian	31	1 year	Painful, cracked nipples
Rachel	White British	32	13 months	Pain during feeds, mastitis, tongue tie

Table 1: Demographics of participants

The participants recruited were distinctive in their specific experiences but shared cultures, including ethnicity, immersion in the context of British medicine and their location within ‘medical’ discourses as women who had experiences of breastfeeding.

2.7.3 Procedure summary. During the process of data collection a number of procedural issues arose. The first came in my working title and conceptualisation of the participants’ breastfeeding experiences which I first described as ‘negative’ but later changed to ‘difficult’ to avoid pathologising the women’s experiences (Henwood, 1998). Newnes (2011) explains how difficult it can be to stand outside the medical model, for example he describes the everyday use of medical terminology in colloquial language such as ‘anxious’ rather than alternative terms such as ‘frightened’ or ‘ill-at ease’. Reminding me I needed to remain vigilant to my relationship to the medical model.

The initial response to online advertisements was very powerful with 10 requests to partake within 30 minutes and several women sending me personal stories in written form, which were not included in the analysis due to

lack of consent. I was struck by how many women wanted to share their stories, how readily some disclosed intimate details to a stranger and what this may indicate. Following the initial messages many women then decided not to take part and whilst there are a number of possibilities for this one seemed to be Kinser's (2010) "*mamasphere*" had perhaps created a space that offers safety through anonymity. Joinson (2001) discusses high levels of self-disclosure which characterises computer mediated communication. The medium created in cyberspace can result in relationships where people reveal more intimate details than they would without the protection of a screen and pseudonym (Reingold, 1993).

An ethical consideration which was particularly pertinent during data collection and analysis is that of my position of mother-researcher. I am aware that I cannot deny the 'mother' as I undertake this research. I felt silenced in my initial weeks of breastfeeding and this research is motivated by the desire to hear the voices of women with whom I unapologetically identify. However, I was careful not to reinforce silencing by allowing my 'mother' position to overtake my 'researcher' position. A critical-ideological paradigm allows me to strike this balance as it views the researcher as active and permits that they be explicit about their role in the production of knowledge (Ponterotto, 2005, Silver, 2013).

2.7.4 Data collection. Data in the form of transcribed interviews and pre-selected images were collected. In this study pre-selected images were used to elicit stories of breastfeeding. Eliciting narratives is often done through using one open ended question (Frank, 2010). However, as stated I am interested in exploring how using self-selected visual aids may serve to both elicit and construct the mother's account. Photo elicitation is a non-directive method which involves the use of image as the basis of an in depth interview, allowing

for collaboration between researcher and respondent (Lapenta, 2011, Ortega-Alcazar & Dyck, 2011).

During recruitment women were told that part of the study would involve the process of pre-selecting images described as ‘saying something about your experience of breastfeeding.’ They were asked to bring up to 6 images to the interview. The first phase of the interview involved using a single narrative-inducing question to elicit the narrative accompanying the pre-selected images: ‘Can you tell me about your images?’ Following this prompts were used drawn from the semi-structured interview schedule² developed prior to interview (see Appendix 6).

Finally, I kept a reflective journal throughout the process of data collection. The journal acknowledges my commitment to reflective practice, a guiding principle of Counselling Psychology. Reflective practice allows practitioners to reflect on their own process of meaning making (Bager-Charleson, 2013) and for me as a researcher and practitioner to accept that I am not a detached expert but rather as Finlay and Gough (2003) state: “*a central figure who actively constructs the collection, selection and interpretation of data*” (p. 5).

In the following section I will outline the process of analysis describing the analytic steps before leading into the analysis and discussion in chapters 3 and 4.

²A semi structured interview schedule was developed to find what Bute & Jensen (2011) describe as meeting in the middle between research objectives and women’s experiences. Prompts were designed to embrace and encourage narratives for example asking for memories of a particular incident of an experience being described, to elicit further detail and encourage exploration of specific emerging themes.

2.8 Critical Narrative Analysis

Analysis was approached with the aim to seek informative and actionable answers to research questions rather than strict adherence to a specific methodology (O'Shaughnessy, Dallos & Gough, 2013). The aim was to investigate how individual responses may combine with social processes to impact on narratives (Esin, 2011).

Whilst I did not use the precise method described by Emerson and Frosh (2004) I drew on their description of critical narrative analysis in order to maintain a dual focus on both the participants' discursive techniques and on the personal and social accountability for the use of these techniques. Maintaining a dual focus allows for exploration of both the individual meaning of difficult breastfeeding experiences and also of the societal pressures identified in the literature review (Baumslag & Michels, 1991; Heffner, 1980; Quandt, 1995). Furthermore, importantly to this study, the body can be acknowledged within a critical narrative analysis. Shilling (1993) states "*the body has become a primary resource for the construction and consolidation of identity – a vehicle for displaying conformity or non-conformity to social norms*" (p.23). Here it can be seen that narratives of embodiment might illustrate how the body as a 'vehicle' is influenced by discourse and social norms as language is. The researcher is responsible for theorising and selecting areas of interest but must also avoid the narrator losing control of their own words (Emerson & Frosh, 2004). Taking a critical approach involves assuming the ideological nature of knowledge; interpretation is therefore seen as bound with power and social practices (Emerson & Frosh, 2004, Squire, 1998). Moreover, a critical approach allows analysis to create a movement to social action and in this regard acknowledges

the future of Counselling Psychology as a place for social change (Emerson & Frosh, 2004; Kegan, Tindall & Robinson, 2009; Squire, 1998).

Emerson & Frosh (2004) use the case study of a young man who has sexually abused others to illustrate their approach. They challenge dominant formulations of sexually abusing boys which typically individualise and pathologise them and subordinate their own attempts at meaning making. Their analysis emphasises that listening is never straightforward but that curiosity, commitment to privileging subjective meaning making and interrogating dominant social discourses is paramount to a critical approach. The analysis is discursively informed and particular attention is paid to how subject positions are taken up and subverted. In my own analysis I applied these principles.

2.8.1 Analytic steps. The transcripts were read a number of times in order to familiarise myself with the texts and with an interest in the overall tone and delivery of the women's stories. I tried to listen to their distinctive voice and understand the way in which they had positioned themselves within their stories (Goodbury & Burns, 2011). This general reading allowed for global impressions of their register and style as well as identification of specific features such as metaphor and affect (Keats, 2009). I reflected on the "*empathic space*" created as I read the data with the aim of learning more of the participants' world (Sciarra, 1999, p. 42). As I read I marked passages significant to the identity of the participant as a mother, paying particular attention to self-experience (Josselson, 2011).

The narratives being elicited from images and semi structured interviews meant that the first reading also involved identifying a narrative framework. Keeping the text whole is suggested to be important in capturing a

holistic narrative and avoiding fragmented analysis (Bute & Jensen, 2011).

Borrowing from O'Shaughnessy, Dallos & Gough's (2013) adaptation of Labov and Waletzky's (1967) analytic structure, the transcripts were summarised using the following subheadings:

- i) Abstract
- ii) Orientation
- iii) Complicating action
- iv) Evaluation
- v) Resolution
- vi) Coda
- vii) Tone of the interview

These frameworks can be found in Appendix 8. Next, in keeping with my aims to highlight the socio-political constructs in which women's experiences can be bound (Fox, Prilleltensky & Austin, 2009, Grosz, 1994), I moved to identifying discourses used in the participants' stories, specifically identifying use of the 'medical' or 'natural' mother discourse (De Beauvoir, 1953; Carter, 1995; Ussher, 2006). Analysis was done in conversation with the theoretical literature to offer critique and extend and deepen existing concepts (Josselson, 2011).

In the first reading I was acutely aware of the 'medical' discourse employed by all the participants. My reflexive journal makes note of this.

Following the first interview I wrote:

As the participant begins to talk I am aware of a dull ache in my left breast, where I had mastitis. I see the image of the cracked nipples and I wince remembering the pain. I feel shocked that she has shown

me such a graphic image first. She talks of the equipment she used to assist with feeding and alleviate pain and I feel angry about the medical discourse her words and emotional experience seem trapped in. I begin to find it hard to connect to the participant as I lose her in a series of stories about midwives, health visitors and lactation consultants. Searching for the mother I spontaneously ask, "What would your breasts say about your experience?"

My feelings of frustration and inadequacy at not being able to capture the subjective experience are evident and were also present during my initial readings of the data. Interpreting this as saying something about the participants' struggles to narrate their subjective experiences I re-read the transcripts attempting to locate the participants positions within the 'medical' discourse. This led to my reading of narratives of 'natural mothering,' bonding and attachment parenting. Some of the women called on this discourse as a site of resistance to the 'medical' discourse. However, expressions of loss, guilt and failure persisted.

Reading the data again and endeavoring to understand the participants subjective experiences I completed a thematic cross sectional analysis of all the interviews (Bute & Jensen, 2011). I grouped the narratives into themes initially called narratives of:

- Pain
- Identity – past, present and future
- Expectation vs. reality
- Disempowerment and silencing
- Connection and disconnection in relationship to self and others

All of these themes related to an overarching experience of loss. I became interested in the expression of this loss and the participants adoption of the 'medical' and 'natural' mother discourses. It seemed that the body as a site of lived experience, meaning making and interpretation offered an opportunity to explore the narrative themes. Therefore, I revisited embodiment theory to inform my final stages of analysis and write up.

In exploring embodiment it became apparent that the women were using their bodies in an attempt to regain control which seemed to have been lost as the act of breastfeeding became difficult. The women's descriptions of isolation, feelings of guilt and failure seemed to be mediated and conversely reinforced through the regulation of their bodies (Blood, 2005; Bordo, 2003).

Finally, a visual reading was completed looking both at content and at narratives elicited (Banks, 2000, Keats, 2009). The images were examined to determine their use as a narrative in their own right, as a pictorial representation of their verbal accounts, or as a sight of resistance to their verbal accounts (Rose, 2007).

What follows in the analysis chapter is a critical examination of the discourses drawn on by the participants to narrate their experiences with an exploration of the themes of disembodiment and disempowerment. Following on from this, in the discussion chapter I shall reflect on the undertaking of this research and how the body came to reveal much about the women's psychological distress. Finally, I discuss the clinical implications of findings for Counselling Psychology.

Analysis: 'My Body, My Baby, My Birth': Mother's Search for Meaning within Oppressive, Disembodied discourse

Following a theoretical scene setting, the first part of analysis explores the discourses established in the literature review as most prominent in the experiences of mothers, namely the 'medical' and the 'natural' mother discourses. I examine how these discourses appeared and functioned in the participant's narratives. Next, I explore a cross sectional narrative analysis, with particular attention paid to how the participants narrate their embodied experience.

3.1 Setting the Scene: Theoretically

It is argued that the everyday world is constructed and transformed through language, built upon socially constructed dualisms i.e. man/woman, body/mind (Kinser, 2010, Sampson, 1998). Furthermore, that power is exercised by the process through which any discourse positions its subjects (Crowley & Himmelweit, 1994). I will argue that discourses drawn on in the narratives of participants result in their disempowerment. Through the examination of the 'medical' and the 'natural' mother discourses I examine the loss of control and resulting feelings of failure and guilt experienced by the participants, here argued to be the result of idealised expectations of mothering reinforced by the socio-political and cultural expectations.

Malone (1998) argues that the body is a representation of the interface between women and their constructions of subjectivity. I acknowledge that the body is not an unmarked autonomous object and that language becomes a medium through which the body is positioned (Cohen & Weiss, 2003; Grosz, 1994; McPherron & Ramanathan, 2011). However, I do not want

to take what Sampson (1998) describes as a “*verbocentric*” approach to interpreting women’s experience (p. 23).

The rational and intellectual qualities ascribed to subjectivity are argued to be those associated with the mind; subsequently it is argued women’s experiences of the body become alienated leading to oppression (Bartlett, 2002; Bordo, 2003; Malone, 1998, Young, 1990). In the analysis I explore how the participants respond to and understand their bodily experiences. I argue that participants survey and control their body’s function in an attempt to conform to socially constructed norms (Bordo, 1997).

3.1.1 Discourse Analysis: Exploring Narratives of Disempowerment

Blum (1999) has described the ‘medical’ and ‘natural’ mother discourses in terms of the medical and maternalist models. The medical model treats women as disembodied producers of milk, the benefit of which is heavily promoted in health terms. This model sees the external expert as the authority on breastfeeding (Ussher, 2006). The maternalist model celebrates motherhood, assumes breastfeeding as contributing to bonding and attachment processes and reinforces ideas of “*exclusive mothering*” (Carter, 1995, p. 3). In the following section I have examined individual narratives which exemplify the ways in which these discourses were interpolated into women’s experiences and stories.

3.2 Disempowerment and the ‘Medical Mother’: Losing the Self in the Medical Discourse

The following narratives examine how the medical model utilises a disembodied voice to ‘teach’ mothers how to maintain bodily functioning and the ways in which the participants accept and reject this voice. It is here argued that

where the lived body does not meet societal expectations the participants inscribe the body with medical discourse to make sense of their lived experience (Burkitt, 2003, Merleau-Ponty, 1968).

3.2.1 Mother's tuition takes over intuition. Participants described their expectations of breastfeeding as constructed through a number of external factors – the media, politics, professionals and cultural and family backgrounds (Miller, 2005). Indeed Williams et al., (2012) identify the power of childcare texts as an external authority on creating subject positions and the limitations this creates. These expectations create an imagined narrative, however, limited availability and acceptability of discourses describing a difficult experience result in women struggling to make sense of the reality they are faced with (Hegney, Fallon & O'Brien, 2008; Hoddinott, et al., 2012; Larsen et al., 2008).

Diprose (1994) argues that the medical discourse is mediated by a political incentive for the body to be healthy and productive, seen in images shared by participants. Bethan describes her frustration with such images saying: *"it's not that I felt pressured to conform to that image but more like what a load of bollocks!"* (l. 28-29).



Bethan talks of the expectation of breastfeeding as presented in NHS literature, seen in the image adjacent³. The image suggests a step by step process, one in which the mother is passive and the baby makes instinctive actions towards the breast. The mother is absent in the image, merely represented by the breast. Such images reinforce the participant's positions as disembodied feeders and breastfeeding as a functional act. She says: "*Being bombarded with 'how to, how to, this is what you need to do, if you do this then it will be fine'*" (l. 178-179).

Bethan explains that if her body conforms "*it will be fine*". The use of the word "*do*" indicates the supposed 'serviceability' of the body and ignores the body as 'being' in any subjective sense (Ussher, 2006, Young, 1990). Bethan is not alone in feeling bombarded by advice, as seen in this image from Rachel:



This image⁴ illustrates Rachel's confusion, it evokes feelings of uncertainty about which path to follow, the search for external guidance at a transitional point on a journey. She says:

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⁴ Image reproduced for educational purposes in accordance with the fair dealing exception to copyright law

...that's all the different conflicting in... you know, info from all the different sources... [I: Yeah.]...and family members, friends err, NHS, that just... so the whole thing as a new mum, because there isn't a consistent line at all, for anybody really (l. 921-925).

Rachel is looking for a “*consistent line*” indicating her need to be provided with a narrative to follow, one which will guide and make sense of her experience.

Both Rachel and Bethan speak of the abundance of changing ideas and cultural expectations within breastfeeding literature (Hoddinott, et al., 2012, Williams et al., 2012). The resulting confusion and frustration described by the participants highlights what Bartlett (2002) describes as the distancing of women from the generation of knowledge on breastfeeding and how women's forced positions of passivity results in undue distress (Ussher, 2006).

3.2.2 Infiltrating the medical establishment from the inside. In Sarah's narrative we hear the ways in which she responds to the lack of autonomy offered by the expert-by-education discourse. Sarah expresses particular frustration with the medical establishment as she feels unheard and 'out of control' in her labour and breastfeeding experiences, leading to a powerful assertion of ownership of her body, as: “*my body, my baby, my birth*” (l. 273 - 274).

This mantra is utilised to resist disempowerment during her labour and later breastfeeding difficulties. She describes how she felt ignored and out of control. Sarah's narrative begins with the process which led her to giving birth in hospital, describing how once in a medical setting she feels an immediate sense of disempowerment, a 'control shift': “*I felt like I wasn't consulted about*

any of it, it was all made up and obviously it was that real control shift" (l. 69 - 70). Later in the narrative she continues:

My labour had like stopped pretty much so then of course the decision was made that they were going to induce me [l: mmm] like no consultation, no option, it's happening so I was like OK I said "if you are giving me the centocinon drip then I want an epidural" [l: mmm] because I am not stupid, like I am not stupid, I wanted to do this one way but I know a lot about this stuff and I am not an idiot I said I know what this is going to be like, so if you are giving me that, [l: mmm] I want the epidural (l. 83 - 90).

The opening of the second quote sees Sarah's body stop 'functioning' and at this point power shifts towards medical intervention. The word "*decision*" indicates no person or relationship, rather a disembodied expert; the rational voice of the medical model takes control (Carter, 1995, Ussher, 2006). Sarah's desperate attempts to regain control over her birth and her body are evident in the demonstration of her medical knowledge. Sarah's insistence at not being "*stupid*" exposes her feelings of helplessness and her narrative reveals how she begins to feel disempowered as interventions are decided upon without any regard for her bodily integrity: "*no consultation.*" Here the invocation of the medical model reinforces a Cartesian dualism - the rational mind is employed to work on the body (Blood, 2005; Bordo, 2003; Gear, 2001). Women become reduced to their bodily functions, here leaving Sarah feeling disregarded, patronised and controlled.

However, it seems there are few positions available for her to resist this control and she chooses to immerse herself within the very discourse which

also serves to disempower her. This can be seen as a strategy of infiltration from the inside, she says: “if you are giving me the centocinon drip then I want an epidural”. Adopting the terminology of the medical establishment Sarah reinforces the medical discourse (Carter, 1995, Miller, 2005); here and as her narrative continues Sarah demonstrates that women are not merely oppressed and passive victims but take up positions that reinforce power structures (Blood, 2005, Bordo, 1997). Tracing Sarah’s narrative it can be seen how she draws on the ‘medical’ discourse and voice of the expert-by-education to make sense of her baby’s experience:



The image adjacent⁵ shows the birth injuries her daughter sustained. Immediately, her baby is positioned as the ‘victim’ of the medical establishment.

Later we hear a story of disempowerment in which Sarah’s physical condition means she cannot dress her daughter:

I went into hospital all prepared I had all sorts of things in the bag like everyone always does [I: mmm] so I had like, what I wanted to put on her as like her first thing, I couldn’t actually and I ended up feeling really upset that she ended up wearing like a little vest which was actually like a second hand vest that someone had given me and I was really like gutted [I: mmm] about that because she had these really like amazing cute new clothes [I: mmm]...the first

⁵Please note all personal images are reproduced with direct consent from participants. See Appendix 5

thing that she ever wore was, I don't even know where it came from so that was annoying (l. 228 - 237).

Her daughter can now be seen to have birth injuries and is wearing a second hand outfit. Slowly, her baby's body is becoming controlled by the medical establishment. Sarah's subjective experience is of feeling "*gutted*" a word associated with the removal of innards. Having just had her baby removed from this part of her body also, it seems she is left feeling empty and bereft. As she is disempowered during her birth, so to her early experiences of motherhood are being controlled, here encapsulated in the object of the vest which she did not chose. Sarah had carefully choreographed the beginnings of motherhood, a home birth and "*amazing cute new clothes*"; this was disrupted by intervention - first medical in terms of the birth and then here in a social/relational intervention by the midwife.

Recounting these experiences at the beginning of her narrative can also be seen to establish a sense of distance between Sarah and her daughter. This disconnection and disempowerment continues as her breastfeeding difficulties begin. Sarah talks of unexplained pain in her nipples during feeds, attributed to tongue tie, and her daughter's reflux that results in distressing behaviours. She says of her daughter's vomiting: "*I just absolutely knew that wasn't normal for it to be that severe...she didn't stop screaming ever*" (l. 563-566). In her narrative Sarah conveyed confusion at her daughter's unexpected behaviour.



Sarah used this image to illustrate her daughter as different to other babies. Sarah's daughter is in the bottom right hand corner of the image. Her face is red and scrunched.

Sarah explains she is in pain and crying as she often did. The original image sees the other babies sleeping or with calm and content expressions. As with Sarah's narratives of birth, the reality is a far cry from the carefully planned beginnings of motherhood she had expected.

Sarah describes how she seeks a diagnosis for her daughter's behaviours. As in her labour stories Sarah utilises the external disembodied voice of the medical establishment in a search for reassurance, so much so that she explains she was mistaken for a medical professional:

She thought I was medical because I was talking so much, I said oh could it be this, could it be this and she said 'oh are you medical? Do you work in the hospital?' (l.739-742).

At eight weeks Sarah suspects her daughter has a milk allergy, when she gives her some formula and she becomes very ill; a diagnosis of reflux follows. Diagnosis provides an explanation for the unsettling behaviours her baby displays: the "exorcist vomiting", (l. 686) "like green poo, green vomit", (l. 696) discomfort and continuous crying. In this way Sarah can position her baby as a patient to be taken care of: "Instead of disliking her or hating her or wanting

her to go away I just wanted to make her feel better" (l. 706 – 707). This can be seen to enable Sarah to discharge her negative feelings in turn protecting her relationship with her daughter and her position as a 'good' mother. Once again we are reminded of Foucault's (1977) suggestions that individuals are not the passive receptors of oppression but actors in it; in standing alongside the medical establishment Sarah is seeking agency within the confines of an oppressive system. However, as her story continues this can be seen to limit her experience of mothering (Blood, 2005; Bordo, 2003; Diprose, 1994); as disappointment permeates Sarah's narrative, she states:

I felt like I wasn't able to enjoy the first part of her life like other people have [l: mmm] and even if that's stupid stuff like sitting in a café or sitting in the park together, I suppose it's like a kind of romance really, I suppose it's like the honeymoon period...emotionally we didn't have that you know (l.1209 -1212).

Sarah expresses sadness and regret; she was not able to fulfil her expectation of emotional closeness, here aligned to a new romance (Ussher, 2006). Despite her 'infiltration' Sarah seems left with a sense of loss, likewise in the following narrative we see how Alessandra loses her breasts, as they become objectified and disconnected during difficult feeding. This could be seen as a metaphor for a loss of self she experienced also (Palmeret al., 2012).

3.2.3 Breasts fall 'victim' to the medical discourse



Alessandra begins her narrative with the image adjacent⁶. Though not her breasts they are none the less exposing and represent her vulnerability – seen in her tearful engagement with the interview. The use of the cracked nipples image first, suggests the need to shock and

reveal an unsanitary view of the body. The stories elicited were full of emotion and the image seemed a way of ensuring I was immediately understanding of Alessandra's experience and her ultimate decision to bottle feed. The two other images of engorged breasts elicited stories of diagnosis and cures. The intimacies of these images get lost in more representational or metaphorical pictures that follow. Alessandra's accompanying narratives see her position herself in the medical discourse; she takes me through the process from protecting her damaged nipples, using: "*nipple shields so he wouldn't have any direct contact with the nipple*" (l. 199 – 200), to expressing milk: "*I was only sort of getting 10/15 ml...in half an hour she was saying I'd be getting double what I was getting from the breast*" (l. 230- 234). Later Alessandra explains that she sought advice from her GP as her breasts become increasingly engorged, she says: "*The GP had actually told me I had caused damage to the breast tissue...so she said to me "stop, just stop"*" (l. 271-276).

In these quotations we see the disembodied voice of the external expert as we did in Sarah's stories and the disconnected breast, described in

⁶Permission to reproduce these images has been granted by St Johns Medical and Dr Mazumdar, Gynecology online (See Appendix 8)

terms of milk production and the objectified nipple. Both Sarah and Alessandra use a medical discourse to explicate disappointing and unexpected experiences of motherhood. On losing their subject positions within the 'natural' mother discourse they turn to the medical discourse (Carter, 1995). Using the weight of the objective and rational truths generated by scientific knowledge they are able to maintain their positions as 'good' mothers (Ussher, 2006). However, attempts to maintain this status was seen here and in other narratives to leave the participants feeling dehumanised and dejected.

3.2.4 Dehumanising consequences of the medical model. In adopting positions within the medical discourse it is argued that experience can be pathologised (Carter, 1995). In her examination of chronic illness narratives Hanako Okado (2011) warns of the dehumanising outcomes of a reductionist approach to interpreting 'illness' narratives. One outcome sees health professionals as 'givers' and patients as 'listeners,' as illustrated in the early feeding experiences described by Esther:



This stark image⁷ is a feeding cup used to give formula to Esther's son shortly after birth. The story elicited is of insecurity and loneliness. She describes:

⁷Permission to reproduce these images has been granted by Medela. See Appendix 8

But one of the nights the midwife didn't let me... erm, do it. She said she had to, erm...she wouldn't let me have a go and she didn't talk to me. I was very lonely and I was like...in hospital, I felt abandoned when my Mum left. So, I had Luke at 16 minutes past 10 at night. I got taken up and like erm...and I just felt like a child almost with a child. I felt really abandoned on my own... and I was actually in hospital for erm, six...six days or six, seven...yeah six days and on that particular night I'm lonely and I wanted to talk...she wouldn't even talk to me and then it's my baby she's feeding (l. 38 – 51).

Esther describes her disempowerment and subsequent regression at this vulnerable time. She feels abandoned, a child with a child and no mother. It seems Esther's vulnerability is reinforced by the staff's engagement in medical practices, divorcing the activity of feeding from the relationship of mother and baby. This narrative illustrates the transfer of breastfeeding knowledge and skill from the embodied subject to the medical professional (Bartlett, 2002). Esther's story is disjointed - the pervasive sadness and confusion is present throughout the interview.

A further outcome of medically mediated interactions suggested by Okado (2011) sees all responsibility lie with the patient, leading to emotions such as shame and guilt: *"Yeah, and I felt like I was tryin' to be really good and to get out and I felt subservient, almost"* (l. 393 -384). Esther describes feeling she must play by the rules of the hospital to go home. She recalls the midwives were keen for her to do *"this many wees"* (l. 158) before she left. Her disempowerment is evident as her body is subjected to the same surveillance as a potty training child (Ussher, 2006).

For Hannah when her 'idealised' body is not conforming according to the medical model we can see her becoming self-critical:

...just, just rubbish. There was just one job that I needed to do and I couldn't and his needs weren't really being met and it was all becau... it was all my fault it felt like, it was all because I couldn't do the thing that I was meant to do (l. 325 -328).

Hannah's identity and worth seems bound to her body's ability to conform to medical expectations (Carter, 1995, Van Estrick, 1989), it can be seen to be increasingly difficult to distinguish a sense-of-self as distinct from the body's performance. Bethan's narrative further illustrates this as she describes a lack of validation and the accompanying isolation: "*I wanted a bit more fuss for me; it's not this beautiful, wonderful thing*" (l. 67-68). And: "*I suppose no one really knew that much of what it felt like [l: mmm] and I was pretty isolated*" (l. 114-115). In these accounts participants' subjective and embodied experiences are given little acknowledgement or legitimacy and this in turn leads to distress and physical isolation (Okado, 2011).

Analysis of medical discourse has highlighted the ways in which women attempt to narrate their experiences according to the voice of the expert-by-education, leaving them feeling safe within the confines of this oppressive discourse, but disappointed at the rejection of the idealised expectation of motherhood (Malson & Swann, 2003; Ussher, 2006; Young, 1990). Alternatively, the participants describe the isolation and dehumanisation resulting from being unable to conform to expectations.

Participants also drew from an alternative discourse in narrating their experiences. The following section explores how they attempted to make sense of their subjective experience according to the 'natural' mother discourse.

3.3 Becoming Subordinated and Hidden in the 'Natural' Mother Discourse

As outlined in the literature review, breastfeeding is intertwined with the 'natural' mother discourse and has become a moral imperative for women (Blum, 1999; Ryan, Bissel & Alexander, 2010; Wall, 2001). When breastfeeding does not happen as expected, this assumed morality is argued to leave women at greater risk of feelings of failure and guilt and a lessened sense of self (Ryan, Todres & Alexander, 2011; Williams et al., 2012). In the following narratives the participants can be seen to subjugate their needs in attempts to establish a position as an idealised 'good' mother within this discourse. Furthermore, they can be seen to retreat into the private realm to do so becoming trapped and unable to maintain their previous 'public' identities. It seems these experiences leave the participants with feelings of frustration and anxiety.

3.3.1 Subjugating needs to achieve moral expectations. In describing how totally and willingly they would assume their identities as mothers, the participants begin to position themselves within a discourse which assumes the subordination of their needs to those of their babies (Woollett & Marshall, 2000). Hannah says of breastfeeding:

*I thought that it was one of the most important aspects of mothering.
That it would be really bonding, and a really kind of loving, special*

thing...and it would be really important for you to sort of do that for as long as they wanted you to (l. 21-25).

Hannah's narrative highlights the deep-rooted ideologies of bonding associated with breastfeeding and the assumption that women as mothers will be gratified in their roles through the fulfilment of their children's needs (Brown et al., 1994; Eyer, 1992; Jackson & Mannix, 2004; Ussher, 2006). There appears no expectation of reciprocity in the relationship as Hannah's needs are absent in this description. Likewise Rachel describes her own expectation of subjugation, she says:

I see myself, at the time, as doing the absolute best for my baby, which I was convinced was what the role as a Mum should be...By my providing for her every need and to...to be the best for her...I always kept thinking, you know, she didn't chose to have me, I chose to have her (l. 494-499).

In her opening statement "*I see myself,*" it seems that Rachel's identity is becoming fused with that of the 'natural' mother. As suggested by Ryan, Bissel and Alexander's (2010) the implication is that this vital role was part of the moral decision making, for Rachel even prior to conceiving: "*I chose to have her*".

3.3.2 'Deviations' from the natural discourse



Bethan shares this advertisement⁸, which evokes the 'natural' discourse through use of metaphor and reference to breastfeeding as a 'bonding moment.' This elicits a story about her reality of feeding she says:

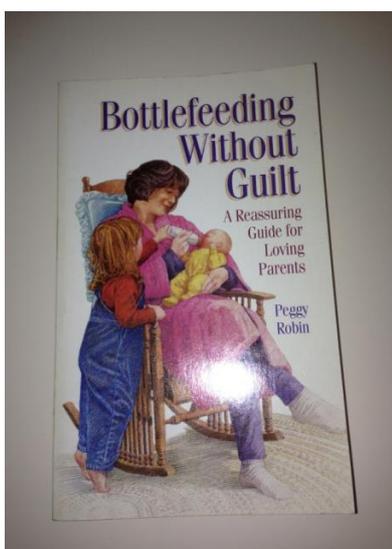
I find these pictures of this woman you know, really comfy with a beautiful pillow that's sparkling clean and this baby that frankly looks like it could be sucking her collar bone (laughing) just ridiculous...not like, it's just not like that and you're...you have this grubby pillow that you traipse round with everywhere...because you daren't wash it cause it's the only way you can get them in the right position (l. 18-25).

In this quote we see how images of the doting mother, in clean, bright and sanitised environments differ from the "grubby" reality. Whereas in the medical model the body is aligned to productivity, the 'natural' mother is aligned to idealised, sanitised femininity, firmly removed from the body's secretions, expulsions and excesses (De Beauvoir, 1953; Braidotti, 1997; Bobel, 2001; Gear, 2001; Roberts & Waters, 2004).

It seems feelings of guilt can follow a digression from this idealised view. In an interaction between myself and Alessandra she gave me a copy of a

⁸Permission to reproduce this image has been granted by Artsana S.p.A. See Appendix 8

book entitled 'Bottle feeding without guilt.' Perhaps in telling me her story she hoped she could externalise and pass on her feelings of guilt. In much the same way she later talks of her desire for a "boob job" (l. 532) one day, disconnecting her difficult experiences from her future identity. It has been argued that the Western cultural assumption that 'good mothering' is a result of the subordination of the mother's needs and compliance to certain standards of cleanliness and purity can result in resentment towards feeding and the baby (Kelleher, 2006, Woollett & Marshall, 2000). The articulation of these negative feelings becomes synonymous with 'bad mothering' and as a result it seems Alessandra tries to separate her bodily performance from that of her mothering (Malson & Swann, 2003; Woollett & Marshall, 2000). She says: "*I felt like I wasn't a Mum basically*" (l. 172).



The front cover of the book presents an image⁹ of motherhood which conforms to the 'good' mother. The guide is for 'reassurance' to a loving mother, implying that love and bottle feeding might not be synonymous and needs reinforcement through this book. The mother in her dressing gown presents the embodied image of a patient, a pillow supporting her fragile post-natal body (Ussher, 2006). Yet she looks serene, her children are well dressed and calm, she is fulfilling her role as nurturer despite her use of a bottle.

Esther also struggles with her deviation from the 'natural' mother discourse through her use of the breast pump:

⁹Image reproduced for educational purposes in accordance with the fair dealing exception to copyright law

I remember...when I came home and I was only usin' the breast pump, that when the rhythm... cause it made [broom broom noises] I think. I used to, let's say, like that the mu... that the rhythm was saying, like, "Bad mum, bad mum..." (l. 605-609).

Esther personifies the pump as her judge, berating her as she tries to do the best by her baby; this guilt and self-criticism permeates her interview.

These images and discourses employ rhetoric relating to the 'natural' mother, supposed to represent a positive, non-medicalised image and yet once again the participants find their bodies positioned as non-conforming and failing (Blood, 2005; Bordo, 2003). It is evident that within this discourse women have little space to win. They are alienated from their bodies by medical discourse and left to accept a discourse which sees reproduction as irrevocably feminine (Ussher, 2006). Their subjective experiences are denied in the process of subordinating their needs, their bodies are aligned to impossible idealised standards and negative feelings elicited are denied through fear of being attributed to their own shortcomings (Jackson & Mannix, 2004; Wall, 2001).

3.3.3 The private domain – the natural habitat of the 'good' mother. Expectations of the 'natural' mother are also related to the private realm which sees the feminine, maternal identity as bound to the home (Banks, 1990). Bordo (2003) sarcastically writes of the "*cosy, plant filled haven of babies...skilfully managed and lovingly tended by women*" (p. 42). Positioning women back in the home serves to reinforce the privatisation of women's embodied experience (Banks, 1990; Kinser, 2010). As breastfeeding becomes inscribed with ideological constructions of womanhood the participants attempt to reclaim what Bordo

(2003, 1997) describes as a feminine ideal and become prisoner of the private domain. In this image shared by Rachel she describes:



That's actually the breastfeeding seat that I had and you can see there's like a table beside it with the DVD. I think it's Downton Abbey, a control pad, a water bottle...I would be sat for God knows how long, in the same position (l. 1429-1432).

We further explore this and Rachel explains that she felt:

Trapped, because she just wanted to feed [l: Hmmm] and if she wasn't feeding she was asleep, but if I moved her, she would wake up. So like needing to go to the bathroom, but not being able to because I'd wake her. Erm, trapped sometimes and maybe a bit like, goodness, how can I not even make myself a cheese sandwich? Like yeah, I battled that it could be this hard and all-consuming (l. 1480 - 1486).

Not only is Rachel trapped she is consumed; whilst her baby feeds from her breast so to her autonomy is being ingested; she is bound to the needs of her baby. Breastfeeding becomes something difficult and limiting; Rachel loses agency of her body and her space (Crossley, 1996; Nicholson, Fox & Hefernan, 2010).

Hannah and Bethan also talk about being at home, on the sofa and alone. Hannah finds ways to distract herself from the experience of breastfeeding:

I thought right I'm actually just going to accept that I don't like breastfeeding very much and get loads of kind of box sets and every time he had a feed I'd put a nice bit of telly on (l. 551 – 553).

Bethan says:

Actually in about 15 minutes he's going to want feeding again and I am going to be parked back on that sofa in exactly the same position I was since he arrived (l. 795-798).

These quotations illustrate how the participants tolerate their position and the inevitability that they will be unhappy and uncomfortable – again subordinating their needs to take up the position of 'good' mother. In these narratives their homes become like a prison, the participants are 'trapped' and their descriptions portray the immobilisation of their bodies and identities as they are consumed by their milk producing duties; brain washed with box sets, not able to move or feed themselves. This imprisonment of the body evokes images of the fashion of corsets which saw women restrict and contain their bodies to fit an ideal of femininity (Bordo, 2003; Sampson, 1998).

Furthermore, McDowell (1983) and other feminist geographers have argued that private space is aligned with reproductive space and so the 'proper' place for this activity, but simultaneously acts to isolate women from each other, and the public realm. Hidden reproductive work highlights a neglected 'other-

half' of the labour market, argued to be subsidising the cuts made in wider society (Brown et al., 2004; Dyck, 2005).

3.3.4 Relinquishing the 'public' self. 'Mothering' is a 'new job' for the participants who have had professional roles and they express confusion at the loss of their former identities. Bethan talks of becoming isolated in her breastfeeding experience and craving acknowledgement for her efforts. She likens this expectation to 'achieve' as relating to her role as a working woman saying:

you know whereas at work it's about do the best you can do, get promoted...you don't as a Mum but you are always trying to do your best aren't you? (l. 335-337).

Throughout the interview Bethan reiterates her search for recognition, earlier she says: "*a little more, "oh well done, you're doing a hard job"* (l. 52). As a mother Bethan works hard but her labours go unrecognised. Bethan's frustrations are in line with previous authors who have described how the unpaid and undervalued work of mothers taking place in the private realm becomes invisible (e.g. Brown et al., 2004; Dyck, 2005). Rachel describes her expectation of an innate ability to breastfeed and her confusion when struggling:

How can this feeding be so hard? I'm 31, you know, intelligent, I've you know, how can I be struggling this much with it when it's something that should be natural (l. 702 – 704).

Earlier she says:

I've had a career, I was intelligent. Like everything else in my life I've been able to fix by being pragmatic and using my brains (l. 370 – 372).

Rachel highlights a number of sociocultural factors involved in the construction of the 'good' mother, age, intelligence and innate ability. Breastfeeding seems to Rachel different in quality to any other task where experience and intellect can be applied. The mind is here aligned with competence and rationality whilst the body performs innate 'natural' functions (Crowley & Himmelweit, 1994; Shildrick, 1997). Furthermore, as suggested by Malone (1998) the more alienated Rachel becomes from her subjective experience, so she becomes increasingly oppressed. The use of the past tense describing how she "*was intelligent*" suggests she felt this had been taken away, a lost part of her previous self. Rachel describes how relinquishing her 'rational' expectations worked to her advantage. She says:

I stopped fighting against her and started listening to her and watching her... I knew in my heart that's what I should have done for six weeks (l. 445-448).

She goes on to explain: "*I co-sleep, baby wear and...don't leave her to cry*" (l. 501- 502). Rachel seemed to renounce her pragmatism and intellect so trusted as a career woman in order to utilise her body to achieve more symbiotic inter-embodied relationship with her daughter (Ryan, Bissel & Alexander, 2010).

Both Bethan and Rachel's narratives see them trying to negotiate a new experience. For women who have been professionals they are accustomed to operating in a public sphere where the 'mind' is privileged, now through breastfeeding they find themselves trapped at home, making sense of their 'failing' bodies. It has been suggested that the home as a place for producing social and economic life should receive more attention so that women can be

rightly positioned as active agents, no longer imprisoned but valued and visible in both the private and public realms (Dyck, 2005; McDowell, 1982).

3.4 Summary of Discourse Analysis

The two discourses explored in this section are contradictory and create conflicting expectations. The medical discourse presents breastfeeding as a functional act whereas the 'natural' mother discourse presents it as serene and loving. However, the two discourses can be seen to interact to suppress the agency of women. In the medical discourse the disembodied voice of the rational and objective expert makes decisions on behalf of women as their bodies 'fail' to meet expectations of productivity (Carter, 1995). The medical jargon is adopted by the participants in an attempt to take up an empowered subject position, yet in so doing the relational aspects of early motherhood are stifled, leading the participants to feel angry, disappointed and guilty (Blum, 1999; Wall, 2001). By subscribing to the 'natural' mother discourse agency is lost, the participants give over their bodies to perform the innate function of producing milk, to nurture and care for their babies (De Beauvoir, 1953; Ryan, Bissel & Alexander, 2010). This activity is positioned in the private sphere, masking the work undertaken by the participants who struggle to take up subject positions as 'good' mothers, their needs subordinated to those of their children (Brown et al., 1994; Woollett & Marshall, 2000). Furthermore, the body is pressured to meet a feminine ideal in which its corporeal functioning cannot be revealed (Bordo, 1997; De Beauvoir, 1953; Gear, 2001). The body has been seen to become inscribed by prevailing discourse and plays a central role in understanding women's experiences. What follows is a cross sectional narrative analysis which explores the disembodiment of participants in their difficult breastfeeding experiences.

3.5 Cross Sectional Narrative Analysis

'Woman' and 'Mother' have been argued to be categories which are produced by multiple influences and lead to regulation of the body (Blood, 2005; Ussher, 2006). Taking a social constructionist reading of Foucault (1979) we see how he describes these multiplicities as the result of a socially produced body, constructed through discourse. As seen in the previous section this can create conflict for women as the available discourses are limited. The following four themes explore narratives in which the participants attempt to regulate their bodies resulting in a disconnection from their identities and their babies; in part as an embodied strategy to preserve a sense of themselves as 'good' mothers'.

3.5.1 Pain is minimised, rationalised and hidden.

The private domain of the participants' breastfeeding experiences makes the more negative of these less visible to the public, restricting the creation of alternative discourses. The emphasis on the 'natural' mother diminishes the social and psychological costs of motherhood pain, exhaustion and loneliness become normalised (Ussher, 2006; Woollett & Marshall, 2000). Rachel describes her experience saying:

I would sit from 8 p.m. until 1 a.m. in the morning with her feeding constantly...I was exhausted on the floor, because it was so physically draining and the pain, you know, sitting...cause she'd basically bit my nipple and sitting there with like bleeding nipples...So...then after two weeks I got mastitis which, it really got me psychologically. I just thought, I can't do this, cause I didn't realise it was mastitis and I had a fever...I thought, oh my god, like ho...how...how can I cope? (l.127-150).

The participants' interpretation and reaction to pain differed in each account though descriptions of denial - of pain, difficulty, personal needs and autonomy were offered throughout. Alessandra says:

I was just curled up in that, at that moment with my eyes closed trying to tense my jaw and just bear it, I didn't particularly like him, (laughing) in fact I hated him, he was the one causing all this pain and sucking the life out of me, erm, but then if I looked down at him he was just this tiny, tiny tiny thing that was so helpless and just wanted food (laughs) basically he was just so little (l. 629- 635).

Alessandra speaks of how she relates to her baby as “*sucking the life*” out of her and so the relationship becomes vengeful and deathly, opposite to the life giving act of breastfeeding. Alessandra's conflict is evident when she looks at her son and sees a tiny helpless baby who she cannot connect to her embodied experience of a life sucking creature. Sarah describes how her body was brutalised by breastfeeding. She says:

By this point I'd like lost part of one nipple and the other one was like hanging off [l: hmmm] it was horrendous, really, really, really bad (l. 432- 434).

Sarah's body is here literally falling apart; she is losing her bodily integrity in the act of giving life to another. Destruction and creation become perversely linked. The participants are describing their body as bloody, engorged and disintegrating. All of the excretions of the corporeal body are being exposed through these painful experiences (Blood, 2005; Ussher, 2006). This is at odds with the sanitised view of breastfeeding painted in health care manuals and the 'natural' mother discourse (Bordo, 2003). These expectations

see the body as innately and cleanly performing their natural functions, serving the needs of their baby in a disembodied fashion (De Beauvoir, 1953; Roberts & Waters, 2004; Ussher, 2006). As described later in the exploration of the monstrous body, here we can see these experiences acting to interrupt the feminine ideal (Basow, 1991; De Beauvoir, 1953; Gear, 2001), leaving the participants shocked and overwhelmed but none-the-less persistent in their endeavours.

Hannah's expectations of the experience of the 'natural' mother, at first met by a positive experience of feeding, emphasising bonding and warmth, are shattered during her experience of pain:

so, it's the eleventh day of his life and we are up night feeding and it started to really, really hurt but this is sort of two o'clock in the morning so there is not much you can do about it so I sort of did my breathing from labour and got through it and then sort of did another feed two hours later and thought "oh gosh this is really horrible" and by the time it got to sort of seven a.m. it was, it was unbearable and sort of toe curlingly painful (l. 182-189).

The pain does not induce Hannah to stop, her expectations of herself lead her to bear the pain; the baby needs to be fed and the responsibility is hers. Pain becomes a normalised and acceptable part of the transition to motherhood (Skitolsky, 2012, Ussher, 2006). Maria states:

It's 40 minutes on the boob, chaffing...sorry, this is going to become quite graphic, but chaffing, cracking, bleeding, lots of Lanolin being used. Erm, you almost start to dread feeding time because you know it's going to be more pain and a bit of frustration but at least you can

see that your daughter is slowly gaining weight but very slowly (l. 232- 237).

Maria speaks in the second person, distancing herself from the narrative. She describes a wincingly painful experience but minimises this as “*more pain and a bit of frustration*”. She is able to rationalise her experience as her daughters needs are being met – her main prerogative as a ‘good’ mother (Woollett & Marshall, 2000). These stories describe the conflict mothers face to endure pain for the health of her child or remove the pain and be seen to deny the child. The relentless exploitation of their bodies leaves them exhausted, hurting and frustrated and yet these feelings are subjugated to the needs of the child (Bordo, 2003, Skitolsky, 2012).

3.5.2 Mining the body for ‘liquid gold. ‘Ideals of the ‘good’ mother seem to outweigh bodily integrity, and the participants described feeling increasingly responsible for the health and productivity of their babies (Blum, 1999, Wall, 2001). The arguments of the body as a natural ‘ecosystem’ and the medical constructions around the value of milk (Schulze & Carlisle, 2010, Wall, 2001) come together to reinforce a political drive for productive bodies (Diprose, 1994). In Maria’s narrative she describes the focus on her breast milk as a commodity not to be wasted and her horror at finding it ‘polluted’ with her blood. She says:

When I was bleeding and it was at its worse I would have to throw milk away cause although the baby could theoretically drink it, it was so...it was so much blood. It was just not going to be a good idea to give it to her. It would have been more blood than milk...

I: How was that? How were you feeling when you look at this milk and its more blood than milk?

Maria: I think, "what a damn waste!" But then I also thought "You know what? This...this is the worst it gets and the pain is the worst it gets and I can deal with this because eventually I will stop bleeding (l. 1040 – 1046).

Maria describes the shocking scene of milk red with blood but her affect does not display any horror – her shock and anger is at having to throw away milk. This may be explained by her later description of breast milk as “*liquid gold*” (l.1069). Maria is fulfilling her role as the ‘good’ mother in putting her children’s needs first (Wall, 2001). This is further exemplified as Maria draws on narratives of strength and resilience and implies that a determined attitude will overcome any difficulties.

I was absolutely convinced that I wanted to breastfeed full stop and I was going to do anything to breastfeed. And it wasn't so much, erm...it wasn't so much the guilt or anything like that it was, "you know what? I was breastfed. I know that there were problems. I'm gonna d...I'll be damned if I can't do this....and by hook or by crook (l. 156- 163).

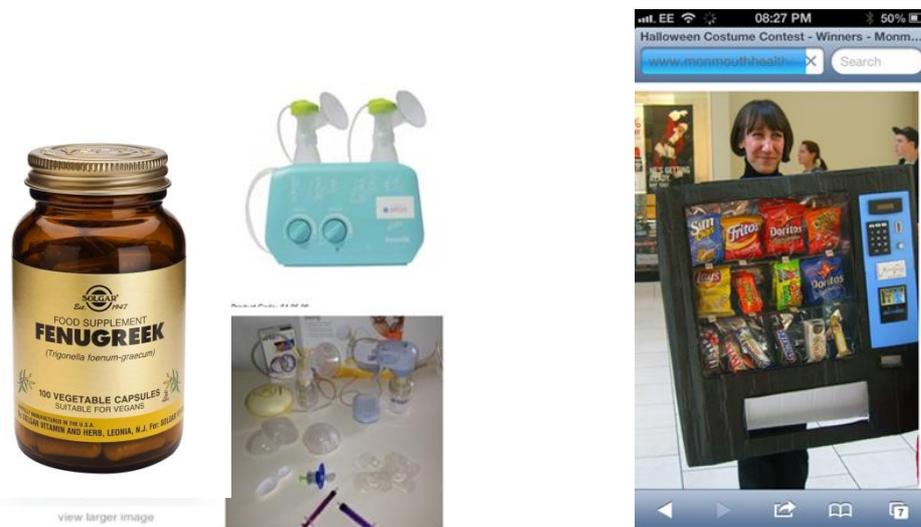
In Maria’s use of the phrase by hook or by crook, she is saying that by any means necessary she will feed her baby resulting in her inattentiveness towards her bleeding nipples; her breasts become mere vessels of milk, manipulated and violated for their functionality (Bordo, 2003). Maria’s response to her body could be seen as neglectful and yet this goes unquestioned as suffering becomes a rite of passage to ‘good’ mother status (Skitolsky, 2012).

Maria is not alone in this disembodied experience of milk production, as can be seen in the following exploration of the participants' reactions to the unruly body (Russo, 1997).

3.6 The Machine, the Monster and the Alien: Attempting to Tame the Unproductive Body

This theme relates to discourses which align women's bodies with machinery and monsters, leading to alienation from embodied experience (Gear, 2001; Shildrick 1997; Ussher, 2006). The exploration begins with Alessandra's narrative of milk production and the lengths she went to to increase her milk supply.

3.6.1 Body as a malfunctioning machine



Alessandra uses the above images to introduce narratives of the body. First¹⁰ is the 'hospital grade' pump and all the paraphernalia she used to increase her milk supply and protect her breasts; the next is a 'human vending

¹⁰ Permission to reproduce these images has been granted by Solgar, Medela and Ameda. See Appendix 8

machine.’¹¹ Both images are used to elicit narratives of a loss of identity and autonomy, giving over her body to the production of milk and interrupting her experience of motherhood. She says:

I felt like I wasn't bonding with him, because of the fact I was permanently hooked up to a expressing machine (l.112 – 114).

And:

I felt like I wasn't a Mum basically... (l.127).

She speaks of being ‘hooked up’ to the breast pump, the language reminiscent of that used to describe a life support or dialysis machine; as if her body’s productivity and her life as a ‘good’ mother depended on it. Speaking of the image of the ‘human vending machine’ and her duty to “*give out food for a baby*” (l. 558) leads her to describe her body as a machine on a constant timer. She explains:

...my life was permanently on a timer, a timer as to how long until I next had to express, how long I had to express for and then as soon as I had finished I'd sort all of the milk together and try and quickly give it to Ed...then the alarm would be going off and I'd look at the clock and kind of think 'what the hell happened' I'd have to start expressing gain, you know, it was relentless, so relentless (l. 562-568).

In this narrative of her body as a machine, Alessandra builds up an image of herself as disconnected from her body and her baby. Alessandra relates to her body as a functional object that is contained, productive and working to the clock, devoid of subjectivity. The body as machine or the “*res*

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extenza – mere body” (p. 73) is explored by Bordo (2003) in her discussions of the legal rights of women to bodily integrity when pregnant. She describes how the woman’s body loses its subjectivity and becomes a “*vesse!*” (p. 84) for the foetus. Likewise Alessandra’s narrative describes how in the production of milk her body becomes dehumanised, a malfunctioning machine. Such a reductionist approach sees any emotional or subjective interpretation excluded (Shildrick, 1997).

3.6.2 The milk production line. The regulation of the body and the lengths taken to respond to its functionality are heard in Bethan, Hannah and Maria’s narratives about their breast pumps. Bethan describes her hatred of the breast pump:

I just hated it, expressing with a passion um and I was never, well I never produced very much so it felt like flogging a dead horse...I used to sit there with that (makes noise of a pump clicking three times) sound which is like, like my 10-15 minutes of the day when he hasn’t got to be attached to me...I still had something on me...and yeah it felt like, I don’t know what the right word is I almost want to say sensitised, like, there is something on my boob! (l.454-464).

Bethan here describes her relationship to the pump. When failing, she uses technology to regulate her body, an experience she finds invasive and uncomfortable (Ussher, 2006). The agency of her body is lost either to her son or to the pump and she feels “*sensitised*”, her breasts are alert to external intrusions and out of control. She goes on:

Vile thing it was so laborious, it felt so unnecessary, my supply would have been fine, he didn't drop down dead because he was having a bottle of formula a day (l. 471-473).

In the above quotation Bethan uses violent imagery. Throughout the interview she uses analogies in which the body is attacked she says “*bombarded*” (l. 1201), “*rammed down your throat*” (l. 145) and “*I was gutted*” (l. 1052). This language reveals feelings of anger at the attitudes surrounding breastfeeding. It also speaks of the way in which she felt abused and violated. She feels as a horse beaten into submission: “*flogging a dead horse*” and an animal removed of its innards; these brutal and inhumane images illustrate the dehumanisation of Bethan’s body (Okado, 2011).

Whilst all the participants shared a negative relationship to the pump not all were filled with such hostility. Maria describes her anxiety at using the pump, she says:

I hardly slept... it always felt as if we were that one bottle of expressed milk away from disaster (l. 245-248).

Hannah says:

I was desperately trying to get milk, you now, line up the next feed so kind of felt like I had become a bit of a, a dairy cow rather than a mother (l. 488-490).

Hannah’s body seems to her as a submissive cow regulated by the pump and subservient to the needs of others. For Hannah expressing milk was a difficult endeavour she says it was:

...never straight forward because of all the palaver of getting the milk out to fill the bottle (l. 275-277).

Her language implies a pragmatic, functional act as if describing irritation at a domestic task, the “*palaver of getting*” something done. Bordo (2003) describes how in attempting to regain control and fit the ideal of a ‘good’ mother with a productive body one can act on it as if separate to oneself. This is seen here as Hannah minimises her emotional connection to her body, treating it as an object rather than a subject. Grosz (1994) argues that a mind/body dualism places the mind (subject) in hierarchical superiority over the body (object). Here a disembodied relationship to the object serves to protect Hannah’s subjectivity and distances her from the emotional disturbance she may feel through failure to conform. She described at the beginning of the interview that she had not prepared herself in any way for this eventuality, so firm was her belief in her innate ability to feed and the conviction that this was the only way to achieve the status of a ‘good’ mother (Ussher, 2006).

However, the anxiety expressed by Maria and Hannah in the above quotations indicate their feelings of powerlessness and desire for their bodies to perform. Here it is argued that a mind/body dualism sees the uncontrolled body as aligned with loss of power and free will (Burkitt, 1999).

In using a pump to regain power and control of their unruly body the participants can be seen to be conforming to regulatory practices, the body becomes a site of struggle and contention, used as an obedient machine (Blood, 2005; Bordo, 2003, 1997; Diprose, 1994; Shildrick, 1997). Alessandra can be seen to adopt what Bordo (2003, p.16) terms ‘micro practices’ to regulate her unruly body: “...*cabbage leaves, nipple cream, cold compresses, hot compresses...*” (l. 544). She here describes her attempts to normalise her

body, to correct her breasts' functioning. Alessandra's active role demonstrates that is not always restraint and coercion, but "*self-surveillance and correction*" to fit norms which reinforces external authority; hence the body becomes a site of power and control (Bordo, 2003, p.26, see also Diprose, 1994; Shildrick, 1997; Ussher, 2006).

Whilst the participants seem to position their bodies as "*docile*" and habituated by external regulation (Bordo, 2003, p.16), their frustration, anger and resentment is evident. In Millsted and Frith's (2003) paper exploring experiences of big-breasted women, they suggest women are not passively positioned in relation to discourses but actively attempt to negotiate their position navigating a "*complex web of discourses, gazes, audiences, identities and visibilities*" (p.463, see also Ussher, 2006). Here the participants' anger can be seen to demonstrate resistance, though this is oppressed by continued pressure to conform to norms of the 'good' mother.

This oppression can also be seen to result in the disconnection of participants from their babies, leading to feelings of sadness and guilt. Recalling how her husband took over care of her son Hannah says:

He spent a lot of time sitting with him and cuddling him and playing with him and doing all of that while I was desperately trying to get milk (l. 486-487).

This can be seen as an example of how participants are unable to sustain relationships with their bodies and their babies whilst regulating the 'machine.' The participants offer distressing descriptions of themselves as other-than-mother as they attempt to re/establish breastfeeding. Hannah says:

Yes it did feel separate and it did feel that suddenly other people were more important in my child's life than I was (l. 483 -484).

Alessandra: "I watched Ed and him bond more and more and more and I felt like I wasn't (cries) and it hurts" (l. 359 -360).

Esther: "expressing milk next to a cot that has no baby in was heart-breaking" (l. 66-67).

In these quotes the participants' can be seen to become isolated and redundant, unable to fulfil their roles as 'natural' mothers (Brown et al., 1994; Phoenix & Woollett, 1991; Ryan Bissel & Alexander, 2010; Wall, 2001). The body as machine remains contained and sanitised, however, the following narratives describe how participants were also confronted by the unfamiliarity of the corporeal body.

3.6.3 Unsanitised excretions of the 'monstrous' body. I have argued that the maintenance of an objective relationship to the body as productive and under control is important in conforming to a medicalised construction of the body. In order for the body to conform to the natural feminine ideal this body is also expected to remain sanitised (Basow, 1991, De Beauvoir, 1953). In the participants' narratives, when unsanitised, they become revolted and confused by their bodies.

Alessandra explains how her husband is shocked by her changing body. His description sees her body becoming 'grotesque'; it smells and swells evoking images of something repellent and monstrous (Gear, 2001; Ussher, 2006; Russo, 1997):

The fenugreek makes you smell like a curry, really badly, really, really badly. And he said, you have cut yourself, being my nipples, you have swollen, breasts being engorged, you have stunk (laughing) (l. 486 – 491).

This imagery is seen also in Sarah's story she talks of her post labour body saying:

I had basically been chopped open and sewn back up again and erm, you know was exhausted, stretch marks everywhere, my feet had swollen up massively (l. 601 – 604).

And:

the plug hole of the shower was like shiny silver, like a mirror [l: mmm] and I remember being able to see like, you know, the reflection of my bits and it just being like black bruised, pure black and black blood as well and it was just like, I remember just thinking how is this right, how does this happen, in like a, in Leicester? You know, this whole barbaric just I don't know but yeah, my boobs were just hu...and also when my milk came in I got loads more stretch marks so that was really sore as well, my nipples were sore... (l. 614 – 622).

In these quotations the participants see their bodies as “*barbaric*”.

The image of the grotesque body is explored by Mary Russo (1997, 1994) who describes how the “*open and protruding*” body is denied by the classical body seen to be “*static and closed*” (1997, p. 325). The female body of the Western world has become increasingly sanitised, deodorised and privatised and yet in

childbirth and breastfeeding such practises become impossible as the body excretes tears and bleeds (Basow, 1991, Ussher, 2006). Grosz (1994) suggests that body fluids affront a person's aspiration of autonomy and "leaking" reveals the fraudulence of the impossibly sanitised body (see also Ussher, 2006); the reproductive body is revealed as disobeying femininity, becoming "dangerous and dynamic" (Gear, 2001, p.322). The participants are disgusted by the body's natural functioning, as Sarah states, their bodies become "alien" (l. 625, Roberts & Waters, 2004; Ussher, 2006).

There are implications for an uncontrollable body on the identity of the participants as women, how they see themselves and who they will become. During the interview I asked Alessandra to give voice to her breasts as I attempted to understand more clearly her subjective experience. I ask and she responds:

I: If your, your boobs could tell us the story of breastfeeding...

Alessandra: They'd say don't do it! (l.784-785).

She goes on:

I think they'd complain, I think they'd complain a lot (l. 788).

And:

I think they'd definitely wonder what the hell happened to them and how they had managed to drop a bit and sort of disappear (l.790-791).

Earlier she has said of her feelings towards her breasts:

I don't think Ed will be seeing those again, I think I might end up having a boob job (l. 531).

Alessandra's breasts become a voice within her story and seem to articulate an internal, silenced voice of her experience. Bartlett (2002) describes how through the personification of breasts they become separate from the subject, but notes that if they can be inserted into language as knowing, speaking and being heard, they might become a powerful agent. Here Alessandra's breasts speak of the transition and transformation Alessandra went through becoming a mother and the impact her difficult breastfeeding experience had on this (Ussher, 2006). The disappearance of her breasts is reminiscent of her consumption by the machines and paraphernalia involved in her experience. Her body's failure to function leaves her wondering "*what the hell happened?*" shocked by the unsanitised and corporeal functioning of a body previously denied.

She describes her breasts as "*slightly saggy and empty*" (l. 529), mirroring the deflation and defeat she felt following her breastfeeding experience. Furthermore, in having a "*boob job*" we see Alessandra attempt to regulate her body. Her breasts no longer conform to a sexualised pre-child feminine ideal in which they are defined primarily as objects of sexual interest and pleasure (De Beauvoir, 1953, Millsted & Frith, 2003); reversion to a sanitised body through surgery is a way to counteract the excessive body of pregnancy and breastfeeding (Ussher, 2006).

In these narratives of the body as machine, monster and alien, the participants' bodily experiences are at odds with the sanitised, sexualised and objectified experience of their pre-child bearing bodies, perhaps explaining their desperate attempts to contain and control their bodily integrity (Blood, 2005; Bordo, 2003; Gear, 2001). Their responses can be seen to be cognitively bound

and culturally informed, translated into bodily dispositions, instilled through what Burkitt (1999) describes as social practices.

3.7 Body, Baby and Breast: Making Space for the Self

A Cartesian view of the body denies an understanding of the multiple levels of interaction taking place during breastfeeding: self-body, body-others, body-body. Denying the impact of embodied experience on individual identity and social relations misses crucial dialectical communications and meanings (Burkitt, 1999). The analysis looked at ways in which this denial impacted on the participants' view of themselves as mothers, their relationship to their breasts and their relationship with others, most notably their babies.

3.7.1 The feminine and sexualised body

Bethan uses this image¹² of feeding bra's to elicit stories of her changing image



and relationship to her body. She says:

just not comfy, not attractive, not supportive...you live in or I lived in and apparently underwire is like some kind of deadly sin and both you and your baby will just keel over dead if you even look at one (l. 751-754).

Bethan goes on to describe how the bras make her feel as a woman.

She states:

...it sort of defeminises you in a way although I don't know if that's what it does because in a way it's the ultimate in femininity, you know you are breastfeeding, but... you're like 'oh so my tummy's going

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back to its normal size, you're starting to look good again. No you're not. Oh no, you are almost going to force yourself looking like, looking...Bland, you know like a Mum, a bit frumpy, that sort of thing...it made you feel rather unattractive (l. 781-788).

Bethan wants a bra which suits her identity rather than one which is purely focused on ease of feeding for the baby. Bethan describes not conforming as a “*deadly sin*,” sarcasm revealing the anger she feels as she is restricted by expectations of a ‘good’ mother and their constructed relationship with their bodies.

Bethan highlights a conflict between femininity as defined by the act of breastfeeding versus the feeling of femininity she felt wearing underwire, “*prettier*” bras (l. 762). Gleeson and Frith (2006) have argued that women’s bodies are connected with heteronormative practices of embodying femininity. Here we see an apparent limitation of femininity, that it doesn’t normatively include the breastfeeding, functional body but only the body as an aesthetic; this mirrors findings in Del Busso and Reavey’s (2013) study of the embodiment of young women in which participants reported their experience of their bodies as objectified ‘surfaces’.

Rachel describes how others perceptions of her breasts created a different kind of invasion on her body and privacy. She describes the reactions of family members to her feeding saying:

My husband’s mum one day... I used to feed in front of people, not like... you know, I’ve always been quite covered when I’ve fed, but his uncle was here and I didn’t wanna feed in the room with them. So I said, “Excuse me, I’m just gonna feed Mollie, I’ll be back in a few

minutes”...His mum said, “Oh, that’s her away to suck on the mother’s tit”...I was so embarrassed and angry (l. 549-556).

Rachel struggles with how others relate to her body, its purpose and function. The normative construction of women’s bodies as sexualised makes breastfeeding puzzling in the eyes of others. The naked female body is common but only when sanitised and sexualised (Basow, 1991). Millsted and Frith (2003) explain that no other part of the body has such “*semi-public, intensely private status*” (p.456). Grosz (1994) argues that this process of sexualisation begins in puberty where breasts are framed as secondary sexual characteristics and subsequent cultural association sees breasts becoming part of a gratifying sexual experience rather than functional for feeding. Furthermore, in both acts the breast becomes a disembodied object present for the needs of others.

In a story shared by Sarah we hear how this obscure conceptualisation of the breasts leads to her feeling confused:

When my milk came in properly, I was not prepared for the intensity and the pain of and the, you know the melon boobs and I remember phoning one of the breastfeeding help lines from my hospital beds just being like, crying and just being like (laughs) what’s going on? (l. 573 – 577).

The word ‘melon’, used colloquially with sexual connotations, here relates to Sarah’s breasts’ expanding size but indicates the lack of vocabulary she has for her breasts. Sarah positions herself as a passive onlooker to her body, shocked and unprepared. Her “*morphologically dubious*” body challenges the notion of the fixed bodily form (Braidotti, 1997, p.64). Sarah’s reaction of

phoning a helpline identifies her with constructs of the irrational body – passive, reactively waiting for intervention of authority and education (Bordo, 2003, Gear, 2001). Women’s experiences are marginalised as no appropriate discourse can be found to describe their changing bodies.

3.7.2 “Protest and retreat”: Resisting the normative body. Bethan navigates her relationship to her changing body by taking up a position of resistance to the intervention of authority and education. Throughout her interview Bethan describes her difficulties with the loss of her identity and her isolation she says *“it took my identity away; I was a breast feeder rather than a person”* (l. 1165-1166). Bethan spoke of smoking as a way to reclaim her previous identity and autonomy. She used the image below to elicit a narrative of her daily cigarette after her son was asleep.



The image¹³ is black and white; it is stark and atmospheric, the steam rising from the coffee and the cigarette casually smouldering. There is a rebellious feel to the image which is mirrored in the way she describes the

subversive act of her nightly ritual.

Explaining the image, Bethan says:

I would have a cigarette in the evenings, just like a skinny little rolly and it was the highlight of my day [! mmm] it was just bloody lovely, it really was because it just always meant that he was asleep and he was asleep for the longest part of the day usually so it was a little bit

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of 'off duty' going on [l: mmm] ...it's just I love smoking, I really love it...ah, yeah, it's just, it's such an old friend [l: so how] so it sort of represents all the things that I couldn't do [l: OK] so all that time you had restricted yourself when you were pregnant and then you start breastfeeding and you are still restricted and it's like oh but I thought I had got to the end of a mountain and then no you haven't at all, you can eat prawn that's about as good as it gets! All the good stuff was off limits...I had a whole regime, as soon as I had finished my cigarette I would go into our downstairs bathroom and I would clean my teeth and wash my hands and then I had a special jacket that I would wear and I would tie my hair back I was really like, well you know, as much I could I would try and keep stuff away from it (l.921 – 943).

Bethan describes with nostalgia her relationship to smoking, positioned as a part of her 'pre-mother' self. However, even in this small act of indulgence there is still a 'regime' in sanitising herself and putting on another 'uniform' in the way she has earlier described her feeding bras. Whilst it is difficult for Bethan to embrace both her previous self and her developing identity as a mother she does find a way to relate to her body and demarcate her different embodied roles. In changing her clothes she transforms from 'feeder' to 'smoker' and so assumes her identity outside of motherhood. Furthermore, she describes the act of taking things into the body, "*all the good stuff*" as an embodied and pleasurable experience which is in stark contrast to the difficult experience of giving out milk. Inhaling her "*old friend*", she is able to find a position of resistance to the restrictive bodily practices associated with pregnancy and breastfeeding. Bethan can here be seen to be using her body as

the primary construction and consolidation of identity “a vehicle for displaying conformity or non-conformity to social norms” (Shilling, 1993, p.23). Bordo (2003) further explores the ways in which women’s bodies can be seen as a locus of control, she suggests that by embracing embodied behaviour women can become empowered, Bethan can be seen to do that here, as her embodied behaviour becomes both her “*protest and retreat*” (p. 168).

In Esther’s narrative, her “*protest and retreat*” is seen in how she uses her body as a way to maintain a relationship with her son. Initially using a breast pump became the only way she could form a union with her child. After a traumatic birth her son was taken to ICU ward and she was left to pump milk to be given to him via a nose feed. The separation from her son was unbearable: “*It was absolute hell. It was awful...I just wanted to put him back inside me*” (l. 77-81). The powerlessness felt at the loss of this symbiotic relationship was for Esther in part relieved by her ability to express milk: “*it was the only thing that was keeping me going, I had to hold onto that*” (l. 92-93).

In contrast to the other participants, Esther uses the pump and her milk to maintain a bodily connection to her baby. Esther shows me an image¹⁴ of her in her nightie, with her son tucked inside feeding, the two in an act of peaceful inter-embodied union (Ryan, Tordes & Alexander, 2011). She recalls:

I knew that if I was away from him for time and I put ‘im back we’d be together. Sort of like a jigsaw puzzle [chuckles] like we’d link in and... and then be close again. [l: Hmmm] And he’d look at me and it’s just... yeah, just healing and that... that’s why that picture... that’s a picture where I was havin’ a sad moment...So, I went upstairs and

¹⁴ Participants consent to describe only

... I put him inside my nightie, erm, and fed him because that way [I: Yeah] I could feel like he was back inside my tummy (l. 1608-1644).

Here Esther's story comes to a resolution as she feels fused again with her son who at the start of her narrative is "*ripped out*" (l. 79). The vital role she held during pregnancy and in bringing her son into the world is reinstated (De Beauvoir, 1953); the loneliness and separation is healed as their bodies come together through breastfeeding.

Esther's story concludes the exploration of the ways in which women relate to and make sense of the conflicts between the idealised feminine and corporeal body. The participant's body have been seen to offer a unique blend of fascination and horror to themselves and others (Braidotti, 1997). Esther's story here introduces the idea of the inter-embodied experience of breastfeeding and the final theme which explores the impact of difficult experiences on the mother-infant dyad.

3.8 The Elusive 'Bond': Making Sense of the Mother-Infant Dyad

Bonding continues to be an elusive and contested concept within breastfeeding literature (Jansen, Weerth & Riksen-Walraven, 2008; Ussher, 2006; Wilkinson & Scherl, 2006). The conflict between death of the self and the life giving breast has been identified throughout the thematic analysis and I will now explore the implications of this on the mother-infant 'bond'. The participants felt disconnected from their babies whilst breastfeeding and were seen to protect their identity as mothers through separating out their experiences of breastfeeding and motherhood.

The participants spoke of how their relationships with their babies developed. Some spoke of an instinctive protectiveness and bond or described

hormonal changes, whilst for others breastfeeding interrupted bonding. Explicit in Esther and Rachel's narratives and implicit in the other participants is the inter-embodied nature of both the pregnancy and post-natal experiences. This echoes Ryan, Tordes and Alexander's (2011) description: "*the baby was born, the cord was cut, but the baby and mother were not yet separate entities*" (p. 733).

The participants respond in different ways to this experience. Whilst some draw on natural mother discourses to find ways to become closer to their baby through breastfeeding, others separate their narratives of breastfeeding and mothering, even separating their bodies from their babies as they attempt to disconnect their 'failing' bodies and selves from their role as mother.

3.8.1 Protecting the mothering relationship: Uncoupling breastfeeding and bonding.

Bethan speaks of breastfeeding and mothering as separate and describe distinctions between 'feeding' as a physical act and mothering as an emotional bond. Bethan says:

I just felt gutted for him, because I didn't like feeding him, I had a much better time when I wasn't feeding him...that makes me quite emotional actually, I feel quite, well hormonal obviously, just for the tape I am pregnant [I: (laughs) yeah] but erm, yeah, I was, I had a better bonding experience when I wasn't having to feed him (l. 231-235).

Bethan here separates her bonding from breastfeeding, protecting her relationship to her baby and aligning any negative emotion to the act of feeding. We also see her attribute her 'emotion' to her bodily moderated hormones. Previously she described herself as competitive and holding the

belief that if she puts her mind to it she can control and regulate her body; in this quotation she wants to remind ‘the tape’ that it is her untamed pregnant body which explains her irrational emotions. Once more she attempts to disconnect her identity as a ‘good’ mother from her unruly and vulnerable body (Bordo, 2003; Grosz, 1994; Russo, 1997; Ussher, 2006).



During her interview Alessandra shared no images of her or her son. However, a week after the interview she sent an image of her son in an e-mail entitled “*just because he’s cute*”. She disconnects the negative experiences and stories of breastfeeding from her son and her future self. The image she shares is of a happy, older child perhaps representing the son who has grown from ‘bottle’ milk and the attentive mothering she aspired to provide which breastfeeding interrupted. Early in the interview Alessandra outlines the almost telepathic relationship she expects mothers to have with their babies saying:

I believe that it’s a mother’s job to respond to their child before they cry... he ends up crying, you failed, you should have responded sooner, your baby doesn’t need to cry he’s been telling you he can’t talk so it’s your job to pay attention and to pick up on what your child wants (l. 603 – 610).

This high standard set by Alessandra sees her draw on the natural discourse in which the mother’s needs are subordinated and her sense of purpose results from her child’s progress and functioning (Brown et al., 2004, Wall, 2001). It is little wonder that in this context Alessandra is left feeling dejected and failing.

Hannah describes how breastfeeding limited the intimacy she craved with her a son:

I felt quite resentful of the feeding really because I felt like it was getting in the way of this really precious time I had with him and I remember this one time where I got really upset because I said its even hurting to cuddle him now because my nipples were so sore (l. 308 – 313).

The act of breastfeeding which is imagined to create connection and intimacy with a baby is described as a divide, physically and emotionally.

This disconnection results in the participants expressions of confusion, guilt and ambivalence. In this quotation we hear Sarah's confusion and ambivalence about her identity as a mother during her difficult breastfeeding experience:

I have always enjoyed being a mum. I didn't enjoy those first 6 months. I didn't enjoy them at all, I didn't enjoy our time together, but I enjoyed, like I loved being a mum but I didn't have a good time at all (l. 918 – 921).

Sarah enjoys being a Mum but during breastfeeding she "*didn't have a good time at all*"; she protects her new identity by placing negative feelings into the act of breastfeeding, the reflux, tongue tie and pain - these are all disconnected from mothering and her bond with her daughter. Sarah's ambivalence here demonstrates the complexity involved in assuming her new role.

In a moving exchange, Hannah describes her feelings of guilt at not enjoying the experience of breastfeeding, central to her identity as a 'good' mother. She begins:

I'd have just felt like a very bad person not to, not to be enjoying it and I'd been selfish (tears up, talks to baby who is trying to take off H's glasses) yeah, no glasses, no glasses, yeah, hahahaha! (Kisses him hard on each cheek)

[She is holding her son as she speaks she begins to cry. The baby, curious about her glasses, is trying to take them off. This gesture seems exposing and difficult for Hannah who turns to interact with him. She kisses him – hard and certain, a demonstration of love despite her negative feelings, the conflict and pain evident.] We continue:

I: So that made you feel a bad person

Hannah: Yeah, yeah and sort of one of those horrible people who always wants things and then gets what they want and still isn't satisfied (silence 6 seconds. Looks at baby and says in a 'baby voice') because you were a bit of a toad weren't you (kisses him) but now you are gorgeous aren't you, a gorgeous toad

Baby: Bbbbb

Hannah: Bbbbb

Baby: Bbbbb

Hannah: Baby

Baby: Buurrr [Interview is paused] (l. 770 – 784).

The intimate exchange between Hannah and her baby suggests that she seeks to heal the wounds of separation caused by her breastfeeding experience, reconnecting to her baby. Hannah finishes by going to get her baby a snack, in leaving the room perhaps she is creating space between what has been said and the continuing interview.

As Hannah has spoken of her son as a “toad”, so to Alessandra describes her son as an animal, saying:

He was just a leech; he was a little leech who just sort of sucked any life out of me... I hadn't gained this bond, a magical bond with your baby that people talk about, I don't know what people are talking about, I think they lie...it's not, let's be honest about it, let's be real...now it is (to Joseph in a baby voice) now it is coz I know you and I love you (l. 988 – 999).

Both these quotes see Hannah and Alessandra describe their babies as slimy animals. They give their children alternative personas protecting their ongoing relationship from the negative feelings they felt towards their babies during the act of breastfeeding. Both adopt a ‘baby voice’ neutralising the negative emotions they are describing. Furthermore, both of these strong reactions are aroused when the mothers are in contact with their babies, demonstrating how the interpersonal space evokes their reaction. Much research has been done into mother-infant interaction and emotional arousal, indicating that synchrony, emotional regulation and intersubjectivity result from interplay between autonomic arousal and behaviours used for emotional modulation. Mothers’ reactions to their babies have been described as ‘psycho-physiological’, creating a communicative space between mother and infant

(Feldman, 2003; Lyons-Ruth, 2006; Stern, 1974; Wiesenfeld & Klorman; 1978).

It can be seen here that a difficult breastfeeding experience can disrupt the equilibrium of such intersubjective communications and Alessandra and Hannah use distancing, through both their vocal tone and the metaphor of the baby as animal, in an attempt to neutralise possible negative arousal. However, the communicative body was also seen to be a site of empowerment as explored in the following narratives.

3.8.2 The 'bestial' mother: Utilising the empowered, communicative body. It has been suggested in the literature review that embracing the body and its communicative potential can assist in women's empowerment through increased self-reliance and control (Bartlett, 2002, Van Estrick, 1979). Furthermore, Merleau-Ponty (1968) suggests the body offers access to reality before it becomes inscribed by language and history. The following narratives examine the ways in which participants used their bodies to increase their confidence in their roles as mothers and communicate power through embodied and inter-embodied experience.



This image¹⁵ was shared by Rachel to describe her motivation to continue breastfeeding. The image is evocative of closeness and nurture. Yet importantly the lion is a symbol of power, strength and autonomy. It

seems Rachel is seeking an alternative position to those offered in the medical or 'natural' mother discourse. Lionesses can hunt as well as look after their

¹⁵Image not protected under copyright law. Fair use and commercial use granted.

babies; Rachel is illustrating the power she feels accompanies her role as mother. In her narrative she describes this saying:

It's such a huge thing that just takes over ... for me. Just this absolutely wanting to protect the baby...that's why the... the journey that we had in the first few months was really tough. It never came into my head to not... to not do it (l. 1127-1131).

In this quote the connection between Rachel and her baby is inter-embodied (Ryan, Tordes & Alexander, 2011). She explains that she wanted to protect her baby; this coupled with the image of the lioness indicates how she is drawing on discourse of the natural mother whilst also responding to the corporeal body, here aligned with a powerful animal. In describing her feelings as taking over, we can see the power of Rachel's body in understanding her subjective experience as she becomes a mother; what is more, she makes no attempt to rationalise this, there is no doubt "*it never came into my head.*" We are here reminded of Merleau-Ponty's assertion that is only through applying reflective thought that we begin to doubt our "*perceptual faith*" (Sanz & Burkitt, 2001, p. 330).

Esther also describes wanting to rely on her "*perceptual faith*" and draws on the animal body as an empowering concept. She says:

...and the biggest thing that struck me that I felt when it didn't go right and I felt let down and, like, people were treating me very, very badly, I felt "I'm a mammal...I'm a mammal." It's a woman's right if they want to breastfeed. It's my right (l. 112-117).

The strength and determination of the lioness is evoked in this quote from Esther. Not being supported in breastfeeding felt to Esther as if her right as

a mother to bond with her child was being compromised. For Esther and Rachel the body is central to the development of the mother-infant dyad. Rachel and Esther are here creating potential discourses which incorporate more 'bestial' elements of breastfeeding denied in both the 'medical' and 'natural' discourses. The animal-body connection does not see the body becoming a passive vessel reduced to its biology, but rather communicates power through embodied and inter-embodied experience.

3.9 Summary of Thematic Analysis

The thematic analysis has described the ways in which despite authors such as Shildrick (1997) arguing that our phenomenological stability is intrinsically tied to our bodily experiences, the participants still seem to resist their embodied experience. The available discourses of the body which see it either aligned to the productive machine or the sanitised feminine ideal leave little space for difficult breastfeeding experiences which see the machine malfunction, and the corporeal body reveal itself and all its 'leaking' truths (Bordo, 1997; De Beauvoir, 1953; Gear, 2001; Russo, 1995). The participants describe how they engage in regulatory practices as they attempt to conform to images of the body to which they are accustomed (Bordo, 2003). Furthermore, they find these attempts distressing and guilt-inducing. Spaces of resistance are found in embodied protests such as Bethan's smoking and the inter-embodied 'bestial' relationships described by Rachel and Esther and suggest that through embracing their embodied experience women are more able to express their subjectivity leading to their empowerment (Bobel, 2001; Carter, 1995; Van Estrick, 1989).

Rose (1996) argues that psychology as a discipline contributes to the image of the people we 'ought' to be, promoting the individual as an

autonomous and freely choosing self. I have argued that this image often leads to disembodied interpretations of subjective experience, privileging the mind and reinforcing a Cartesian dualism (Burkitt, 1999; De Beauvoir, 1953; Malson & Swann, 2003). Moreover, there is little space for the 'failing' body in such a reductionist and objective philosophy (Bordo, 2003). I have argued that the participants in this study find themselves isolated and experiencing many negative emotions due to the lack of available subject positions for them in the 'medical' and 'natural' mother discourses (Ryan, Bissel & Alexander, 2010). Their bodies become disconnected at best, and violated and abused at worst (Ussher, 2006, Young, 1990). The implications of this and suggested responses which might be made by Counselling Psychologists are discussed in the final chapter, as well as reflections on the process of undertaking this research and possible future areas of exploration.

Discussion

This chapter will bring together the process and findings of this thesis and discuss possible clinical implications for Counselling Psychology. Drawing on the structure suggested by Willig (2012) I shall start by summarising the findings, and then I shall describe my personal reflexivity concerning the undertaking of this project. Next, I will discuss epistemological reflexivity, considering the way in which this project generated knowledge and the successes and weaknesses of the methodology employed. To achieve this, I have drawn on Emerson and Frosh's (2004) framework for examining micro-processes within interviews. Finally, I will discuss clinical implications for Counselling Psychology, explicitly thinking about the role of social justice within the discipline and clinical applications of involving body work within therapeutic interventions.

4.1 Summary of Findings

The research questions were concerned with understanding how women narrate their difficult breastfeeding experience, with particular interest in the social processes which influence the construction of these stories and what can be learned about how such women understand their identities as mothers. It was seen in the analysis that becoming a mother involves an embodied experience with culturally located feelings of responsibility relating to meeting the baby's needs. This was seen to have profound implications for a woman's sense of self (Miller, 2005). The analysis focused on two key concerns, firstly the impact of prevailing discourses on the participants' understanding of their difficult experiences and the impact this had on their subject positions. Secondly, on the way in which themes of embodiment illustrated women's subjective experience.

The 'medical' and 'natural' mother discourses were found to be restrictive, limiting the ways in which the participants were able to narrate their experiences. What is more, the subject positions taken up by the participants within these discourses found participants subjective experiences and needs coming second to attempts to adhere to 'good' mother status. These attempts were seen to leave the participants feeling exhausted, guilty, sad, confused and often isolated. The expression of frustration and anger heard in some of the narratives highlighted the desire to resist rather than conform to these discourses. In exploring embodiment, opportunities for resistance were found.

The participants' relationships to their bodies saw them attempt to conform to either a productive or feminine idealised norm. The productive body was regulated as an object devoid of subjectivity. Here their bodies were described as being subjected to reductionist, objective, rational standards valued by a Western society (Gear, 2001) and 'worked on' with little regard for the "*ethos*" of the person (Diprose, 1994, p. 19). In responding to their bodies as machines the participants described feeling isolated and disconnected from their bodies and their babies. They expressed being unable to fully embrace their maternal identity when involved with disciplining the body.

However, as suggested in the literature review the body did offer opportunities for resistance to the oppressions of dominant norms and discourses. The body was given 'voice' as in Alessandra's personification of her breasts, here providing an opportunity to embrace a communicative body (Bartlett, 2002). Moreover, in Bethan's narrative, different embodied positions were used to demarcate and hold multiple identities, demonstrating that the lived body can find ways to express itself multiply within linguistic confines. Finally, the 'bestial' body, neither defined by productive or feminine ideals but

rather embracing strength and perceptual inter-embodied communication was utilised by both Rachel and Esther as part of their identities as mothers.

4.2 Personal Reflexivity

Reflected on throughout the thesis has been my role as mother-researcher. Sciarra (2011, p.40) describes research involving personal experience, warning against “*going native*”. He describes the conflict in your position as expert and learner considering the dilemma faced between accentuating distinction between yourself and the participants which may result in difficulties allowing the participants to narrate for themselves. Similarly, Letherby (2002) expresses concern about analysing data from her own political, personal and intellectual position potentially resulting in making her voice the loudest. I am aware that during the course of this project my relationship to it has changed. Initially, my wounds were raw and I sought explanation and validation through the research; over the years of training I have found my convictions as a mother and professional women have grown stronger and more robust. I believe this to have been mirrored in my initial focus on external authority as the locus of control over mothering experiences to a more holistic and nuanced understanding which I have developed as the project comes to an end. I appreciate more fully now that a different researcher, or indeed me at a different time, would have heard the stories narrated quite differently.

Another dilemma I have faced has been in maintaining a critical ideological position whilst wanting to convey the unique experiences of the participants. Laura Brown (2004) suggests that we take a radical approach to feminist psychotherapy saying that undertaking such work ought to be “*a conscious and intentional act of radical social change*” (p. 30). However, Ussher (2002) warns against more radical views reminding us of the importance to

balance this with holding onto and being with real distress. Hearing women's narratives should involve empathy and acknowledgment of their emotional experience (Hubert, 2002). To simply examine discourse would again silence women and their subjective experience.

Harter (2009) states that: "*meaning does not reside in the mind or words of any single participant but rather emerges in the interfaces between people, stories and contexts*" (p.142). This ongoing construction was a dilemma during the process of attempting to preserve the uniqueness of the individual account, whilst assimilating concepts and themes. My aim to hear the idiosyncratic voice of women and privilege their subjective experience as 'expert' seemed at times to be jeopardised by the search for integrating themes (Bute & Jensen, 2011). I was pulled between the theory and the poignant experiences I had had with the participants. Arguing and interpreting the impact of discourse on the participants' narratives felt at times disloyal and unsympathetic. Letherby (2002) suggests the inevitability of such a dilemma acknowledging the impossibility of combining a full representation of participants with an assertion of work which makes a difference suggesting that either you speak for others or you relinquish your aims to produce research which creates political change. In her study of the female prostitute, Anna Jansdotter (2008) describes her attempts to retain the 'subject' who she describes as being "*just a figure circulating in a narrative*" (p.309). Keeping this image in mind, I absolved myself of the responsibility of gaining access to the 'subject' as unique from their context, remembering they are inextricably bound and that my critical position is not to provide an exact account but to understand a re-telling.

4.3 Epistemological Reflexivity

I will discuss two key methodological issues firstly, the use of image and secondly the micro-processes within the interview.

4.3.1 Making sense of visual data. The use of images in this study was helpful in eliciting narratives and giving participants initial control over the structure of the interviews. However, my inexperience led to a possible underutilisation of the images. A more integrated use of the images and direct questions may have led to the participants assisting in discovering the meanings of the image (Collier & Collier, 1986). Rather, the images were taken at face value and meaning and interpretation often applied during my analysis.

Furthermore, participants' engagement in the production of images might provide interesting insight into the participants' subject positions and experiences. For example, Alessandra was very engaged in the task, making collages from pictures. She followed the brief very closely and during the interview was apologetic for showing the 'wrong' image first. All of these processes seem to link to her attitudes to being a perfect mum, her high standards and cultural norms:

in my village...its 'oh no, she should be staying at home and listening to the children' and 'do you know that she stopped breastfeeding' and 'do you know that duh, duh, duh, duh, duh, duuh'... they put a lot of expectations on people (l. 414-418).

Bethan, on the other hand, seemed to engage in the interview as a polemic and many of her images relate to external political messages. Esther spent a lot of time preparing for her interview but her fragility was evident. In

trying to get the computer to display her images she became cross with herself when she couldn't, the implication being she gets it wrong just as her self-critical narrative sees her getting it wrong as a mother. Images can be seen to present an important opportunity to explore meaning making and process. The participant's engagement with the visual methods offers further insight into their subjective experiences which could be usefully explored.

4.3.2 Micro-processes. Whilst I made every effort to be mindful of my position and biases, I was aware that narratives are co-produced and that my own subjectivity would influence process. I therefore adopted Emerson and Frosh's (2004) idea of exploring micro-processes within the interview as part of my reflexivity exploring moment by moment interactions. These interactions remind us that a unique, transparent self, unaffected by social relations is not possible even in 'research conditions' (Diprose, 1994). I will illustrate this using an example. I suggest this might be useful in considering the therapeutic relationship, power structures within the therapeutic frame and ways in which dialogue and dynamics can both inhibit and enlighten our understanding of an individual's sense of being-in-the-world (Heidegger, 1996).

The example can be seen in an interaction between myself and Sarah, where in exploring her experiences I utilise a therapeutic 'script' taken from my Cognitive Behavioural therapy (CBT) training:

I: What did it say about you that things weren't going quite as you wanted them to?

Sarah: What do you mean what did it say about me? Like, wha, what, um what did it say about me? Well I suppose it's just out of your control isn't it, that you can't ever control these things but. I don't

think that fact that I cared about it so much was weird because I think, I think these are all really normal things to feel and I don't think they were unreasonable and I think most people in my situation would've probably have felt the same [I: mmm] but I don't really know what it says about me, maybe just that, that you know I just had normal feelings about it that everyone has always, no one has ever said you are unreasonable thinking like that [I: mmm] no one has ever [I: no] I think they are quite legitimate

I: Does it feel like that question was making them not legitimate somehow [Sarah: which] about asking what it says about you?

Sarah: No, I don't think so, no I don't think so, um no, I just don't really know how to answer it I suppose (l. 238-254).

In this exchange I ask Sarah what it said about her that she was having unexpected difficulties. The phrasing of the question is taken from scripts you might find in CBT when exploring a person's 'core belief' (see, Westbrook, Kennerly & Kirk, 2011). Sarah's response seems defensive and during the interview I felt wrong-footed and embarrassed; I attempted to explore the moment-by-moment process to understand Sarah's response. It could be seen here that my use of a phrase taken from a therapeutic model which itself is aligned to a reductionist paradigm, like the medical model Sarah feels disempowered by, reinforces a success/failure dualism and leaves Sarah feeling that her search for legitimacy is further undermined. She says she does not understand the question and it is possible that my search for an internal explanation, a core belief, does not fit with Sarah's externalising of the problem. Whilst I would still want to hear Sarah's subjective experience I might more

usefully have explored her feelings rather than individualising and pathologising her experience in asking what it says about her.

Inadvertently, I encourage an understanding of identity seen through individualistic and competitive discourses for which Psychology is often criticised (Fox, Prilleltensky & Austin, 2009). Highlighted in this exchange is what Milton, Craven and Coyle (2010) have described as the creation of a “*meta-narrative*”, which sees the therapist as the “*socially accredited expert*” (p. 64) reinterpreting an individual’s experience to fit a modernist model. It is argued that in this way people become objects, dehumanised and interpreted according to a particular meta-narrative, be it the “*tale of family romance*” (p. 64) as in psychoanalysis or the story of rational thinking as in CBT.

It was apparent in the micro processes of the interview that my different positions in relation to the research were present in the co-production of the participants’ narratives. This example sees me adopt my ‘therapist’ position which in this instance perhaps overrides the other ‘mother’ and ‘researcher’ positions. This is just one illustration and the micro-processes throughout all the interviews could make an interesting focus of future research, highlighting linguistic conflicts where each respective position is interpreting the exchange according to their own subject position.

4.4 Clinical Implications

The following section explores the clinical implications of the findings as relevant to Counselling Psychology.

4.4.1 Social justice. To deviate momentarily from breastfeeding I would like to share a story. Through doing this research and training my mind has been taken back many times to my previous job and my motivation for training. I

worked managing a floating support service for people diagnosed with severe and enduring mental health problems. Initially I was inspired by discussions around recovery, personalisation and empowerment and felt that I might challenge the stigma and exclusion surrounding mental health. However, I became increasingly cynical of the work of social care. I was consumed by rhetoric of empowerment and faced with a bleak reality that the language of social care didn't translate into action, change or experience for those we supported (Beresford, 2013). Jenny Morris, a disabled commentator, is critical of the use of 'care' highlighting how its meaning in support services has moved from that of love and caring 'about' to caring 'for' with its "*custodial overtones*" (1993, p.174).

It was this experience of feeling like a prison guard and 'jargon junky' that inspired me to train as a Psychologist, I wanted to learn how to truly hear people and understand their worlds, to understand how a reparative relationship with an individual might be transformative and healing. It was with these same principles that I approached my research and I have been surprised how the experience of motherhood and the experience of mental health service users have come together, how the threads of my personal and professional development have been woven into the same tapestry. Now, as when I left social care, I am left with a similar dilemma about how to move away from the rhetoric and into action. What follows in my discussions around social justice and therapy are my initial thoughts on how this might be achieved.

Community Psychology and Critical Psychology with their social justice agendas allow an important opportunity to challenge dominant discourses, avoid the pathologising of socially constructed symptomology and empower individuals to resist oppressive subject positions (Fox, Prilleltensky &

Austin, 2009, Rafalin, 2010). As has been demonstrated in the analysis, where there is power there is the potential for resistance and an opportunity to reinvigorate and diversify dominant discourses (Bordo, 2003). Counselling Psychology, both through research and clinical practice, can contest the status quo. By challenging realist assumptions around 'normality' and 'abnormality' which restrain and influence people's behaviour, we can alter the hierarchies of power (Milton, Craven & Coyle, 2010).

One place to begin is with the dissemination of this research. My hearing and interpreting the narratives presented here is to some extent a selfish act, as in doing so I am completing an aspect of my training which will lead to future employment. However, most of the participants asked who would hear about the research hoping that it might lead to changes in professional practice. To this end I am presenting my findings at the DCoP conference 2015, have already presented preliminary findings at the Psychology of Women's conference 2013 and have set up links with local midwives and a Perinatal service at which I have worked in order to share and discuss the results.

I have explored the ways in which the medical model reinforces a Cartesian dualism and individualises and pathologises behaviour (Carter, 1995; Fox, Prilleltensky & Austin, 2009; Newnes, 2011). Therefore, I suggest it is important to think about ways in which we might challenge this model as mental health practitioners. This is not an easy task as often Counselling Psychologists find themselves working in contexts which adhere to the medical model, for example the NHS. In medical models, the individual is treated as the locus of pathology which can divert attention away from the sociocultural context (Milton, Craven & Coyle, 2010). Goldie (1977) describes three positions available to non-medical professionals in relation to the medical model. The first is one of

compliance which involves not disturbing the status quo and standing alongside the medical model for example in the use of psychometric tests. Secondly, there is eclecticism, which involves a continued collaborative endeavour but with attempts to offer alternative explanations to diagnosis; an example might be the advocating of therapy alongside medication. Thirdly, there is radical opposition, which Goldie argues leaves Psychologists with no alternative than for fight or flight i.e. to stand against the medical model which he suggests is not possible from inside the profession or to leave the profession and find alternative positions from which to oppose the model. There is pessimism in these options presented by Goldie and I believe alternatives are available, especially to Counselling Psychologists. I would like to offer some thoughts on possible ways to oppose the medical model from within the profession, empowering both our clients and us as clinicians. I suggest this to endeavour to be twofold, addressing ways to promote an egalitarian agenda and investigating how the use of the body in therapeutic intervention might resist modernist principles in therapy.

4.4.2 Challenging oppressive discourse. The first part of the aforementioned endeavour would see Counselling Psychologists finding ways to challenge oppressive discourses. As argued by Ryan, Tordes and Alexander (2011), I would suggest introducing an alternative discursive model, which highlights the socially constructed and linguistically dominated understanding of subjective experience, into the therapeutic encounter. In so doing the silencing and oppression of women might be limited. To make this achievable it is necessary to acknowledge power differentials and move away from the idea that changed minds leads to changed lives. Therapy has been criticised for reinforcing the false pretence that people's fate can be controlled by the use of psychological

resources *within* the individual (Smail, 2011). Embracing Community Psychology's concept of second order change, presents an opportunity to challenge discourse and systems of oppression and to seek change beyond the individual (Orford, 2008). The ambition to embrace a critical and constructionist position could be seen to conflict with Counselling Psychology's phenomenological aim to privilege individual experience within the therapeutic encounter (Strawbridge & Woolfe, 2010). In order to create new discursive practices and challenge social or moral corruption we encounter in therapeutic exchanges Counselling Psychologists' must make challenging decisions about their roles.

Finding ways within the therapeutic encounter to contest social injustice challenges practitioners to step outside of their roles. Studies have indicated the difficulty clinicians have in making explicit their egalitarian agenda through fear of backlash and a pull to be value-neutral when developing a therapeutic alliance (Kagan & Tindall, 2002). However, formulation offers a valuable opportunity to create a holistic and integrative understanding of a person's experience embracing all levels of the story a client has shared (O'Brien & Houston, 2007). Furthermore, authors have advocated Counselling Psychologists using their expertise and pronouncing their values outside of the therapy room to induce political and societal change (Goodman et al., 2004).

4.4.3 Body work. For the second part of the aforementioned endeavour to promote an egalitarian agenda, I advocate listening to the embodied experiences of women and how these interact with the assumptions and preoccupations of the historical and sociocultural context. Therapeutically this calls on clinicians to engage in a dialogue which emphasises the experience of individuals in all its complexity, being careful not to privilege or separate the

body from being and knowing, or being and knowing from its social constructions (Tordes, 2007). Reconstructing our understanding of subjectivity to include the body requires a shift from the two dominant discourses explored in this thesis, the 'medical' and the 'natural' (Brown et al., 2011). These discourses have been problematised in this research where women have been seen to struggle to make sense of their difficult breastfeeding experiences resulting in isolation, frustration, guilt and confusion. For body psychotherapists this is not a new concept as they understand the body to be a "*physical manifestation of something much larger and less definable*" (p. 93, see also Young, 2006).

Diprose (1994) challenges how we understand and explore our sense of 'being-in-the-world' (Heidegger, 1996). She raises the question of whether 'being' is determined by mind or matter and how the two relate. Psychology has built its understanding of the individual on principles of cognitivism; the mind holds the key to a person's power and free will (Burkitt, 1999). A trend towards the denial of bodily experiences and a growth of understanding about the brain (Young, 2006) has seen therapy increasingly concerned with cognitive processes. Such structuralist approaches allow dualisms to thrive; subjective experience becomes intertwined with dominant power discourses (Burkitt, 1999). Indeed the current prominence of CBT reinforces a belief that rational thought is a more reliable (and measurable) channel to improvement than the exploration of emotions or body work (Feltham, 2008). It has been argued that such a linear approach to therapy demotes the complexity of human experience, reducing it to seeing people as information processing machines (Johanson, 2009). Furthermore, therapies focused on outcomes and goals imply that a homogenous world is possible and

reinforces oppression and marginalisation (Fox, Prilleltensky & Austin, 2009). I argue that a therapeutic endeavour which fully acknowledges our embodied experience is one way to avoid such marginalisation.

Outlining its numerous uses in the therapeutic encounter, Young (1996) argues that the body can be utilised in multiple ways: a source of information on a client's state of being, a repository of emotions and memories, an entry point for change and a vehicle for psychological intervention and somatic counter transference. Emphasising the body in this way can be seen to redress the mind/body hierarchy and encourage clients to "*listen to and trust the wisdom of their bodies*" (Mize & Iantaffi, 2013, p.63).

However, in my experience of practice and training, Counselling Psychologists are yet to fully embrace body-orientated psychotherapies so as to address the needs of clients who have become cut off from their corporeal reality (Connolly, 2013). In searching for articles relating to Counselling Psychology and body work, body, body interventions or body therapy the database 'PsychInfo' yielded no specific results. Only one special edition of 'The Counselling Psychology Quarterly' (2008), which related to multi-cultural practice and traditional healing, was found.

Mehling et al. (2011) have suggested that one reason for the lack of uptake by Psychology of such body-orientated approaches is that the conceptualisation of the body has been dominated by concerns that heightened awareness leads to somatosensory magnification. Body awareness is framed negatively in conceptualisations of anxiety and panic disorders, seen as cognitive dysfunction whereby an individual becomes overly focused on physical symptoms, rumination, and beliefs of catastrophic outcomes. These

understandings reinforce the pathologising of experience and encourage a narrative of the unruly body (Bordo, 2003).

Blood (2005) suggests drawing from spiritual ideas, for example those contained in Buddhism, which do not view the body as a “*cut off, flawed aspect of ourselves but integral to who we are and to be cherished*” (p. 128). Experiencing ourselves compassionately as embodied beings is central to many mind-body approaches, for example yoga, Tai Chi and Mindfulness (Mehling et al., 2011). This idea raises an important point about this research which is that it takes a distinctly Western perspective. Eastern and indigenous practices of traditional healing have long held the body as the central medium through which to achieve physical and psychological health (Moodley, Sutherland & Oulanova, 2008; McCabe, 2008; So, 2008). Non-western medicine is grounded in mind-body holism and therefore makes it an obvious place for the West to turn to find ways to introduce the body into therapy (So, 2008). However, adopting Eastern principles into a Western medical model is not easy. For example, I have heard clinicians speak of the “*MacDonaldisation of mindfulness*” (personal communications, 2014) warning of a mass produced and reductionist version of treatments which adhere to the demands of the NHS. These warnings follow on from criticism of the uptake of therapeutic models such as CBT, argued to have become a “*freeze-dried*” version of the original model (Mansel, 2008, p.265), with its application based not on its effectiveness but it’s comfortable integration into existing cultural and institutional power arrangements (Guilfoyle, 2008). Despite these warnings, Mindfulness is being steadily adopted into practice and NICE guidelines (2009).

Defined as “*a form of self-study in which we observe our present experience with curiosity and without judgment*” (Mize & Iantaffi, 2013, p.64),

mindfulness practice is achieved through the self-regulation of attention, an orientation towards the self in the present moment and a focus which is curious, open and accepting (Bishop et al., 2004). Mindfulness is not a practice which distinguishes mind from body but in emphasising the body it encourages embodiment and enhances individuals' capacity to be connected to their physical selves. It utilises the body in two ways to explore the mind-body relationship. Firstly, it can explore mental-emotional material evoked when undertaking body-centred interventions, such as a body scan, or secondly, in noticing how the body responds to some mental-emotional experiment (Johanson, 2009). For example we may ask Esther how her body responded to the internal dialogue she described when using a breast pump: "*bad mum, bad mum*" (l. 609). The purpose of such an intervention is to increase awareness in the present moment, preventing moving too quickly away from the "*experience-as-lived*" (Stern, 2004, p. 38), in turn challenging fixed narratives such as Esther's, which can result in derogatory feelings about the self and the body. Johanson (2009) suggests that mindfulness can allow clients to move from 'being' symptoms to 'having' symptoms, creating a crucial distance which allows for a reduction of self-critical interpretation of the body and self.

It is argued in embodiment theory and seen in the results from this research that certain constructions of the female body lead to feelings of inadequacy, shame and self-hatred (Blood, 2005). These feelings can be seen to be bound to a cognitive engagement with the body as it becomes mediated by observational judgements, in turn denying body ownership (Connolly, 2013, Roberts & Waters, 2004). The construction of the self as an object for others' gaze is suggested to result in '*de-selfing*' (p. 16), argued to deny subjectivity (Roberts & Waters, 2004). It is suggested that CBT can be used to challenge

assumptions associated with bodily inadequacy and that highlighting the cultural discourse which underpin these assumptions might empower individuals to have a more realistic and compassionate relationship with their bodies (Roberts & Waters, 2004).

Mehling et al., (2011) have argued that crucial to any body-orientated intervention is that it encourages integrity of the self. They asked a variety of practitioners involved in body awareness therapies to describe their theoretical positions. In describing integrity of self, the practitioners expressed a concern for individuals to embrace themselves as embodied beings, able to integrate the mind and body and view their bodies as knowing. The emphasis is on an overarching self-awareness not purely as a cognitive activity but as a physical, mental and emotional interaction. Furthermore, they described that many patients seek support for the body, but that in fact the treatment required is to reinforce denied embodiment. This bodily integrity was seen to be lost during the difficult breastfeeding experiences of participants in this research and it has been argued that adopting a mind-body holism into Psychological treatments might assist in reinstating such lost integrity.

4.5 Summary of Clinical Implications

In the discussion I have outlined a two pronged approach to address concerns raised by the findings of this research. Firstly, describing ways in which a social justice agenda might be used by Counselling Psychologists, both within research and clinical practice, to promote therapy as an emancipatory and egalitarian practice. This has been argued to involve reflection by individual practitioners and within the discipline more broadly about conflicts arising from our epistemological values. Secondly, I have outlined the benefits of utilising body work in therapy to challenge the mind/body dualism which was pervasive

in the narratives explored in this study and can be found throughout the medical establishment. In line with many authors I suggest that encouraging an embodied and integrated sense of self allows people to challenge notions of cognitivism, the unruly body and a linear and deterministic view of lived experience (Blood, 2005; Bordo, 2003; Johanson, 2009; Mehling et al., 2011; Roberts & Waters, 2004).

Conclusion

The findings of this research concurred with the suggestion that we construct meaning and understand ourselves according to context but are also influenced by our embodied experience (Manafi, 2010). The discourses described were the 'medical' or 'natural' mother discourses, both underpinned by a Cartesian dualism which was here seen to reinforce disembodied, disconnected and disempowered subjective experiences.

Returning to my reflective journal I recognised the clinical challenge with which the results of this study left me. At the end of Hannah's interview I sat on a bench waiting for my taxi. I felt sad and anxious, somehow disturbed by how she had drifted upstairs with her baby at the end of the interview, leaving me to let myself out. With other participants I left feeling dominated and beaten by their narratives and yet also no closer to them as individuals. Reflecting on these experiences I wondered if they speak of what is left for those who cannot find a satisfactory subject position: sad, anxious and lost like Hannah or angry and defended as others. Shildrick (1997) would perhaps argue that what we see here is that the essential difference between men and women leaves women in a helpless position of either replicating male standards of disembodied rationality and autonomy or accepting the isolated, irrational embodied subject position. However, seen in the results were resistances to dominant discourse, for example the 'bestial' inter-embodied experiences described by Rachel and Esther and the 'protest and retreat' explored in Bethan and Esther's narratives (Bordo, 2003, Ryan, Torders & Alexander, 2011). The implication is that women are not accepting of the 'essential difference' described by Shildrick, and their embodied subjectivity provides a powerful site for communicating this.

Furthermore, in the discussion I have suggested the possible avenues for creating new discursive practices in the therapeutic setting. In line with the writing of Merleau-Ponty (1968), I have argued that embracing the body as a central medium in understanding lived experience might provide opportunities to critique existing representations of women, to elaborate new understandings and to allow for less homogenous, oppressive ways to interpret peoples' subjectivity (Bradotti, 1997). The findings of this study positioned the body as an object for others whilst also a lived reality for the subject, with the relationship between the two mediated by discourse and dualism which privileges the mind (Grosz, 1994). However, by refusing to regulate experience as a given category but recognising it as bound by social, political and historical forces and by accepting lived embodied experience as directly relevant to the production of knowledge, these discourses can be challenged and our understanding of lived experience broadened (Burkitt, 2003).

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Appendices

Appendix 1: Ethical procedure and consent

The study requires ethics approval via UEL. Detailed below is the ethics procedure undertaken, followed by the ethics consent form and amendment to ethics form.

Informed consent: Following advertising of the study, information about the study will be provided to all respondents. This will include the contact details of the Research Team (the student and supervisor) so that potential participants can find out about the study in further detail. Participants will be given time to consider the letter and their participation. Before interviews commence, the researcher will discuss and outline the consent process with participants and obtain informed consent. Information for participants outlines the purpose and nature of the research, what involvement in the research means for participants (in terms of times, activities), voluntary participation, anonymity and confidentiality (including explaining in what circumstances confidentiality would be breached and how this would occur).

Anonymity and confidentiality: Participants will be informed in both written materials and in discussions of their right to withdraw from the study at any time. Any data which may have been collected prior to a participants' decision to withdraw from the study will be destroyed. Personal information gathered will include names of the participants' and perhaps their babies or other family members and email/postal addresses. This personal information, audio recordings and transcripts will be saved on computer files. This information will only be accessed by the researcher and will be destroyed at the end of the research project. To ensure confidentiality, real names and any identifying information will be removed from transcripts and the reporting of data. Anonymised transcripts and audio recordings will be kept on computer for up to six years after the study ends and the participants will be informed of this in written material. Paper copies of transcripts will be kept in a locked file in the researcher's home or at UEL. Audio recordings will be erased from the audio recorder once audio file has been saved on computer.

Protection of participants: Interviews will take place at a mutually convenient place. Participants will be offered a private room at UEL or for the researcher to come to their home. The agreed place will be private, comfortable, quiet and safe for both participant and researcher. The interviews will cover sensitive, potentially upsetting issues, relating to a difficult breastfeeding experiences and early motherhood. The information letter will explain the nature of the research and the potential that sensitive issues will be discussed. The interview letter will detail organisations which the participant may wish to use for support prior to or following the interview. Should the participant become distressed during the interview the researcher will ask if they wish to stop, either to take a break or to discontinue. Following the interview regardless of expressed distress the researcher will remind the participant of support organisations. Before the interview commences, consent will be discussed and participants invited to raise any issues. Debriefing for participants will include checking in to see how they found the interview process and with appropriate signposting to services for further support.

Please note:When thinking about exclusion and inclusion criteria for participants, I began by excluding women who were still feeding considering the possibility that the emotional arousal in the immediacy of the situation may impact on the participants' ability to analyse their experience (Pals, 2007). However, during recruitment a number of women asked to participate who were still feeding, though no longer experiencing difficulties. I neither wanted to deny participation nor limit interview opportunities so the criterion was changed to include these women. In doing so I considered the impact of the interview including the participant's well-being and any potential impact on the continuation of breastfeeding. Ethics was amended and approved accordingly.

Potential risks to the researcher have been considered and may include exposure to distressing information and to health and safety risks relating to the field location of the interviews. Should the agreed place be the participants home the researcher will inform an appropriate person of the location and duration of the interview to ensure their safety. The researcher will have access to regular supervision to raise any issues as they arise over the course of the study. The researcher will make use of the therapy they are engaged in as part of their ongoing training on the professional doctorate.

Ethical approval form

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: Laura McGrath

ASSESSOR: Mike Chase

STUDENT: Rebekah Fowle
assessor): 06/02/2013

DATE (sent to

Proposed research topic: Exploring the mother infant dyad following difficult breastfeeding experiences

Course: Professional Doctorate in Counselling Psychology

1. Will free and informed consent of participants be obtained? YES
2. If there is any deception is it justified?
N/A
3. Will information obtained remain confidential?
YES
4. Will participants be made aware of their right to withdraw at any time? YES
5. Will participants be adequately debriefed?
YES
6. If this study involves observation does it respect participants' privacy? NA
7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically? NA
8. Is procedure that might cause distress to participants ethical?
YES
9. If there are inducements to take part in the project is this ethical? NA
10. If there are any other ethical issues involved, are they a problem? NO

APPROVED

	YES, PENDING MINOR CONDITIONS	
--	--	--

MINOR CONDITIONS:

Is videoing and analysis of 'non verbal communication' necessary? Supervisor and supervisee should discuss what value that will add; whether it will help or ethically hinder the study given the "sensitive" topic. If videoing Ps is judged to be warranted then I would expect a referenced theoretical framework to analyse the data + more consideration of the ethics of videoing and data management (although I acknowledge some of this detail was incorporated in the numerous consent forms).

Will permission from website administrators be sought before the researcher advertises and 'snowballs' the study?

The invitation letter is vague and I would like to see more explanation in places e.g., wouldn't a naive participant want a bit more guidance about what is meant by "images"? I understand that the researcher does not want to be too directive but it is also important that the Ps are fully aware what they are consenting to.

I think that in the Debrief Ps could again be reminded of support organisations available to them should issues surface after the researcher has gone.

REASONS FOR NON APPROVAL:

Assessor initials: MC

Date: 20th February 2013

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: Laura McGrath

ASSESSOR: Mike Chase

STUDENT: Rebekah Fowle
06/02/2013

DATE (sent to assessor):

Proposed research topic: Exploring the mother infant dyad following difficult breastfeeding experiences

Course: Professional Doctorate in Counselling Psychology

Would the proposed project expose the researcher to any of the following kinds of hazard?

- | | | |
|----|--|----|
| 1 | Emotional | NO |
| 2. | Physical | NO |
| 3. | Other
(e.g. health & safety issues) | NO |

If you've answered YES to any of the above please estimate the chance of the researcher being harmed as: HIGH / MED / LOW

APPROVED

YES		
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MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: MC

Date: 20th February 2013

For the attention of the assessor: Please return the completed checklists by e-mail to ethics.applications@uel.ac.uk within 1 week.

SCHOOL OF PSYCHOLOGY

Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of
East London
www.uel.ac.uk

School of Psychology
Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,



Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

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The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853



UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Mark Finn (Chair of the School Research Ethics Committee).

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Mark Finn at m.finn@uel.ac.uk
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
3. A copy of the approval of your initial ethics application.

Name of applicant:	Rebekah Fowle
Programme of study:	Professional Doctorate in Counselling Psychology
Title of research:	
Name of supervisor:	Dr Laura Mcgrath

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
Changing the inclusion criteria to include women still breastfeeding but no longer experiencing difficulties.	During recruitment a number of women asked to participate who were still feeding, though on longer experiencing difficulties. I neither wanted to deny participation nor limit interview opportunities so the criterion was changed to include these women.
Interviewing participants over Skype.	I wanted to hear the stories of as many women as possible but I had few respondents from London and travel costs were increasing, Skype is a more affordable and realistic way of interviewing these participants. Though video will be used so as to be 'face to face' this will no longer be an interview in person and could result in some technical difficulties or less ability to maintain privacy.

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	x	

Student's signature (please type your name):

Rebekah Fowle

Date:

07.06.2014

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments		

Reviewer: M Finn

Date: 12/06/14

NB: Wording but not formatting appeared online



Are you a first time mother?
Did you breastfeed your baby?
Did you find the experience difficult?

I am interested in understanding the experiences of women who breastfed their baby and the difficulties they encountered. I hope to understand how this experience impacted on your image of yourself as a mother and your relationship with your child. I also hope to understand how this may have been influenced by external factors such as peers, family and wider society.

If you are aged between 25 and 35, stopped breastfeeding your first child no more than one year ago, found the experience difficult for whatever reason and are interested in sharing your experience for the purpose of my research, then please contact me and I can provide you with further details of what the study will involve.

Thank you

Rebekah Fowle

Counselling Psychologist in training

u1100527@uel.ac.uk



UNIVERSITY OF EAST LONDON

School of Psychology

Stratford Campus

Water Lane

London E15 4LZ

The Principal Investigator

Rebekah Fowle

E-Mail: u1100527@uel.ac.uk

Phone: 07517216546

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this research study. The study is being conducted as part of my Professional Doctorate in Counselling Psychology at the University of East London.

Project Title

Exploring the mother infant dyad following difficult breastfeeding experiences

Project Description

This research hopes to explore mother's experience of breastfeeding, in particular how difficulties in breastfeeding impact on a mother's identity and her developing relationship with her child. It also strives to understand how social and political ideas about breastfeeding may impact on a mother's experience. This research contributes to Counselling Psychology by addressing therapeutic concerns and the role of the discipline in bringing about social change.

You will be asked to take part in an interview which will ask questions regarding your experience of breastfeeding. The interview will last approximately 60 minutes and will be audio recorded in order that it can be transcribed for subsequent analysis. Prior to the interview you will be asked to consider and

bring with you up to six images relating to your experience of breastfeeding. These images will be used as part of the interview process and copies will be taken for use in the write up of the study and any subsequent publications. Consent relating to the reproduction of images will be discussed and confirmed prior to the start of the interview.

I acknowledge that the topic of the research is personal and sensitive and may be difficult for participants to discuss. Therefore I would draw your attention to the following organisations that may provide support prior to or after participation:

Family Lives: www.familylives.org.uk

or 0808 800 2222

Parenting UK: www.parentinguk.org

or 020 7553 3080

For general support with mental health and counselling:

MIND – www.mind.org.uk

or [0300 123 3393](tel:03001233393)

SANE - www.sane.org.uk

or 0845 767 8000

Confidentiality of the Data

Your identity will be protected and confidentiality maintained by keeping your name and contact details in a safe place that only I have access to. This information will not be shared with anyone else. The data collected will be treated confidentially by anonymising - changing all names and identifying references (e.g. a name of a place) in the transcriptions of interviews. Following the transcription of the interview and the selection of video stills recordings will be destroyed. My research supervisor and examiners will read extracts from the anonymised transcriptions of interviews. Anonymised transcripts and visual aids will be kept in the event of any further research or publications in which the data will be used. Data will be kept for no more than 6 years.

In the event that a serious or imminent risk is identified confidentiality may be breached. This would involve first notifying my supervisor and then if

appropriate external organisations for assistance. You will be made aware should confidentiality need to be broken.

Location

The interviews will take place at a mutually convenient place and time. This may be in a private room at the University of East London or if preferred in your own home. If preferable and possible the interview can be conducted over Skype.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this information letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor **Laura McGrath**, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Telephone: 0208 223 2695. E-mail: l.h.mcgrath@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: **Dr. Mark Finn**, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Thank you in anticipation.

Yours sincerely,

Rebekah Fowle



UNIVERSITY OF EAST LONDON

Exploring the mother infant dyad following difficult breastfeeding
experiences

Consent to participate in a research study

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me that anonymised transcripts of the interview and visual images provided will be shared with the research supervisor and examiners.

I understand that in any instance where there is a serious or imminent risk identified confidentiality may be breached.

It has been explained to me what will happen once the research study has been completed.

Full consent

I hereby freely and fully consent to participate in the study which has been fully explained to me. I agree to the reproduction and use of the visual aids and anonymised transcripts in the write up of the study and any subsequent publications. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

Date:

Additional levels of consent

Transcript only

I am aware that the transcript will be anonymised and shared. I freely and fully consent to these extracts being used in the write up of this study and any subsequent publications. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

Date:

Visual images

I am aware that I will be asked to provide visual images as part of the interview process and I freely and fully consent to the following images being copied and used in the write up of the study and any subsequent publications.

Please circle as appropriate: Image 1 / Image 2 / Image 3 / Image 4 / Image 5 / Image 6

Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

Date:

Visual images with faces blurred

I am aware that I will be asked to provide visual images as part of the interview process and I freely and fully consent to the following images being copied and used in the write up of the study and any subsequent publications if any faces are blurred in the printed images.

Please circle as appropriate: Image 1 / Image 2 / Image 3 / Image 4 / Image 5 / Image 6

Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

Participant's Signature
.....

Researcher's Name (BLOCK CAPITALS)
.....

Researcher's Signature

Date:

Appendix 5: Image instructions and interview schedule

Image instructions

The following information will be provided to participants prior to the interview.

Before the interview I would be grateful if you could collect some images, e.g. personal photographs, pictures from magazines, which you feel say something about your experience of breastfeeding. Please bring these images (up to 6) with you for the interview. I will ask, with your consent, to take copies of these images when we meet. During our time together, I will ask you to tell me more about your chosen images and I may have some more questions about these and your experiences.

Interview Schedule

Ask the participant to place the images on the table for us both to see.

Can you tell me about each of these images in turn?

Prompts

- What made you chose that image?
- What can the image tell us about your experience of breastfeeding?
- How do you feel about the image?

Additional questions

These may be asked at any point during the interview and may be used repeatedly as necessary.

Identity

How did that make you see yourself? / How do you see yourself?

How did you understand that experience?

What did that say about you?

How do you see your life over the next few months?

How do you see your life developing?

Prompts

- What sort of person do you think you will like?
- What do you think you will feel like?

Image of the child

How did that make you feel about [child's name]?

How did you respond to [child's name]?

What did that say about your relationship with [child's name]?

External factors

What motivated that decision to breastfeed?

Can you tell me a bit about the breastfeeding experience as a whole?

Prompts

- How were you treated by professionals?
- Who else played a role in your experience?

What were your expectations of breastfeeding?

Prompts

- How were these expectations created?
- How did this differ from the reality?
- What were other people's expectations – partner / mother / midwife

General prompts

- When was that?
- How did that come about?
- Who else was involved?
- Where did that take place?
- How did that make you feel?
- How did you understand that?
- What impact did that have on your relationships?
- Can you tell me more about...?

Appendix 6: Use of images

Images used in this thesis were reproduced following consultation with and guidance from the University of East London Vice Chancellor's Group, Governance and Legal Services.

All images used in the thesis and appendices were reproduced following attempts to gain explicit consent from the manufacturers, publishers or producers of the images. Where consent was granted this is made clear in the full text and specific correspondence detailed below. Where attempts for consent were made but not responded to images were reproduced for educational purposes in accordance with the fair dealings exception to copyright law.

E-mail sent to manufacturers/producers of images used:

"To whom it may concern,

I apologise if this e-mail is reaching the wrong person and I would be grateful if you could re-direct it in this instance.

I am a Counselling Psychologist in training at the University of East London. I am completing a PhD looking at women's experiences of breastfeeding. As part of the process women bring images to an interview. A participant has used an image of [details of image] and I am e-mailing to ask your permission that this image might be reproduced in my thesis?

Many thanks

Rebekah Fowle"

Replies from relevant parties:

Solgar Vitamin and Herb (Fenugreek image):

"Dear Rebekah,

Many thanks for your email requesting permission to use the image of one of our products.

The image you have googled is a US image, so I have attached a UK image, and we are happy for you to use this image.

Best wishes,

Lesley Constable

Sales and Marketing Manager

Solgar Vitamin & Herb

Aldbury

Tring

Herts

HP23 5PT”

St John’s medical journal (cracked nipple image)

“Dear Rebekah,

Please go ahead. We grant you permission to use the image. Apologies for the delayed reply. If you have already used the image that is also OK with the editorial team.

Ramesh.A

Editor

St John's Medical Journal”

Artansa (Boppy pillow advertisement)

“Dear Ms Fowle,

thank you for you e-mail and informing us of your intention to use the attached image in your thesis.

About advertising, Artsana authorize you to reproduce the image in your thesis, even if we can’t guarantee for any issues of the woman.

Feel free to contact me if you have any question.

Kind regards

Daniela Bigliati

Legal Dpt.

Artsana S.p.A.”

Medela (Hospital breast pump, home breast pump and feeding cup images)

“Hi Rebekah,

You are fine to use the images you require, thanks for checking.

Would it be possible for you to kindly send over a copy of your work when complete please?

It sounds really interesting, good luck with completion.

Kind Regards,

Stephen Ryan

Marketing Assistant”

Dr M.D. Mazumdar (Gynecology online, engorged breast image)

“Rebekah,

Please feel free to go ahead and use the image. Best wishes.

Sincerely,

Dr. M.D.Mazumdar”

Appendix 7: Narrative frameworks (adapted from O'Shaughnessy, Dallos & Gough, 2013)

Alessandra's story

i. Abstract

Alessandra begins her story describing her lack of preparation for breastfeeding. She describes how this lack of preparation seems to have resulted in her uncertainty about her difficult experience and how to manage it. She describes the variety of ways in which she approached the pain and low milk supply she experienced.

Alessandra describes the resulting isolation and separation from her son she experienced. She describes how she came to discontinue breastfeeding.

ii. Orientation

She described that she was a 29-year-old woman, living with her husband and her parents in her childhood home, where the couple had returned during her pregnancy for financial reasons. At the time of the interview Alessandra was no longer breastfeeding and her son was 6 months old.

iii. Complicating action

Alessandra described the pain she experienced during her initial feeds and this leads to a narration of events during which she reports the ways in which she tried to overcome this pain and continue breastfeeding.

iv. Evaluation

Alessandra returns many times to the theme of 'bonding' and 'being a mother.' She seems to associate the difficulties in breastfeeding and the methods she employed to improve this, including breast pumps and a lactation consultant as interrupting her abilities to mother and make a connection with her son. She speaks of various measurements, quantity of breast milk, weight gain and time as if struggling with the measure of motherhood and how to quantify her

relationship with him. This use of the medical discourse seems also to be an avoidance of the guilt experienced by the physical separation these measures created between her and her son.

v. Resolution

Alessandra describes how her decision to stop breastfeeding and bottle feed her son renewed her confidence in her mothering abilities, resolved her feelings of separateness from both her son and her husband and allowed her to begin reclaiming her body, which she also describes becoming distant from using metaphors of machinery and productivity.

vi. Coda

Alessandra ends her narrative speaking of ways in which services could be improved for breastfeeding women. The narration becomes generalised and she seems less connected to her account. The presence of her son during the final 20 minutes may account for the avoidance of an internal response to her narration.

vii. Tone of the interview

Alessandra was tearful but engaged throughout the interview. She was at times apologetic of her use of images and the way in which she expressed herself, perhaps relating to her feelings of shame and inadequacy surrounding her narration. Her tone indicated her movement between what seems to be an internalised and externalised position where her voice could be heard to be assertive, angry and disappointed when drawing on externally mediated discourses and sad, guilty and reflective when drawing on internally mediated experiences.

Sarah's story

i. Abstract

Sarah begins her story with a long account of her labour experiences including her expectations and the more traumatic reality she

experienced. She describes the pain she experienced feeding, her daughters reflux and the lack of support she received, feeling her requests were unheard and ignored. Sarah narrates how she overcame her difficulties to continue to breastfeed and the impact she feels her experiences had on her well-being and identity.

ii. Orientation

Sarah describes herself as a 25-year-old woman, living with her husband. At the time of the interview her daughter was 18 months old and Sarah had discontinued breastfeeding though not due to her difficult experience but through a decision to wean at one year.

iii. Complicating action

Sarah describes her isolation on the ward following the birth of her daughter and her intuition that breastfeeding was not going 'right.' She explains that the lack of support offered resulted in difficulties with feeding and her daughters continued painful experience of reflux.

iv. Evaluation

Sarah reports the experience of being ignored and unheard during her labour and it seems that this experience goes on to define her relationship with medical services following her daughter's birth and during the difficult breastfeeding experience. Sarah describes her 'battle' with services as deepening her relationship with her daughter for whom she tried to advocate. It seems that her identity as a mother was challenged by her feelings of disempowerment, felt especially in relation to services but also within her husband's family where she spoke of feelings of jealousy at being separated from her daughter by older generations of women.

v. Resolution

The diagnosis of a tongue-tie and reflux in her daughter seemed to provide Sarah with the validation she was seeking and also resulted in the treatment of both conditions allowing breastfeeding to continue.

vi. Coda

Sarah ends her narrative speaking of a loss of what she describes as the 'honeymoon' period with her daughter but reflective about how she remained strong and coped with her difficult experience.

viii. Tone of the interview

In Sarah's narrative there was an implicit tone of resentment and anger that her expectations of her daughter and herself were not met. However, it seemed the explicit anger directed towards health services may have been an avoidance of these internal experiences. Moments in the interview were challenging as it was hard to elicit Sarah's internal interpretation of events as it seems these were received as criticisms and Sarah's objective for participating seemed to be to engage in a polemic about services. This may also explain the few images and the seeming lack of preparation prior to meeting with me.

Bethan's story

i. Abstract

Bethan describes her frustration at the image presented of what to expect from your breastfeeding experience. She draws on images from the NHS and advertising to illustrate her expectations and narrates her reality as challenging, lonely and unenjoyable. She speaks about her experience of her son's weight gain and her feelings around his not adhering to the NHS charts on this matter. Bethan describes how she dealt with her unenjoyable experience and how this has informed her expectations of being a mother for a second time.

ii. Orientation

Bethan describes herself as a 30-year-old woman living with her husband. At the time of the interview her son was 2 years old and she was 7 months pregnant with her second child. Bethan had

discontinued breastfeeding at one year due to a decision to wean him at this age.

iii. Complicating action

Bethan speaks of her exhaustion and isolation when breastfeeding, the lack of recognition from others and the feelings of loneliness that accompanied this.

iv. Evaluation

Bethan describes how much she wanted recognition and praise for breastfeeding, especially as her experience did not match the enjoyable and effortless image presented to her in media and promotional literature. It seems that the lack of recognition resulted in her becoming 'defensive' and she describes a determination to succeed that became a mantra for her experience. She also spoke of the loneliness and frustration which accompanied this and it seems finding ways to maintain her identity prior to motherhood, including smoking, enabled her to minimise these feelings. Bethan also speaks of her imaginings of the future ahead of her and her son, without breastfeeding and with more interaction and verbal communication as being part of her coping strategies and transition into her new role.

v. Resolution

Bethan describes how she continued to breastfeed and used the challenge to succeed as her motivation. Bethan's determination and defiance seemed to mediate the internal conflict stirred up by her experience.

vi. Coda

Bethan talks about her relationship with her body and her self-identity before motherhood and the loss she experienced due to changes in these brought about by breastfeeding. She explains that she feels her relationship with her son was less affected by breastfeeding than her relationship with herself. During breastfeeding she reflects that she became a 'feeder rather than a person.'

vii. Tone of the interview

Bethan was engaged throughout the interview and often employed humour in the narration of her experiences. Her anger and defiance were explicit though at times she generalised her experiences it seems to minimise some of the more painful feelings of loneliness and loss.

Hannah's story

i. Abstract

Hannah describes her expectations to breastfeed exclusively for 6 months and her strong desire to feed into her son's toddler years, explaining that this seemed natural and had been what her mother had done. Hannah describes her experience of pain in her nipples during her feeds. Hannah describes how she sought support to alleviate this pain and how her confidence with feeding gained over the following months but never to her prior expectations. Hannah explains that following the introduction of solid food her son had weaned from the breast earlier than she had imagined she would stop feeding. At the end of the interview Hannah describes expectations for a more co-dependant relationship with her son but anxiety about his development.

ii. Orientation

Hannah describes herself as a 34-year-old-woman living with her husband one year old. Her son was present throughout the interview. On occasion the recording was paused and once stopped so she could attend to him. Hannah was not breastfeeding at the time of interview.

iii. Complicating action

Hannah begins by describing her expectations of breastfeeding and the feelings of bliss and happiness at her son's arrival home from the

hospital and how this had changed in the middle of the 11th night home when she began to experience nipple pain during a feed.

iv. Evaluation

Hannah speaks of her desperation to resolve her difficulties and the feeling she had that she was a failure. It seems that the idealised image she had of herself as a breast-feeder made it harder to accept the difficulties and Hannah spoke of her feelings of loss that her difficulties interrupted 'precious time' with her son. Hannah spoke about her assumptions around what not being able to breastfeed according to her idealised image meant including that she was undeserving and not good enough. It seems the external image Hannah had of breastfeeding led to an all or nothing image of herself as a breastfeeding mother. These same expectations seemed to extend to her son and Hannah spoke of the difficulties she experienced in his not sleeping at around 5 months and her concerns that something was wrong with him. This was also seen at the end of the interview where Hannah expressed concerns over her son not having reached certain developmental milestones and what this might indicate.

v. Resolution

Hannah explains that when her son began eating solid foods breastfeeding became less of a focus and she was able to enjoy being a mother and regaining some independence. She showed a picture of the two of them at a wedding and spoke of her feeling of contentment.

vi. Coda

Hannah speaks of her guilt about the ambivalent feelings she had towards her son and her hopes that he will never know this. Hannah ends by talking about her and her son 'surviving' her difficult breastfeeding experience and her relief that he seemed to be OK.

vii. Tone of the interview

Hannah had prepared a visual representation of her story with accompanying notes and she seemed anxious during her narration. Hannah's story was delivered with a tone of sadness and loneliness which resulted in my concern when leaving at the end of the interview. Perhaps this indicates some of her fears about her son's future which she alludes to at the end of her narrative. Hannah's son's presence led to interesting interactions as she attempted to mediate her feelings whilst seeming aware and self-conscious of his being with us.

Esther's story

i. Abstract

Esther's story starts with her explaining her initial feeds after birth which was 'not going quite right' and how she felt insecure about support offered by midwives. Esther explains she was kept in hospital for a while due to contracting Streptococcus during labour and her epilepsy; she describes her desperation to get home with her new son. Esther describes her concerns that her son seems lethargic during feeds but is reassured her son is putting on weight.

Remembering how her concerns are not responded to she becomes very angry - 'really mad'. At 15 days old her son is taken back into hospital for severe malnutrition. A period of confusion and self-doubt follows as Esther recalls how she questioned her feeding and how she had not realised her son was not gaining weight. Esther both describes her feelings of strength and resilience at having come through her difficult experience and her continued guilt and mourning for the loss of time with her son in the first few weeks.

ii. Orientation

Esther described herself as a 31-year-old woman who lived with her husband and her son who was 12 months at the time of the interview. Esther had requested that her mother sit with her during the interview, expressing anxiety that she may become confused or overwhelmed

during our interview. Esther was still breastfeeding at the time of the interview. Her son was not present and had gone out for the morning.

iii. Complicating action

Following her return home from hospital Esther describes how she felt she must keep the house clean and was a little preoccupied with keeping on top of things. She described enjoying feeding and not being concerned that anything was wrong. The midwives who visited did not weigh her son, which she now felt extremely angry about. During a home visit one of the midwives noticed that Esther's son was very underweight and he had to attend the children's ward for treatment. This event led to Esther feeling angry, guilty and confused. She describes the children's ward as a safe place where she felt she and her son were treated with kindness and care.

iv. Evaluation

Esther presented as anxious and spoke with some caution, although also great honesty. Her account was disjointed, easier to follow whilst in the room with her than when listening back to it and reading the transcript. Esther was concerned throughout about others' judgements of her and this seemed to impact on her engagement with me as she disclosed her fears that I might be judging her as a mother. Her own mother's presence throughout the interview seemed to be reassuring for Esther and mirrors her expressions of needing her mother and feeling vulnerable during her difficult experiences. Of interest was the stop-start nature of the interview. Twice Esther paused the interview to go to the toilet, on both occasions expressing her apologies and asking permission. On both occasions she exits whilst describing feelings of being a failure, being judged and her anger about this. It seems she may have been retreating from her critical thoughts.

v. Resolution

Throughout the interview Esther asserts her rights and strong desires to breastfeed, interrupted by her initial ill health following birth and her

son's time on the NICU ward. Resolution comes as she is supported to reinstate breastfeeding and Esther and her son are joined as a 'puzzle'. However, Esther describes how she remains distrusting of and angry towards health services and expresses a desire for future therapy or support to come to terms with what has happened. She is signposted to organisations in the participant material and her GP.

vi. Coda

Esther expresses her pride for continuing to breastfeed and reasserts her bond with her son despite the trauma she has experienced. She draws once more on a bestial strength, describing herself as a 'phoenix rising from the ashes.' We end in discussion about possibilities for additional psychological support to help resolve feelings of trauma.

vii. Tone of the interview

Esther was anxious throughout the interview and concerned about being clear and getting her story 'right.' The interview took place in her front room and it seemed mid-way through decorations, sparsely furnished and with bare walls. This reflection on my surroundings struck me as mirroring the lonely isolation expressed by Esther. Furthermore, following the interview, I frequently forgot the participant's name and found her difficult to hold in mind, again perhaps mirroring her expressed feelings of abandonment. The experience of being in the interview was overwhelming for us both and e-mails were exchanged following the interview to reiterate services available for support. However, final correspondence from Esther saw her thanking me and wishing me well with the research, with no further questions asked.

Maria's story

i. Abstract

Maria begins describing the mismatch between media images of feeding and those she has seen since in women's accounts of

their experiences on the internet. She explains her choice to have her baby in a private hospital so as to have increased support following the birth, including with breastfeeding. Maria describes difficulty latching on in early feeds and giving her daughter some formula which she expresses guilt about. Despite continued difficulties Maria describes her determination to feed, coping with pain and exhaustion and using a breast pump to ensure her daughter was getting breastmilk. Maria explores messages surrounding feeding and the unrealistic image presented. Maria talks about her relationship to her breasts and assumptions that large breasted women will naturally be able to feed. Maria describes briefly the difficulties as they developed but concludes that she got there in the end.

ii. Orientation

Maria described herself as a 31-year-old mother who lives with her husband and their one year old daughter. The interview took place in a busy, noisy café near to Maria's office. Maria had just an hour to meet as she was returning to work following our interview. Maria continued to express milk at work at the time of the interview.

iii. Complicating action

Maria describes extreme pain and cracked, bleeding nipples during feeding and her attempts to continue breastfeeding despite these difficulties.

iv. Evaluation

Maria was determined in her efforts to feed, based on her own mother having fed her and a firm belief that regardless of difficulties it is possible to breastfeed and an important part of early mothering and nurture. Esther described her experience and attitudes in black and white terms, often using the word 'essentially' perhaps indicating her pragmatism and reductionist view of her experience. Furthermore, a strong narrative of

resilience is heard in description of her family heritage as 'survivors' and a conviction to 'battle through' her difficulties. It seems at times this left little space for expression of her own needs and feelings, her experiences often aligned with hormonal change; for example she cites how oxytocin helps her to 'mitigate the worst of it'.

v. Resolution

Maria describes that at five months old her daughter is able to 'latch on' and advice not to use nipple shields helps alleviate the pain. Maria expresses frustration at not having been given more advice about feeding but also expresses relief that her daughter was able to feed, despite her pain.

vi. Coda

Towards the end of the interview when asked how Maria saw herself as a mother she admits to not giving it much thought due to her desire to be a good mother and seeing breastfeeding as the primary concern for this. The interview finishes in the middle of a discussion about the nutritional benefits of breastmilk as Maria needs to return to the office.

vii. Tone of the interview

Maria came in the interview without any images but had a couple in mind. The brevity of our interview and her lack of preparation made me wonder about her engagement in the process. However, her narrative delivery seemed very prepared and I reflected on feeling that I was in a board meeting receiving a presentation. She spoke matter-of-factly but with conviction. Of all the participants she was most keen to hear of my own breastfeeding experiences though this was not discussed. Affect was minimal in her narrative and I left without a strong sense of Maria as a mother, but certain of her strong will and determination to feed.

Rachel's story

i. Abstract

Rachel explains her expectations and strong desires to breastfeed and a positive initial feed led her to believe she would be able to continue. Rachel explains on returning home she experienced pain, frequent and exhausting feeds, an episode of mastitis, which left her feeling desperate and questioning how she would cope and her daughter's oral thrush. This experience continues and using a bottle becomes difficult also until a diagnosis of tongue tie. Rachel reports feelings of frustration with herself and two instances of anger with her daughter. Rachel talks about her family's attitude to her parenting and feeding and her efforts to find a way of being with her daughter that suited them both.

ii. Orientation

Rachel describes herself as a 32-year-old mother, living with her husband and their daughter who was aged 13 months at the time of the interview. Rachel was interviewed over Skype due to her geographical location in Britain. Rachel reported she had stopped breastfeeding at 11 months.

iii. Complicating action

On returning home from hospital Rachel experiences pain during feeding, this is the beginning of a series of difficulties she experienced breastfeeding and her struggle to find a way to relinquish what she describes as her image of herself as a 'Gina Ford' mum to finding an alternative which will suit her and her baby.

iv. Evaluation

Rachel sets out her interview with a desire to demonstrate through her narrative that difficulties in breastfeeding can be overcome, expressly stating that she wanted to ensure the research was balanced when talking about difficulties. Her adoption of

attachment parenting seems to have provided her with a way to frame her relationship with her daughter and allow her to make sense of previous difficulties. Despite the painful and exhausting accounts Rachel shared openly, hers was in many ways the most straightforward of interviews.

v. Resolution

Rachel describes resolution coming when she was attended a 'baby calm' class and her intuition to demand feed, not live to a routine and follow the needs of her daughter were all validated. Rachel describes this as the end of a battle and the beginning of a meaningful and fulfilling relationship with her daughter. It also seemed to help Rachel to make sense of and reconcile her initial difficulties.

vi. Coda

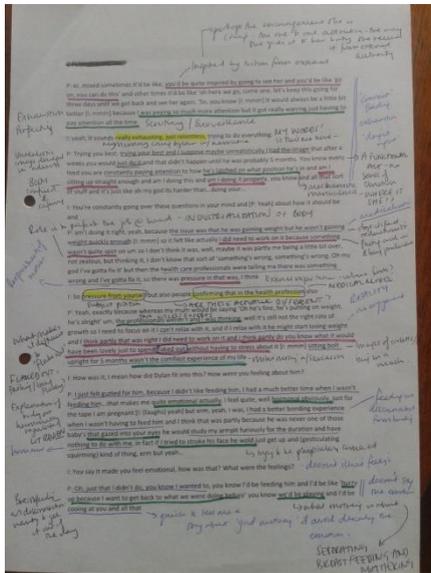
Rachel concludes her story with an image of her daughter asleep in the cot and explains she had shared this image with her sister when they were exchanging images of what they wake up to in the morning. Rachel expresses her happiness at deciding not to return to work and reflects on how different her life has become, practically, financially and emotionally.

vii. Tone of the interview

Rachel spoke with honesty and fluency throughout and her narrative seemed to have been processed and integrated. Her position as a mother within an attachment parenting model seemed to give her confidence and reassurance and Rachel was keen to assert that breastfeeding difficulties could be overcome and that hers was a positive story. This led to increased prompting on my part about her subjective experiences and the ways in which she made sense of them at the time, before her uptake of attachment parenting.

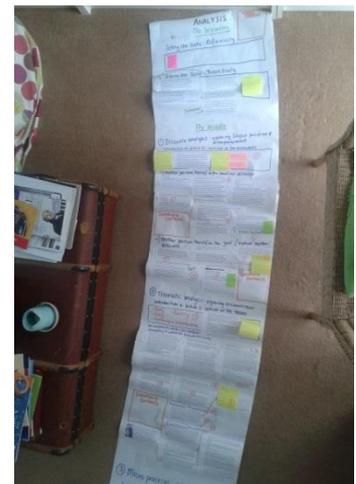
Appendix 8: Constructing the analytic narrative

The analytic process: The interview data was deconstructed and reconstructed as illustrated in these images



Above: Dissecting the narrative: collating narrative themes

Left: Holistic understanding: annotating the transcripts



Above: 'Crafting' the data: constructing the analytic 'story'

Below (L): Confused and conflicted: moving between theory and data, (R) The reconstructed narrative

