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Elizabeth P. Duffy  
*Edith Cowan University*

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# **Bottle-feeding mothers' experiences of coping in a pro-breastfeeding context: The case for a Caring-Options-Responsive model of midwifery services**

Elizabeth Philomena Duffy, RN, RM, HV, BSc, MN, IBCLC

A thesis submitted in fulfilment of the requirements for the award of:  
Doctor of Philosophy (Nursing)

School of Nursing and Public Health  
Faculty of Communications, Health and Science  
Edith Cowan University  
Churchlands  
Western Australia

Submitted November 2002

## USE OF THESIS

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

## **A bstract**

The original contribution of this qualitative study is that it sketches the front-line of the contested domain of infant feeding choices by exploring the under-researched experiences and perceptions of mothers who actively choose to bottle-feed their babies. Twelve bottle-feeding mothers in Western Australia participated in open-ended, in-depth interviews. The interview findings were further explored using participant observations of relevant hospital practices and critical, hermeneutic re-readings of midwifery's professional and policy documents.

The thesis argues that bottle-feeding is marginalised by the midwifery profession that currently defines its practices in accordance with policies such as the Baby Friendly Hospital Initiative. Bottle-feeding mothers described experiencing negative, antagonistic encounters with midwives moralising about infant feeding choices, pressuring them to choose breastfeeding, and obstructing rather than supporting their infant feeding choice.

The bottle-feeding choice is often marginalised in the literature by the deployment of nebulous concepts about parental emotions, most notably so-called "mother-child bonding". However, the mothers presented an identifiable "bottle-centric" perspective by which they considered bottle-feeding the best choice to support their priorities of overall life-style organisation, avoidance of discomfort and anxiety, and optimal family inter-relationship dynamics. Notably, the bottle-centric perspectives described breastfeeding as a threat to those goals and values. This study also identifies a previously unexplored phenomenon of the mothers' concept of "father bonding" with its symbolic meanings of bottle-feeding for the mother desiring the father's emotional involvement with the baby. A speculative theory of an evolved socio-biologic concept of "Father bonding/bondage" is forwarded.

Theoretical dimensions of current health belief models, especially that underlying the BFHI, cannot adequately recognise or service this client group's needs. Bottle-feeding mothers intelligently engage in health decision-making processes when deciding their infant feeding options, considering a broad range of factors to optimise their family relationships. However, the mothers' value systems are diametrically opposed to those of the midwifery profession.

Midwifery's approach to limiting information and practical educational demonstrations of bottle-feeding is a key aspect of marginalisation. The mothers strongly criticised bias in antenatal classes, poor support for their own training in bottle-feeding, experiences of learning by making mistakes, and some mothers afforded more credibility to advice from sources outside midwifery. These alarming findings appear to result from WHO/UNICEF anti-marketing principles mistakenly being generalised to educational functions in the BFHI policy.

Variations in the mothers' levels of satisfaction with their experiences in hospitals depended upon whether facilities suited or inconvenienced their needs, how efficiently hospital administrative procedures upheld their choice, and staff attitudes towards them. Major differences appeared related less to public or private sector differences and more to how well facilities were oriented towards either bottle-feeding or breastfeeding.

Exemplary support should be provided to both breast- and bottle-feeding client groups but will require a more sophisticated approach. Practical suggestions for developing and disseminating more timely and relevant information and support for bottle-feeding, and suggested research projects to expand the present study's findings are forwarded. The thesis proposes a "Caring-Options-Responsive" model of Midwifery services suited to fully informing and respectfully supporting clients in their choice.

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

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

Signed: \_\_\_\_\_

.....9-3-2003.....



## Dedication

This thesis is dedicated to Esme Kershaw, with fond love.

Esme, a wonderful nurse and educator, who recently retired, inspired my interest in nursing research through her manner of always being kind, caring, gentle, loving and supportive. Those qualities flowed through to her enthusiasm for new knowledge and her optimism about the nursing profession. I strongly admired that approach when she taught a postgraduate course about health beliefs and later supervised my Masters research, and I hope to have upheld those principles in the investigative directions of this PhD thesis.

## Acknowledgments

My grateful thanks and acknowledgment are owed to many people, without whom this doctoral work would not have been possible.

I am greatly indebted to the participants in this study, the twelve mothers and one father, for their openness, earnestness and generosity. Their interviews generated valuable data and I hope this thesis has done justice to what they had to say.

I would like to acknowledge the support and assistance I received from Associate Professor Lynne Hunt who was consistently accessible as my principal supervisor throughout the entire four years of this study's research journey. Lynne encouraged me to move outside my comfort zone of researching breastfeeding to tackle the under-researched dimension of bottle-feeding mothers' experiences.

My appreciation also to the co-supervisors of the study, Dr Rycki Maltby, Dr Yvonne Hauck, and Associate Professor Bronwyn Jones, who provided input and resources at various times. My sincere thanks to Ms Anne Crawford, who expertly transcribed the tapes for the interview data. Additionally Mrs Denise Hynd, a truly dedicated midwife, who kindly loaned me many originals of policy documents, and the study benefited from her insight into current BFHI goals. Equally I am grateful to a number of people working in hospitals, too many to name individually, who responded professionally to my requests for information.

I appreciate all the support I received from Bethesda Hospital where I was permitted to work very flexible part-time hours during my PhD candidature. The hospital provided an important safety valve when I felt the need to maintain some of the reality of nursing.

Edith Cowan University provided a scholarship and supported the research budget. The University also contributed to costs of conference attendances in Adelaide, Perth and Ireland, where the positive audience responses were reassuring and motivating during the arduous task of writing-up.

Most of all, I should like to affirm my very special love and affection for my husband, Peter, and our son, Andrew. I appreciate them both for sharing my dismay and amazement that one PhD study could take so much time and effort, all the while unstintingly helping me bear much of that burden through their ongoing love, support and encouragement, for which I feel truly blessed.

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# **CHAPTER 1 - Introduction and Background**

## **Introduction**

This thesis describes the experiences of bottle-feeding mothers in Western Australia, based on in-depth interviews with twelve mothers of infants under one year old. The study itself has been iterative. From listening to the bottle-feeding mothers with the intention of discovering what Midwifery can or should be doing to better facilitate breastfeeding, the study took on a different hue because it found that the mothers had few regrets about not having breastfed. They were very happy about their bottle-feeding experiences, however, the mothers strongly felt they had been marginalised in various ways by Midwives. This finding prompted an analysis of what underlies the mothers' perspectives of Midwives' marginalising actions, and prompted an investigation of these largely unrecognised issues from a Midwifery perspective. In this context, the politics of infant feeding loomed larger than the "medical health" assumptions on which the study was originally based. The recognition that various policies and practices of health care institutions impact in highly complex ways upon divergent client groups emerged as an important finding. From this extended research journey, the thesis draws on the voices of the participating bottle-feeding mothers to identify some directions for Midwifery that could enhance health care services for this group of clients. Optimistically, I hope the profession will be able to listen constructively to the bottle-feeding mothers and the thesis' findings, although my research journey included discovery of a number of ways endemic in Midwifery's research and practice whereby bottle-feeding mothers' voices fall on deaf ears.

The present chapter provides an overview of the research journey. The background contextualises infant feeding issues, discussing relevant Midwifery and health care knowledge from both dominant and critical perspectives.

## **Background: A grand tour of contemporary infant-feeding practices**

### **Modernist beginnings of bottle-feeding issues**

This section on modernist bottle-feeding issues will briefly outline a number of historical changes that led to Australia, especially the state of Western Australia, boasting some of the highest breastfeeding rates in the developed world during the mid-to-late-1990s, when the present study began. Contemporary research and professional practices surrounding infant

feeding have naturalised the promotion of breastfeeding as beneficial and support mothers who breastfeed. The naturalisation of pro-breastfeeding activity has now replaced the former acceptance of bottle-feeding that had come to be the preferred practice in many Westernised countries during the mid nineteenth century. The account in this section traces the effects of criticisms of milk substitutes that resulted in global action against the marketing of breast milk substitutes. The relationship of that organised action against bottle-feeding to current health policies and professional standards globally and in Western Australia will be explored.

### ***Recent history of pro-breastfeeding/anti-bottle-feeding ideologies***

Religious, cultural and scientific beliefs throughout history have influenced what and how infants are fed. Forms of artificial feeding have existed since antiquity, including milk from other species and broth (Walker, 1993; Palmer, 1988; Blaffer Hrdy, 2000). Commercially produced baby foods, including milk substitute formulas, were developed from the late 1800s (Palmer, 1988; Blaffer Hrdy, 2000). The commercial development of infant formula began around the 1950s concurrent with rapid progress in science, medicine and technology and changing social and economic trends (Greer & Apple, 1991). Commercial infant formula was devised with the intention of being an emergency back-up option, yet, together with the sudden demise of wet-nursing, it became the option of choice for significant percentages of women and continues to be so. For example, White, Freeth and O'Brien (1992) reported bottle-feeding rates of 37 per cent among women giving birth in the United Kingdom, and Glover and Woollacott (1992) reported that 23 per cent of women in Australia bottle-feed their newborn infants. However, there has been a worldwide shift away from bottle-feeding and increasingly strong professional support for breastfeeding. The peak of bottle-feeding in Australia occurred in the very early 1970s. Hartmann (1997) states that national breastfeeding rates reached their lowest ever when less than 50% of women were leaving maternity hospitals breastfeeding. The downward trend began to reverse in 1972 - a few years earlier than in most other developed countries.

The series of events that has been most defining of contemporary pro-breastfeeding professional attitudes to infant feeding surrounds the exposure of infant death and malnutrition related to bottle-feeding problems in Third World countries (Palmer, 1988). Infant-feeding formulas came to be seen as an example of how First World technologies and Capitalism sometimes negatively affect the Second and Third World (developing countries)<sup>1</sup>. Poorer Third World countries were significantly expanding markets for the First World's milk substitute manufacturing companies

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<sup>1</sup> More recently there is the category of Fourth World countries unfortunate to have receding economies and associated negative health consequences.

such as Nestlé. However, because parts of Africa, Asia and elsewhere had inadequate sanitation for sterilising bottles, infant health was seriously jeopardised. Poor sanitation standards led to diseases such as gastro-enteritis that were often fatal in these contexts, and the cost of infant formula exacerbated existing poverty levels, adding to starvation and malnutrition. Health agencies became alarmed that milk formula companies continued to aggressively market in those regions. In particular, the Nestlé company was criticised for its aggressive marketing of milk-substitutes, and this led to high profile organised action and debate on the issues during the 1970s.



This well-known image of a dying African infant in a bottle illustrates the ideological criticisms and concerns of the time.

**Fig. 1**

**Illustration of ideology generating the movement against bottle-feeding**

("Logo used on the cover of *The Baby Killer* (Andy Chetley/ War on Want, 1974", Palmer, 1988, p. 204).

Since 1981, there has been an International Code of Marketing of Breastmilk Substitutes aimed at limiting the effects of marketing that targets consumers, health workers, and health organisations. The code did not ban the use of milk substitutes. Neither did it ban the dissemination of information about bottle-feeding. However, it did clearly state conditions that might redress the imbalance of information which, at the time, was dominated by pro-bottle-feeding marketing. The World Health Organisation (WHO) and the United Nations International Children's Emergency Fund (UNICEF) developed the code with the following ten recommendations:

- (1) No advertising of breastmilk substitutes.
- (2) No free samples to mothers.
- (3) No promotion of products through health care facilities.
- (4) No company mothercraft nurses to advise mothers.
- (5) No gifts or personal samples to health workers.
- (6) No words or pictures idealising artificial feeding, including pictures of infants, on the labels of the products.
- (7) Information to health workers should be scientific and factual.
- (8) All information on artificial feeding, including the labels, should explain the benefits of breastfeeding and the costs and hazards associated with artificial feeding.
- (9) Unsuitable products, such as sweetened condensed milk, should not be promoted for babies.
- (10) All products should be of a high quality and take account of the climatic and storage conditions of the country where they are used.

(WHO/UNICEF, 1981, cited in Palmer, 1988, p. 223-4)

Many of these recommendations are reflected in the current policies of Midwifery and maternity care and child health institutions in Australia. As such, from an international peak in the 1960s and early 1970s, when bottle-feeding had become very popular (Palmer, 1988), by the 1980s and 1990s breastfeeding was in ascendance. The 1960s accolades of bottle-feeding as a 'convenience' became increasingly negatively redefined amongst health professionals. For example, in Australia it was considered in some quarters to be "the social equivalent of smoking" (Cannold, 1995, p. 2), and sometimes bottle-feeding was lobbied against intensively as a "life-and-death matter [where] not only poor children in every society, but hypersensitive or particularly vulnerable children of the rich, may die or be profoundly brain-damaged as a direct consequence of bottle-feeding" (Minchin, 1985, p. 310)<sup>2</sup>. Globally, by the 1990s, in professional health care attitudes to infant feeding there was an "impenetrable discourse" (Seidel, 1999) of 'breast is best'.

### *Current policies of infant feeding*

The Baby Friendly Hospital Initiative (BFHI), a culminating policy about infant-feeding that was developed by WHO and UNICEF following its 1989 statement on "Ten steps to successful breastfeeding", is strongly influential on contemporary Midwifery policies in Australia and elsewhere. The BFHI was introduced into Australia in 1993 (Bice, 2001). It sets standards for hospitals, and some of its principles reflect the code arising from the WHO-voted decision to rigorously control marketing by formula companies, including not displaying formula companies' literature, not accepting discounts at the hospital from formula companies, and not allowing free samples of formula or bottle-feeding products to be distributed. However, most BFHI principles move beyond issues of marketing, and have been used to define contemporary Midwifery professional practice as pro-breastfeeding.

Since 1995 Midwifery professional associations in Australia oversee the BFHI. This professional arrangement is also the norm globally. The following statement from a 2001 newsletter is indicative of the orientation of the profession during the period of this study:

<sup>2</sup> As evidence of the strength of the anti-bottle-feeding movement, Minchin's book, *Breastfeeding Matters*, became a well known textbook and was endorsed in the preface by J. D. Baum, a Professor of Child Health in England. Baum allows that the book is a political treatise, but introduces it as follows: "This book...is not a mindless crusade, but is a marshalling of facts from the literature in support of the claims made and criticisms levelled [over 600 references are cited]." However, many of Minchin's claims appear to be exaggerated and unsubstantiated rhetoric. For example, she asserts through inference the likelihood that all bottle-fed babies are damaged, probably profoundly:

For others, it matters less; unrealised intellectual and physical growth potential, chronic or intermittent illness, and/or shorter life span may be the only consequences. Perhaps for some others there are no consequences, though I have yet to meet any such children myself. For all these children, there may be profound psychological consequences due to the disturbance of normal parental attachment.

(Minchin, 1985, p. 310)

The National Executive unanimously agreed that breastfeeding is core Midwifery business, and as such agreed to maintain the governance of BFHI in Australia. This decision has the complete support of UNICEF Australia. The state committees have been asked to continue the important work they do and processes are being established to ensure consistency of policy, communication and information on a National level.

(Australian Midwifery News, 1, (3), Nov 2001, p. 3)

The WHO Code has voluntary status in Australia (Knowles, 2001) recognised through the 1992 Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement (MAIF Agreement) that facilitates self-regulation of the marketing of infant formula by manufacturers (Commonwealth Department of Health and Aged Care, March 2001, p. 3). The Australian Commonwealth government "promoted and provided in-principle support for the World Health Organisation/United Nations Children's Fund (sic) *Baby-friendly Hospital Initiative*." (Advisory Panel on the Marketing in Australia of Infant Formula, APMAIF, 2002, p. 15) from 1993 to 1994. Thereafter, the Australian College of Midwives Incorporated facilitated the initiative and gained BFHI accrediting rights whereby 28 Australian hospitals were accredited by 2001 (APMAIF, 2002, p. 15). Notably, only one Western Australian hospital, a large suburban establishment, was accredited by that time, but accreditation itself was not the only outcome of the BFHI developments that were designed to implement, assess and monitor the WHO/UNICEF guidelines (1989). Ten Steps to Successful Breastfeeding BFHI material rapidly became widely used as a reference that benchmarks maternity hospital standards. WHO/UNICEF'S (1990) Innocenti Declaration had called on governments of all nations to develop national breastfeeding policies and targets and national systems for monitoring breastfeeding rates. BFHI materials formed the basis of commonwealth and state government breastfeeding target projections and action plans (Health Department of Western Australia, 1995; Health Department of Western Australia, 1998; Nutbeam, Wise, Bauman, Harris & Leeder, 1993). The breastfeeding targets for Australia were set at 90 per cent breastfeeding at hospital discharge by the year 2000 (Donath & Amir, 2000). The Australian Commonwealth government also provided grants for infrastructure and work by the Australian Breastfeeding Association (ABA) to support it "in educating mothers and counsellors in breastfeeding, and in the development and public availability of breastfeeding sources", and commissioned the promotion of breastfeeding in the NHMRC (1995) Dietary Guidelines for Children and Adolescents and Infant Feeding Guidelines (APMAIF, 2002, p. 15).

Thus, the BFHI marked the shift from anti-marketing of formula to a more focussed program to effect changes in maternity health care practices. The Health Department of Western Australia (1998, p. 4) stated:

The Baby Friendly Hospital Initiative aims to eliminate hospital practices which may interfere with the successful initiation and maintenance of breastfeeding and hospitals are encouraged to adopt the 'Ten steps to successful breastfeeding'.

Since that document is so central to the analysis of the present thesis, the ten steps are reproduced in full here.

#### TEN STEPS TO SUCCESSFUL BREASTFEEDING

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed and how to maintain lactation even if they are separated from their infants.
6. Give newborn infants no food or drink other than breastmilk unless medically indicated.
7. Practice rooming-in — allow mothers and infants to stay together — 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies and soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospital or clinic.

#### A JOINT WHO/UNICEF STATEMENT (1989)

Based on those ten steps, the BFHI developed a set of training manuals specifying how local agencies, such as Midwifery organisations, could set local breastfeeding targets and implement procedures whereby hospitals can be assessed and accredited as well as measure and monitor themselves. What these documents demonstrate is the incorporation of pro-breastfeeding policy into national health policy objectives and into the policy of institutions. Whilst the steps are by no means universally upheld, with only 28 Australian hospitals being accredited by 2001, the goals have become increasingly naturalised within Midwifery professional discourses. Some researchers express surprise that the USA voted against the global WHO Code in regard to marketing of infant formula (for example, Knowles, 2001), but this reflects the importance given to free-trade and competition in the USA. It is an important aspect that also affects the Australian situation where, according to Knowles, the power of the voluntary APMAIF agreement is over-estimated by the non-industry representatives on the committee<sup>3</sup> since there are democratic processes in governing a voluntary code. There are also democratic processes in governing the running of individual hospitals that do not make it easy to meet accreditation

<sup>3</sup> The Knowles Report made this point, which is relevant to conflicting directions such as the Trade Practices Act (TPA) which has greater legal status although Knowles did not explicate anything about the TPA in the report. Knowles was not supporting industry necessarily, and instead pointed out that the code could be legislated; whether or not it would be legislated is impossible to foresee, but the threat to do so is intended to sway the balance of power amongst the members of the APMAIF Board (Personal Communications, 2002, Department of Health and Aged Care).



requirements<sup>4</sup>. Nevertheless, such disappointments appear to have strengthened the Midwifery profession's will to "protect, promote and support breastfeeding" as mandated by the BFHI. Successes and disappointments alike appear to have done much to strengthen the discourse that breast is best within the Midwifery profession.

Policies can be influential and this section has shown how WHO/UNICEF ideals have been decisive in shaping and constraining practices in national policies for health and nutrition, the directions of the Midwifery association and maternity hospital administrative reporting procedures. In turn, these have influenced the care practices of individual Midwives and the experiences of new mothers. The target rates set for Australia in the year 2000 were as follows:

At hospital discharge	90% breastfeeding
At 3 months	60% fully breastfeeding 80% partially breastfeeding
At 6 months	50% fully breastfeeding 80% partially breastfeeding

The first rounds of government monitoring of breastfeeding took place in 1995. Donath and Amir (2000) found Australian rates to be high compared to Britain and the USA but not as high as Denmark and Norway. However, the national rate of 81.8% on discharge from hospital, (87.0% in WA), appeared to be levelling off and they predicted that the year 2000 targets were unlikely to be achieved. In particular, Donath and Amir pointed out that rates achieved over time are nearest to target following discharge from hospital and further away on the measures over longer time frames. Critics of the BFHI suggest that those differences reflect the levels of unwanted pressure in hospital whereby mothers who would prefer to bottle-feed are forced to breastfeed until they can return home. Most health commentators speak as proponents of the BFHI and suggest that hospital policies are successfully moving in the right direction but that more resources will be needed to support women in breastfeeding after being discharged from hospital.

### ***Biological, psychological and health service breastfeeding research's links to BFHI***

This thesis focuses on the experiences and perceptions of bottle-feeding mothers in contemporary Western Australia. It does not dispute that breastfeeding is likely to be the healthiest option for mothers in good health who choose it and that current research mostly shows breastfeeding rather than bottle-feeding to be beneficial. Examples of research supporting breastfeeding above bottle-feeding will now be briefly outlined.

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<sup>4</sup> As an example of democratic processes, not including client preferences, in some near-BFHI hospitals the obstetricians will not support rooming-in for their clients (Personal Communications, 2001, sources undisclosed).

Breastfeeding is considered to meet all of the infant's nutritional requirements in the first six months of life, and to be the most vital food for a further six months (Hartmann, Cox & Duffy, 1997; World Health Organisation, 1989). Breast milk contains antibodies that enhance the infant's ability to resist infection and, therefore, has long-term cost implications as far as avoiding a number of illnesses (Howie, Forsyth, Ogston, Clarke & Forey, 1990; Du v Florey, Leech & Blackhall, 1995). Maternal benefits include reduced risk of pre-menopausal breast cancer and certain ovarian cancers (Newcombe, Storer & Longnecker, 1994), in addition to unique mothering contact (Rubin, 1967). Encouraging breastfeeding is not only desirable on individual health grounds, but is also an advantage for purchasers and providers of health care (Dykes, 1995).

Furthermore, within the Midwifery profession, the links between research and the recommendations of the Ten Steps to Successful Breastfeeding are commonly thought to be clear and sound (Hauck, 2000; International Lactation Consultant Association, 1992; McIntyre, 1993). Aside from the fact that, even in countries like Australia, some areas and communities have very poor health standards (McVeagh, 1994), the BFHI mandate to "protect, promote and support breastfeeding" has resulted in extensive research efforts to prove that breastfeeding is advantageous, not just in Third World countries but universally. Wooldridge, Phil and Baum, for example, claimed that:

Increasingly, [better designed research studies such as theirs on neonatal infants] ... have been able to produce concrete support that the properties of breast milk do in fact provide real health benefits for breast-fed infants in industrialized cultures, as has previously been shown in developing countries.

(1993, p. 10)

McVeagh (1994) was highly supportive of the Ten Steps to Successful Breastfeeding, despite pointing out that research findings could not *clearly* link all of the steps *causally* with improved breastfeeding rates. The use of dummies (step 9) is one example that is contentious in research and practice. Newman (1990) states that the use of dummies and bottle-teats limits milk supply, adds to breast pain and makes babies too lazy to suck adequately on human nipples. He suggests using fingers as pacifiers and eye-droppers, spoons and cups for non-breastfed milk formula intake. Those approaches are promoted in some WA hospitals but using fingers as pacifiers is contentious in terms of hygiene (Personal Communication, 2000, undisclosed Maternity Wards). Other professional literature can be used to establish links to the policy issues, for example reviews by Scott and Binns (1998) which indicated that rooming in (step 7) is supported by Larson and Tulloch (1995). Early infant-mother contact (step 4) was found to indicate increased breastfeeding duration rates (Buxton et al, 1991; Bernard-Bonnin, Statchenko, Girard & Rousseau, 1989). The hospital environment and level of support available

to breastfeeding mothers (steps 1, 2, 5, 6 and 10) is regarded as the strongest predictor of breastfeeding success or failure (Kearney, Cronenwett & Reinhardt, 1990). Mothers' commitment to breastfeed (steps 3 and 8) is a strong factor (Perez-Escamilla, Segura-Millan, Pollitt & Dewey, 1992). It is noteworthy, however, that the issue of some mothers' *lack* of commitment to breastfeeding and their possible commitment to bottle-feeding is not as well researched. This lies at the heart of the present thesis which challenges the relevance of research into breastfeeding. It is aligned with the work of Ford et al (1994) who argue that most research links between optimal factors and breastfeeding success or failure do not indicate causal factors as much as the pre-existing attitudes of mothers, which provide the focus of this study.

This thesis investigates the experiences and perspectives of bottle-feeding mothers. In this context it is important to briefly visit some issues about undertaking literature research in a pro-breastfeeding context.

1. Research findings are nearly always contentious<sup>5</sup>. A classic example relevant to infant feeding is the differing findings about intelligence. It is now widely argued that higher levels of intelligence are an outcome of breastfeeding rather than bottle-feeding. There is, however, a widespread debate about this. An alternative argument is that mothers' levels of intelligence correlate more highly with that of their offspring than with differences in infant feeding method.
2. An effect shown in research affects a range of people, and very rarely does it uniformly affect all people. For example, breastfeeding may reduce the risk of certain reproductive cancers but it is not an inoculation against them, and neither do all women who bottle-feed suffer breast, ovarian and other reproductive cancers. Studd (2002) reported that British women could apparently reduce their present 7 per cent risk of breast cancer under the age of 70 by breastfeeding for longer. In developing countries most women breastfeed for over two years as is recommended by the World Health Organisation, and they have on average six children. As a result their risk is 1.5 per cent.<sup>6</sup>
3. Acceptance and reluctance for particular health actions does have an impact on overall health, and Schwartz (1990, p. 64) stated that it was better to remove anxiety by switching to bottle-feeding if a mother was just not happy about breastfeeding, because, "the baby will undoubtedly benefit from the reduced anxiety, will feel more loved and comfortable, and the feeling will be reciprocated". Similarly, Kitzinger (1991) contended, "Unsuccessful breastfeeding comes a poor second to happy bottle-feeding". This point in relation to infant

<sup>5</sup> Sarah Blaffer Hrdy (2000) offers an extremely detailed account of the contentious nature of research in relation to 'attachment' and 'bonding' from breastfeeding.

<sup>6</sup> Studd's report was based on research appearing in *Lancet* by Valerie Beral and her team in the UK.

feeding approach appears to be discussed much less frequently in the present BFHI era than previously.

4. The reporting of health research to consumers is also contentious. Informing practices for bottle-feeding have been debated heatedly, although again apparently less so recently. For example Carlisle (1997, p. 60) wrote: "The WHO/UNICEF Baby-Friendly Initiative has particularly come under attack for its alleged activities in suppressing information on bottle-feeding."

While there is a growing body of evidence supporting the benefits of breastfeeding, this is unsurprising because that is the orientation of researchers (Cannold, 1995). Cannold - who prompted vehement debate in an Australian journal (by Holmes, 1995; Minchin, 1995; Horsley, 1995) - defended bottle-feeding mothers as a minority facing discrimination "at the hands of government policy, researchers, health workers and breastfeeding activists" (p. 4). Furthermore, Cannold (Fox, 1990 cited in Cannold, 1995, p. 4) argued:

While the principles of the WHO Code are vitally important, they developed in response to the decline in breastfeeding in developing countries, where poverty, poor sanitation and illiteracy make the health implications of formula for infants vastly different to the implications of formula for babies in the developed world (Fox, 1990). She believes that the implementation of the WHO Code in Australia has wrongly 'encouraged the belief that formula feeding is dangerous and even lethal, rather than that the use of formula in the wrong situations by uneducated people is the danger'.

To summarise this section, a perusal of the literature shows that the BFHI recommendations are related to research findings supporting the superiority of breastfeeding over bottle-feeding. However, such research is contested. For example, the notion that mothers who prefer to bottle-feed rather than breastfeed may have relatively broadened choices by living in a developed and democratic country reappears in the literature from time to time, but it seems to have become increasingly submerged by other concerns. The dominant Midwifery and child health research effort appears to be focussed on establishing or measuring contemporary, pro-breastfeeding policies and finding ways to increase women's success in breastfeeding rather than exploring the full range of infant feeding options.

### *Australia, especially Western Australia, as the context of high breastfeeding rates*

Australia has some of the highest breastfeeding rates in the Western world. Research suggested the rate had remained stable over nine years into the mid-1990s, with national 1993 rates as high as 83.8 per cent of mothers initiating breastfeeding with their newborns (Scott & Binns, 1996; Scott, Binns & Arnold, 1997; Woodcott, 1988). The state of Western Australia (W.A.) maintained a higher rate of 87% (Donath & Amir, 2000). As such, the remaining 16.2 per cent of Australian bottle-feeding mothers and 13% of W.A. bottle-feeding mothers constitutes a

significant minority in the contemporary socio-cultural context. W.A. bottle-feeding mothers' experiences have been identified as worthy of research by Hauck (2000), whose study of long-term breastfeeding mothers in Western Australia and their weaning practices proposed:

Given the significance the [breastfeeding mothers] placed upon their breastfeeding experience reflecting their mothering competency, ... to not attempt to breastfeed within this pro-breastfeeding context must produce a unique [mothering] experience not encountered by the majority of Western Australian mothers.

(Hauck, 2001, p. 281)

Australia was one of the first developed countries to reverse the trend away from bottle-feeding in 1972. The enthusiasm and activism within the Nursing Mothers Association of Australia (NMAA, now Australian Breastfeeding Association (ABA)), which was established in 1964 contributed to Australia's comparatively high breastfeeding rates (Knowles, 2001). In recent years, morale has been high in the W.A. Midwifery profession, which has seen innovations of better breastfeeding preparation and support. Those innovations include teaching feeding positioning techniques, better breastfeeding support such as the International Council for Lactation Consultants (ICLA) places in hospitals and development of milk flow monitoring equipment, and the expectations of establishing local specialist Breast Clinics (Hartmann, 1997).

Expectations of mothers' feelings of mothering incompetence should they fail to breastfeed are commonplace in Midwifery, reflected in professional attitudes towards bottle-feeding mothers' guilt being debated in the profession. Maureen Minchin (1985), for example, suggested that failure was due to improper professional guidance, and Midwives and other responsible institutions need to face their guilt rather than continue in a "conspiracy of silence" ostensibly to protect from their guilt "those mothers who've tried and failed to breastfeed, or who 'choose' to bottle-feed" (p. 43). The present thesis does not comment substantially on mothers who tried and failed to breastfeed. It concentrates on mothers who chose not to breastfeed. If Midwifery discourse is correct, such mothers will prove to have high levels of guilt. This was not the case. The bottle-feeding mothers were entirely satisfied with their choice.

The Australian environment, with high breastfeeding initiation rates, has fostered a "conspiracy of silence" amongst professionals. Bottle-feeding is not discussed other than pointing out its risks and providing minimal, essential information post-natally. Locally, the ABA, (formerly NMAA) forms a strong pressure group. Originally an independent organisation, in 2000 it gained government funding of \$50,000 that was subsequently increased to \$300,000 in line with recommendations by the Knowles report. The ABA is very active in community education in line with Step Ten of the Ten Steps to Successful Breastfeeding BFHI requirements. Its reputation is not entirely positive. Some women have referred to the organisation as "The Milk

Mafia" (Hauck, 2000). A pointed view echoed by a humorous columnist for a local newspaper magazine, in an article entitled "Repressed Mammary Syndrome", irreverently and facetiously summed up some of the negative community attitudes about the power of this group, as follows:

For a mother to admit that she hates breastfeeding is a social atrocity second only to consuming one's young, or wearing black stocking with white sandals. When I came clean about my own lactation intolerance a couple of years ago, I shouldn't have been surprised when the Nursing Mothers' Association put me on its hit list. ... Of course I pretended to love breastfeeding. Well, you have to these days — or so we are told by everyone from (male) obstetricians to the (childless) infant health researchers.

(Maushart, 1999, p. 49)

This shows that the dominant discourse that 'breast is best' is not absolutely seamless and uncontested in Australia or Western Australia. Nevertheless, it is the dominant discourse, and it has become strongly institutionalised as part of the practices of professional health care facilities and of the Midwifery profession.

## **The Critical journey begins**

The previous section documented the recent naturalisation of breastfeeding and the institutionalised constraints against developing bottle-feeding or addressing the needs of bottle-feeding mothers. This section will elaborate the background to the study by critiquing relevant Midwifery and Nursing practices. It takes a Foucaultian perspective that discourses are ideological (Marshall, 1998) and that language can affect everyday practices through particular conditions that make certain discursive formations possible and allow their influence to creep into social structures. They are made possible by "historically produced, loosely structured combinations of concerns, concepts, themes and, types of statements" (Marshall, p. 163). The thesis aims to develop a 'voice for Midwifery' that is mindful of the bottle-feeding clients' perspective, and it does so partly by reviewing the literature from the Midwifery field. However, Fairclough's caution is relevant, "that analysis of texts should not be artificially isolated from analysis of institutional and discursive practices within which texts are embedded" (1995, p. 9). As background to the analytic chapters' problematisation of contemporary Midwifery and health care provision, this section starts with a short critical history of infant feeding, and continues with an examination of Midwifery discourses that have competing beliefs about professionalism, caring, choice and advocacy, each of which will be de-constructed in turn.

### ***A critical historical perspective of infant feeding***

Discourses on infant feeding are historically contingent and shift over time. Yet there are some remarkable similarities in the so-called "expert" arguments about infant feeding which historically, as now, smacked more of evangelism than science in some influential cases.

Blaffer Hrdy (2000) describes the joint influence of French Physician Jean-Emmanuel Gilibert, an activist against wet nursing and Swedish taxonomist Carolus Linnaeus, who identified Mammalia (mammals) as the group in which females develop milk-secreting glands. He felt it was unnatural for any woman to deviate by failing to nurse her young. Blaffer Hrdy (2000, p.11-13) traced their influence to contemporary views of what constitutes a naturally good mother:

Our views of motherhood (including such scientific-sounding phrases as "the maternal instinct") derive from these old ideas and even older tensions between males and females. The fact that most of us equate maternity with charity and self-sacrifice, rather than with the innumerable things a mother does to make sure some of her offspring grow up alive and well, tells us a great deal about how conflicting interests between fathers and mothers were played out in our recent history. Sad to say, these old conceptions about maternity infiltrated modern evolutionary thinking.

(p. 134)

Blaffer Hrdy argues that the association made between breastfeeding, by the mother in particular, and infant survival, became the dominant link for notions of "the maternal instinct", may not, in fact, be that clear cut, either for the 1800s or for the more contemporary times. Her comprehensive review of maternity in terms of nature and evolutionary society explores in fascinating detail perspectives of:

The compromises that being a mother, or a father, inevitably entails ... [and the problem of the way that] much lip service has been paid to 'Biology', 'Instinct,' and 'Natural Laws' without a great deal of attention paid to how maternal behaviour unfolds in the real, everyday environments in which mothers actually live, or in those very different ancient environments in which women evolved.

(p. 26).

Blaffer Hrdy argues that the choice of method of feeding is "contingent" on social issues and mothers will weigh up chances of infant survival. Her findings include historical evidence that the apparently cruel and unnatural mothers in Paris in the 1780s who had their babies fed by wet-nurses had, in fact, in sound socio-biological ways, optimised survival rates of their offspring. Infant mortality from wet-nursing at home was 20% (the same as the mother herself breastfeeding), with a cheaper rural wet-nurse it was 40%, and in a foundling home was 85%.

She argued against simply associating those figures with maternal instincts for offspring to survive. Looked at in a different way, the Paris example demonstrates that often the best chance of infant survival was in fact for many of those mothers to use wet-nurses rather than keeping the child with them in the districts in which they lived where mortality rates were even higher where they were "eking out a precarious existence" (p. 368). Thus her analysis takes into account the effects of income levels and fertility together with the dual tasks of survival and child rearing. She found that, "at any given point in time, need for the mother's labour was a better predictor of what would be done with the infant (kept at home, sent to a wet-nurse, sent to a foundling home) than were infant mortality rates" (p. 368).

In a contemporary example, she argues that childcare for intelligent working women optimises the chances of success in terms of how society has evolved for both mother and child. Also, the standard of care provided is allocated competitively according to parental financial investment, and thus indicates affordability for the mother rather than any measure of "mother love". Blaffer Hrdy traces the use of alloparents (non-parental assistance in raising children) across time and across cultures to argue that childcare used by working mothers is not especially new or rare, least of all it is not cruel and unnatural (as some attachment theorists would have us believe). Another example of evolutionary changes in child rearing that may be read less emotively in a study of infant feeding, is the move towards what she calls "subsidised long childhoods", whereby in most societies there has been an evolutionary shift towards greater training, and hence longer childhoods, before reaching independence.

Blaffer Hrdy's work had little to say about bottle-feeding, since she was showing the inter-relationships of those dual instincts of providing/working and child-rearing. Nevertheless, the relevance of her work to this study on the choice of infant feeding, is her theorising around mothers weighing up contingent factors to optimise parental and offspring survival and development. This theoretical approach may have explanatory power as to why some women do not opt for the overtly more 'natural' breastfeeding, and instead choose bottle-feeding<sup>7</sup>.

There are several interesting points to notice historically. One is that infant feeding has been contentious in various ways, and that it is important to treat with caution assumptions of what is natural or instinctive, as well as considering that there may be multiple and evolving ways of achieving the instinctive drive to nurture and raise offspring. Another point is that the ideological nature of infant feeding issues is actually not new, as shown in the following picture.

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<sup>7</sup> Whether or not Sarah Blaffer Hrdy would personally approve of the link made in this thesis or not remains unclear. Following a public lecture, sponsored by the University of Western Australia, 2001, when asked about this, she refused to be drawn into linking alloparental care with fathers bottle-feeding, stating instead that issues such as alloparental lactation by non-child-bearing women were far more interesting. The comment does reflect that her book says nothing about bottle-feeding. As a participant observer, however, I was amazed how the whole event of her lecture encapsulated the local passionate feelings that breast is best. There was an excited tension by an audience of less than 100 hanging onto her every word, (that she held together graciously despite the hall having a faulty slide projector). At the finish, two men in turn spontaneously applauded her on behalf of "breastfeeding mothers". For her to slide-step the question about fathers suggests that even a stranger can quickly deduce that now in Perth is not the time or place where it is acceptable to say the "bottle" word.



**Fig.2**

**Early depiction of bottle-feeding associated with unhappiness**

("Grandville's illustration, I DID NOT MARRY TO BECOME A WET NURSE, c. 1830-1840. From the book *GRANDVILLE'S ANIMALS* published by Thames and Hudson." Cited in Donahue, 1985, p. 6.)



This illustration, from over 160 years ago, showing a cartoon on the topic of infant feeding associates bottle-feeding with an unhappy situation. The adult bottle-feeding, which may be either the mother or a hired nurse since the infant is cross-species, and the children, all appear to be upset and on bad terms with each other.

### *Discourses and discursive positions in Midwifery*

Nursing is a contested and dynamic field. This section will examine discourses relevant to this thesis that shape Midwifery and underlie professional dilemmas about the provision of health care services to clients who do not comply with the profession's recommended choices. It will examine notions of professionalism, caring, choice and advocacy.

### *Professionalism in health*

Various nursing histories provide examples of nursing directives being a challenge to the medical hierarchy. Keith Cash (1998, p. 42) considers how nursing's main "competing traditions are managerialism and medicine". In the Midwifery field, breastfeeding is one of the defining issues of professional Midwifery's opposition to the medical tradition. Midwifery has a historical and current suspicion of obstetrics for overly intervening medically rather than "being with woman" or "working with the birth process" as such.<sup>8</sup> Midwives have criticised the overuse of forceps, caesarean sections, inducement, unnatural labour positions, and some have lobbied against delivering in hospital rather than home environments. As such, Midwifery has developed an image for itself partly of privileging nature, and these Midwifery profession's anti-

<sup>8</sup> Donahue (1998, p. 96) explains the link between the women's movement along with other activist groups in generating more client decision-making in various versions of 'A Patient's Bill of Rights'. This document aims to draw the reader's attention to the fact that as well as 'alternative' care propositions to medical intervention, 'over-servicing' is an aspect of the consumer-led suspicion of obstetrics and medical traditions in childbirth: such anti-interventionist views have had a shaping effect on contemporary Midwifery practices of defending the caring relationship between clients and professionals.

interventionist discourses lend strength to its self-image of holding a particular respect for and sensitivity towards what is natural.<sup>9</sup>

The relationship between those foundations of Midwifery that have stressed harmony with women's natural functions and 'breast is best' policies is readily apparent to most Midwives. What is less readily apparent is the political connotations of 'breast is best': it epitomises Midwifery's resentment towards existing medical hierarchies and is the result of concerted, continuing, long-term efforts to move forwards from being only handmaidens of physicians towards independent professional status. Although Midwifery is also moving towards separating itself from Nursing, this has not been well established in Australia, and the historical and practical link between the two professions remains strong. Therefore, a Nursing example will be used to show changes in medical hierarchies, evidenced in Nursing ethical codes. One of four parts of the Florence Nightingale Pledge for Nurses written by Lysira Gretter in 1893 was, "With loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care" (cited Deloughery, 1998, p. 24). More contemporary codes develop a more direct nurse-client relationship with much more diagnostic and evaluative responsibility and accountability placed upon the nurse (Edelman & Mandle, 1994; Donahue, 1991). Donahue, however, points out that such a shift is not as recent as commonly perceived and the responsibility for nursing diagnosis had been discussed as early as 1947 by Lesnik and Anderson in "Legal Aspects of Nursing".

They described diagnosis as the "art or act of recognising disease from its symptoms; also, the decision reached." In a long commentary similar to an anecdotal footnote, they emphasized that although diagnosis had long been the province of physicians, clarification was warranted regarding nursing activities. They argued that not every aspect of the "art of diagnosis" is the exclusive right of the physician.

(Donahue, 1998, p. 71)

Against this political background, discourses of supporting a 'natural' approach to infant feeding simultaneously achieves resistance to the 1960s and '70s medicalised promotion of bottle-feeding and supports breastfeeding through policy incorporating the 'superior' Midwifery knowledge that breast is best. Whilst this shift facilitates the advancement of Midwifery, the establishment of guidelines is not without problems in that once more the professional judgement may be impaired by dogmatic assertion of "managerialist" policies (Cash, 1988).

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<sup>9</sup> The 'breast is best' discourse of Midwifery has evolved as eschewing a particular respect for and sensitivity towards 'nature'. However, not every aspect of Midwifery would privilege nature. Although less strongly organised, the dominant contemporary Midwifery practices regarding post-natal contraception would be inclined to suggest limiting or spacing the family through medical intervention such as 'the pill'. Notably, client education for contraception, which professionally recommends not leaving childbirth spacing to nature, is pro-active and responsive to the needs and feelings of individual women in comparison to education on using milk-substitutes for infant-feeding. Midwifery is able to involve the client in understanding their options, the risks of those options and supporting clients in their choice often using referrals. (For a discussion on how nurses might support clients' theological values of love and life that regards contraception as a "moral evil", see Carole Edelman and Carol Mandle, 1994, p. 138).

Whilst nurses and Midwives may be partially relieved from being the handmaidens of physicians, it may be that they renew this function as the handmaidens of policy developers and hospital administrators. Policy defining professional attitudes as pro-breastfeeding (Royal College of Midwifery, 1991) might also interfere with Midwives' ability to develop empathetic relationships with all clients, especially those who choose to bottlefeed.

Other discourses similarly become problematised when considering Midwifery's position regarding bottle-feeding in contemporary Westernised societies. For example, 'caring', 'client choice', and 'advocacy', are all professionally required functions. However, as Robert Veatch and Sara Fry (1987) point out, these can involve contradictory demands and create strong ethical dilemmas for Midwives. For example, how is it possible to advocate for bottle-feeding when it contravenes BFHI policies?

### *Caring in health*

Most health professionals would consider that caring is the essence of their job (Leinenger, 1984). It is difficult to specify what caring entails since it has a range of meanings including the delivery of services, empathetic involvement, or the adoption of a moral or ethical position (Caelli, 2001).

According to Veatch and Fry (1995), the most fundamental ethical imperative for nursing is "avoiding killing". Even in the Australian context, some would argue that breastfeeding is a way of avoiding killing (for example, Minchin, 1985; Palmer, 1988; Wooldridge, Phil & Baum, 1993). Others consider that typically in Australia the choice between breastfeeding and bottle-feeding is not as serious as a life and death matter (Fox, 1980; Cannold, 1995). Fox's and Cannold's proposition that bottle-feeding is professionally misrepresented in Australia finds fault with the Midwifery profession improper attitude about caring for its clients. Cannold's criticism of representing milk formula as a form of poison, for example, points towards breaches of what Veatch and Fry term as nursing's ethical imperatives to protect patients' "autonomy" and the "veracity" of information.

Veatch and Fry also discuss justice as an aspect of ethical issues relevant to the provision of health-care. The principles of justice, as defined by ethicist John Rawls, give primacy to individual needs and preferences, providing equality of distribution of resources is achieved. Rawls' position would suggest that mothers who choose to bottle-feed their babies are entitled to equal care and health-care resources. However, some other views about justice in allocating resources would give primacy to generating the greatest overall benefit of health-care, through differential distribution of resources (Veatch & Fry, 1987, p. 94). This latter view would suggest

that Midwives are enacting care by upholding pro-breastfeeding policy and focussing their resources on trying to achieve BFHI goals. Presently this is the dominant Midwifery perspective.

### Choice in health

Closely related to the issue of caring is the matter of who should choose a health action. In developed countries, most health guidelines provide for patients' choices. Adults have the right to take responsibility for their own and their children's health and it is expected that those adults should make informed decisions. However, there are health targets set for many health outcomes, including targets for breastfeeding in line with the BFHI-influenced policies of most maternity hospitals. What this means in practice then, is added pressure in a situation in which many Midwives believe that the most caring action might be to persuade clients to make the choice to breastfeed, thereby contravening a patient's right to choose. They can do this by distorting the truth about health options or health consequences. Such practices are problematic. As Veatch and Fry point out, distortions which may be "benevolent deceptions" (1987, p. 123), whilst made with the best of intentions, are nevertheless ethically deceptive because they shift the locus of decision-making power from the individual client to the health provider.

One perspective on choice in infant-feeding method is that it is an issue on which feminists have become silent (Cannold, 1995). Indeed dominant feminist discourse has shifted to sponsoring the choice to breastfeed (Minchin, 1985; Palmer, 1988). This can entail calls to restructure society's attitudes towards paid maternity leave or, more directly, that pro-breastfeeding policies uphold client choice in making it possible for them to do the right thing.

Much of the literature recognises the importance beyond the initial choice of a health action in terms of support that impacts upon the success or otherwise of the ensuing chosen health action. Brack (1975) has shown the importance of social support in women's ability to succeed in breastfeeding and Dennis (1999) has demonstrated the importance of emotional support in building mothers' confidence in breastfeeding. The Midwifery profession's discourses emphasise their role in supporting the breastfeeding choice.

In summary, the choice to bottle-feed is currently perceived as a problem, for professionals, babies, mothers and the wider society. Professional Midwives are in a dilemma; encouraged to support the Royal College of Midwives (1991) policy of promoting breastfeeding, but at the same time also encouraged to empower women, and help them exercise choice and control. There is no easy solution to this problem. However, this thesis will enhance the evidence-base

for this debate by describing and explaining the currently neglected aspect of bottle-feeding mothers' views on choice.

### Advocacy positions in health

In the context of advocacy, it is common in Midwifery training to consider the dual responsibility both for the mother and for the infant or foetus by discussing ethical dilemmas such as maternal-foetal conflicts. As an example, in Edelman and Mandie's text book (1994, p. 147), they present the issue of foetal pre-natal exposure to cocaine. Simultaneous obligations to protect the foetus and guarantee liberty and privacy to the mother are incompatible. As such, hypothetical siding with either the mother or the foetus are typically discussed in nursing training in terms of the different actions a nurse would need to take depending on whether the nurse is 'mother-centred' or 'baby-centred'.

The BFHI policy assists the advocacy of breastfeeding. This is an implicit deployment of 'baby-centred' discourse. The term 'Baby Friendly' for the title of the BFHI policy, is the same, it appears to exclude bottle-fed babies. Most mothers choosing to bottle-feed their babies are anticipating establishing their long-term role of caring for their baby. It would seem impractical, not to mention ethically disturbing, to attempt to privilege the infant's status as a client separately from the status of the mother who is destined to care for the infant (Cannold, 1995).

Another area of advocacy takes place through the monitoring of the Infant Formula marketing codes. Health professionals along with activist groups like Baby Milk Action advocate for mothers' "rights" to not be influenced by formula marketing as well as for mothers' rights to pro-breastfeeding information of the benefits of breastfeeding and risks of bottle-feeding. Note, however, that a criticism of bodies like the APMAIF is that there is no credible consumer position regarding consumer rights to information, especially not on bottle-feeding information (Carter, 1996).

One area that will be explored in the thesis is how Midwifery advocates a particular role for fathers as key supporters for breastfeeding. The importance of this role to mothers' breastfeeding success is recognised in the literature (Scott & Binns, 1998). Whereas the literature shows that bottle-feeding mothers increasingly desire the support and involvement of the baby's father in bottle-feeding (Earle, 2000).

The critical perspective and problematisation of contemporary Midwifery discourses offered in this section highlight the complexity of health care provision and infant feeding issues. The aim has been to prepare for the analytic chapters of the thesis that question the dogma underlying aspects of current Midwifery practices which, according to the bottle-feeding mothers of

Western Australia, worked badly for them. Critique typically aims to open possibilities by showing contradictions and difficulties with the existing system.

### **Return to 'rational, social reality', together with post-modern findings**

So far in this account of the research journey, I have shown how understanding the complexity of health care discourses as well as infant feeding policies and research results is not a straightforward matter. As a consequence, the parameters of the research grew iteratively. The critique offered by bottle-feeding mothers led to a trail of critical literature that challenged my own assumptions about Midwifery. This redirected the original aim of the study, which was to know 'the enemy' to better persuade mothers to breast-feed. Instead, it became a description and analysis of bottle-feedings mothers' social constructions of reality. However, postmodernism indicates that all actions are the result of ongoing struggles between competing discourses. It therefore became necessary to explore bottle-feeding mothers' experiences of coping in the pro-breastfeeding context established by Midwifery discourse and hospital policies.

The risk in a study of this nature is that it might be read as establishing a 'binary-opposition' of professional and client perspectives. Rather it is intended to deconstruct existing binary oppositions and expose the resultant marginalisation from contemporary infant feeding discourses that form part of what Seidel (1999) critiques as an "impenetrable discourse" of 'breast is best'. The binary oppositions in breast-bottle debates would suggest that in all cases of mother-baby dyads and in all contexts, (1) breastfeeding epitomises health *versus* (2) bottle-feeding that epitomises disease or death. Minchin, for example, sets in place a common (albeit marginalising and denigrating) binary opposition of: (1) breastfeeding as mother bonding and love *versus*; (2) bottle-feeding as mothers' selfishness and child-abuse. She writes, "For all these [bottle-fed] children, ... [their parents] may or may not become baby batterers." (1985, p. 310).

While informed by postmodernist paradigms of multiple perspectives, along with Porter (1998), I cannot escape the modernist belief in a "rational" approach to a "social reality" - that problems can be identified by research and become the basis for suggesting viable improvements (p. 225), and that those suggested improvements, even though they cannot be absolutely predicted, if followed would constitute "progress" for the socio-historic context in which they have been identified. As Fairclough maintains:

Of course, discourse analysis cannot per se judge the truth or well-groundedness of a proposition, but then critical discourse analysis is just one method to be used within wider critical projects. Judgements of truth and well-groundedness are not just a prerogative arrogantly claimed by intellectuals, they are a constant and necessary part of life for everyone, including Foucaultians (Dews, 1988).

(Fairclough, 1995, pp. 18-19)

Therefore, in this study, the postmodernist rejection of rigid binary oppositions and single truths is maintained without "retreating into a helpless relativism" (Fairclough, 1995, p. 19). Indeed, the postmodernist position that underlies this study leads to recommendations for improvement to Midwifery care practices. Once this "social reality" (Porter, 1998) of diversity of needs amongst women is recognised, incorporation of the knowledge about client diversity could be the basis for the profession to reconsider its discourse and services.

Returning briefly to accusations of a professional "culture of silence" amongst professionals about "the intractable differences between breast and bottle" (Minchin, 1985, p. 43), recommendations based on findings of this thesis are not a contribution to silence about good breastfeeding practices. The thesis demonstrates and explains the effects of Midwifery's current discourses, and provides evidence that its dominant discourses are selecting-out important co-existing truths and silencing discussion of the subjective experiences and perceived needs of bottle-feeding mothers. Old or new, knowledge is not a solid "body" but a dynamic, changing set of understandings. For example, tragic new issues such as the transmission of HIV through breast milk highlight that even "truths" that 'breast is best' are never "intractable" for all people in all contexts (Seidel, 1999)<sup>10</sup>. A responsible profession needs to remain open-minded and allow for circumspection even about its own traditions and knowledge base.

This thesis will demonstrate that Midwifery has moved beyond being pro-breastfeeding into a dogmatic position, closed off to other knowledges, and even subtly hostile towards clients who choose the other option of bottle-feeding. This has created a set of mutual "deficit" models of mothers and of Midwives likely to prevent the profession from moving forward and overcoming the rift. Therefore, a *rational* acceptance of multiple truths, diversity of needs and complexity in the client cohort, may be the way to enhance future directions for Midwifery.

## **Frameworks for health policy and information standards**

A key area to be explored in this thesis is Midwifery's relationship to knowledge. The notion of professionalism is premised on the ability to apply scientific knowledge, and therefore to be

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<sup>10</sup> Refer to Appendix B

able to access and develop understandings based in truth. Anything less is a vocation, a craft or something lesser, such as superstition or witchcraft. Thus, it implies a sense of using knowledge rationally, and that rationality avoids dogma but encourages the use of professional judgement of each new case. Thus the relationship to knowledge includes a necessary openness to truth. It is irrational to choose to be closed off to other knowledge. If an organisation such as Midwifery wishes to avoid dogma in order to be professional, then it needs to acknowledge complexity. Dogmatic positions silence other valid truths. A common description of the difference between a professional and non-professional in health care is as follows:

The professional nurse always looks for new meanings in nursing phenomena. The ability to see new relationships in human behaviours or new patterns of response leads to more questions about nursing actions. Rather than revert to lock-step thinking — where if X happens, then Y is the appropriate nursing action — the professional nurse critically analyses multiple factors and examines all feasible possibilities.

(Donahue, 1998, p. 99)

This thesis discusses Midwifery's orientation towards informing bottle-feeding mothers in the context of health policies such as the BFHI. It documents the significant differences between the way in which Midwives prepare mothers for infant feeding and what the bottle-feeding mothers consider to be adequate information.

The section following will outline the tensions for Midwives between: (a) promoting policy and providing balanced information, (b) the field's health objectives as explained in health-beliefs models, and (c) the field's understandings about the nurse's/midwife's role in health as explained in nursing health models.

### ***Policy promotion or balanced information?***

Part of a health professional's role is to try to influence clients to make healthy choices. It becomes a grey area about what they should do if the client seeks treatment or assistance in a health action that does not accord with what the health professional considers best. In such a case, our society and associated professional practices normally would let the client make the decision within parameters of 'informed choice'. This is also accepted in the written BFHI document (although how it is enacted in practice might be different, and is certainly more complex than this simple solution sounds).

Edelman and Mandle (1994) suggest that often there is a dilemma for health professionals between trying to persuade a client and giving them straightforward facts. They discuss the importance of "marketing" and "promotion" in delivering health services: "Preventative health care and health promotion involve a great deal of voluntary consumer participation. Often the



need for health habit changes is not apparent, and the less apparent the need, the harder it is to convince persons to buy."

Fairclough (1995, p. 138), concerned with language and discourse, discusses the phenomenon of how: "Contemporary culture has become characterized as 'promotional' or 'consumer' culture ... [whereby it is more common to have the communicative function of] 'selling' goods, services, organizations, ideas or people."

Fairclough argues that this creates problems of trust because it is hard to know when someone is being authentic and caring, or when they are "using friendly talk ... [that is] simulated for instrumental effect". He suggests it goes even deeper than difficulties associated with trust. "It is difficult to not be involved oneself in promoting, because many people have to as part of their jobs ..." (p. 140). Promotional responsibilities affect Midwives who are bound by various policies on patient relations, including promoting breastfeeding.

As well as promotion, Edelman and Mandle (1994, p. 127) discuss the ethical problems of presenting information in particular ways in relation to informed choice of patients. Bok (1978) identifies two ways to interfere with legitimate, autonomous choices by patients. These are overt coercion and deception. She defines deception as manipulating the information reaching patients so that they accept what they would not have chosen had they been correctly informed.

Midwives' daily work is affected by policies, such as the BFHI, governing the kinds of information that should be delivered about infant feeding.

In some of the infant feeding policy documents, there are guidelines about presenting information about bottle-feeding that is "appropriate" and defining limitations on who can be taught to prepare formula, under which circumstances they can be taught, and which perspectives on bottle-feeding and breastfeeding need to be conveyed. Whilst recognising the desire of professions to make their policies work and have practices that support rather than contradict those policies, it is worth considering how those guidelines affect bottle-feeding clients. Fairclough discussed language education policies that were legitimated as supporting "appropriateness models" in terms of the effects on different groups (sociolinguistic groups) and which might be informative in the debates on infant feeding advice and information in terms of the effects on different groups' preferred methods.

Appropriateness models derive from a confusion between ... realities and political projects in the domain of language: social order. Appropriateness models in sociolinguistics or in educational policy documents should therefore be seen as ideologies, by which [they] ... correspond to the perspective and partisan interests of one section of society or one section of a particular social institution — its dominant section. ... [Alternatives may] coexist, but the issue of dominance relationships between them generally arises. And dominance commonly means not the elimination of all but one practice, but the relative marginalization of non-dominant practices, or the incorporation of non-dominant practices into dominant ones.

(Fairclough, 1995, p. 248)

Fairclough's view shows the other side to what seems like a sensible approach in having policies where the advice and information given to clients is "non-contradictory", for example, Hauck's (2000) suggestions for mothers' needs of non-contradictory pro-breastfeeding information. That suggestion is a commonplace conclusion in health professional literature, which as it happens creates dominant and marginalised positions for different groups.

The disenfranchising effect of current health practices on bottle-feeding mothers is a concern that will be explored in this thesis. So too will be the problems for Midwifery, of competing professional imperatives to persuade and clearly inform, each of which carries its own sets of ethical dilemmas in relation to delivering information. To fully comprehend the issues it is important to understand aspects of contemporary health promotion theory.

### *Health-beliefs models*

The fields of Nursing and Midwifery, charged as they are with the responsibility to help clients make healthy choices, find it useful to understand why people make particular decisions that guide their health actions. Sometimes this information is used in a marketing fashion to be able to better persuade clients to 'buy' a certain policy. Differently to this (and perhaps less commonly) it can also develop understanding of client's perceived needs in order to deliver services they desire (Edelman & Mandle, 1994). As such, various models aimed at explaining and predicting health behaviours have been developed (Janz & Becker, 1984; Rutledge & Kinman, 1986).

The Health Belief Model (HBM) first formulated by Hochbaum, Leventhal, Kegeles and Rosenstock (Champion, 1984) was originally developed as a systematic method to explain and predict behaviour. In this the HBM reflects the influence of psychologist Kurt Lewin, who noted that it is the world of the perceiver that determines what an individual will and will not do (McCormack Brown, 1999). Like Lewin, early researchers included a strong component of the individual's perceptual world. In sociology, too, W. I. Thomas was writing, in the early 1930s, that: 'what is real to man (*sic*) is real in its consequences'. Later, in the 1960s, Berger and Luckman (1968) expanded the analysis into theories of the social construction of reality which recognise that individuals interpret and construct their own social worlds. The HBM arose from this theoretical background and has been continually adapted by others in the field.

Rosentock (1974) stipulated that in order for an individual to take health action, four components would need to be present:

1. perceived susceptibility;
2. perceived seriousness;
3. perceived benefits;
4. perceived barriers.

In brief, there must be a belief that one is susceptible to a condition that would have an adverse effect on quality of life. Further, before a health-decision is taken it must be understood that taking a particular action may reduce susceptibility, and that the cost in time, money, and energy is not unreasonable.

The HBM has provided a framework for numerous studies investigating all types of health behaviour. For example, topics such as breastfeeding in which Kim (1998) showed that the HBM explained how successful breastfeeding mothers were able to concentrate on the perceived benefits of the health of their baby and overcome the perceived barriers of breastfeeding problems. Similarly, in studies on breast self examination (Champion & Scott, 1997; Choudhry, Srivastava & Fitch, 1998); and cervical cancer screening (Neilson & Jones, 1998); the HBM was effective in explaining how women who presented for routine screening of breast lumps and cervical cancer understood the benefits of early diagnosis for effective treatment which helped them overcome the barriers of discomfort and embarrassment. The HBM was also used in wider areas such as, non-compliance with medication orders (Muliak, 1992); AIDS risk perception (Brown, 1998); smoking (Haddock & Burrows, 1997); hypertension (Wagner, 1998), and osteoporosis prevention (1998), where it was deemed appropriate as a paradigm for health-protection or preventative behaviour (Pender, 1987).

Janz and Becker (1984) conducted a critical review of 29 HBM related investigations published during the period 1974 to 1984, and concluded that their summary results provided substantial empirical support for the HBM in that it predicted health behaviours to some extent. However, the model was seldom used on its own, but combined with other models. As Knight and Hay (1989) suggested 'one can be unduly limited by focusing just upon a single health behaviour model' (p. 1314). Therefore, in this study of bottle-feeding women, the HBM is considered to be a useful framework for a highly complex body of knowledge. For analytic purposes, aspects of health beliefs and health decision-making will be considered in terms of their relevance to and explanatory power for the present study's findings. Well-known models of health decision-making will be deployed in the analysis in terms of their primary focus categorised in this thesis as motivation, the social-health-environment, confidence and self-efficacy, values, and life-style priorities.

### ***Nursing models of health***

Understanding why Midwives take certain courses of action is also important in this study because it accounts for the dissatisfaction (and some satisfaction) of bottle-feeding mothers. It is also important to understand professional motivations when making recommendations for new models of Midwifery practice.

Donahue (1998, p. 83) outlines the essential elements of a health model in the field of nursing:

1. Nursing — the roles and actions of nurses;
2. Client — recipient of nursing care;
3. Health — clients' place on the health-illness continuum; and
4. Environment — context for nurse-client interactions.

In relation to this study, those elements correspond as:

1. *Nursing* — Midwives' role in establishing and monitoring early infant-feeding and mothers' health, with the expectation that they will promote breastfeeding;
2. *Client* — mothers are educated pre-natally, assisted during the birth and supported post-natally by Midwives, child health nurses (health visitors); bottle-feeding mothers are often regarded as non-compliant with Midwifery's advice;
3. *Health* — infant-feeding is closer to a health matter than an illness matter; and
4. *Environment* — Western Australia is located in an affluent, developed country with policies such as the BFHI and the WHO Code guiding Midwives, combined with democratic values that allow client choice and consumerism.

This framework underlies much of the analysis and recommendations of this thesis.

### **A critical and rational destination — does the study come far enough?**

The orientation of this study, which listened to mothers, is in the 'caring' model of nursing (Donahue, 1998). Caring itself is a complex concept; nevertheless, as the thesis will demonstrate, the services received (or denied) by Midwifery, hospitals and other organisations were an important aspect in the mothers' experience of care whilst establishing bottle-feeding with their babies. At the same time, the reality facing Midwifery is that the profession has an important educative function (Bandura, 1997) that would not support 'free-choice' because their influence can positively influence client, hospital, national and global health outcomes (Green, 1986). In line with policy and bottle-feeding mothers' needs, the right of the mothers to make an informed decision, and the role of Midwifery in enabling this right, is explored in the thesis. This thesis does not reject the superiority of breast milk for infants in the majority of healthy cases, nor the advantages to most mothers

(medical, emotional and possibly social) if those mothers are content to breastfeed. Extrapolated from the bottle-feeding mothers' descriptions, what they implied would be a desirable attitude towards them by Midwives overseeing their infant-feeding experiences, in many ways this overlaps with the caring model of nursing:

Human beings are viewed as unitary wholes who are free-willed, intentional beings and who actively participate in continuous interactions within their dynamic social, cultural and historical world. The human's lived experience is in the fundamental, preeminent reality of concern to nursing and includes what the person thinks and feels, along with their complex past, present, and future as perceived and experienced in relation to the here and now. This emerging perspective of nursing is a major shift from the biologic model.

(Donahue, 1998, p. 86)

Whilst this study considers the experiences of bottle-feeding mothers in Western Australia, what will be documented in the analytic chapters is that they felt dissatisfied with Midwifery's services. Therefore Midwifery has become a second major focus for the thesis. In seeking to understand Midwifery actions, it is clear that in Australia the profession is currently highly influenced by policies and directions of the BFHI. The thesis takes a critical perspective in that it analyses power relations between the health providers and the clients. It does not assume personal struggles of dominance and subordination between those two groups but it considers the constraints on professionals by policy and the freedoms available to clients to choose. Neither does the thesis critique the BFHI policy as being altogether wrong; it examines the problematic effects of a pro-breastfeeding policy that in writing apparently makes more concessions to serve bottle-feeding clients, than some instances of practice appear to be support. The BFHI policy is, in fact, extremely useful to Midwifery. What is positive about the BFHI in the dominant discourse of Midwifery, is that it gives the profession accrediting powers and, more recently, has allowed the opportunity for the profession to oversee funding as part of a national nutrition strategy. The Australian Midwifery Association has described breastfeeding as its core business. Thus, the profession has become positioned to actively implement policies for which it has previously lobbied very hard. In the context of the Midwifery profession's other (contentious) recent gain and loss of home-birth practices<sup>11</sup>, the value of the BFHI asset for developing professional effectiveness is even greater. Nevertheless, the BFHI and current Midwifery practices are problematic, especially in terms of how the bottle-feeding mothers were found to feel marginalised, and deprived of that information and support. This finding is also influential in terms of what the thesis will propose in relation to how the BFHI might be interpreted, built upon or adapted to take a more sophisticated overall perspective of Midwifery's full range of clientele.

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<sup>11</sup> Although affecting only a fraction of births and professional Midwives' activities, home births were lobbied for within the profession. Rising indemnity insurance costs are expected to end the viability of such home births; this factor occurred in a similar time-frame to recent bad publicity about the practice and lobbying against it.

## CHAPTER 2 - Methodology and Methods

Qualitative research seeks to explain social meanings. Its relevance to the health-care field is its usefulness to gain an understanding of the experiences of particular client groups. In this study, a qualitative approach was used in order to develop Midwifery's understanding of the experiences of bottle-feeding mothers in Western Australia.

Social meanings are dynamic, and it is therefore important for qualitative research to be both reflexive and open-minded. In being reflexive, qualitative researchers must try to be aware of their own social meanings in order to take them into consideration. In being open-minded, qualitative researchers must also accept and even seek opportunities whereby multiple readings of the same reality can surface (Cheek, 1996, p. 503, cited in Streubert, 1999, p. 3). The idea of multiple realities is accepted in contemporary postmodern approaches to research but also dates back to the foundations of social research when Weber remarked:

There is no absolutely "objective" scientific analysis of culture - or put perhaps more narrowly but certainly not essentially differently for our purposes - of "social phenomena" independent of special and "one-sided" viewpoints according to which - expressly or tacitly, consciously or unconsciously - they are selected, analysed and organised for expository purposes.

(Max Weber, 1949, p. 72)

Weber's views and contemporary postmodern perspectives each acknowledge the impossibility of absolute objectivity, but each tradition demands the researcher's consciousness of subjectivity and effortful incorporation of processes of reflexivity and openness. In qualitative research, the rationale and justifications of the research processes argue for the ultimate acceptance of the study's adequacy of objectivity. These imperatives apply both to the observing processes of qualitative research and to the reporting processes.

In the present study, various qualitative approaches were systematically applied to collect, analyse and interpret data in order to understand and then explain as objectively as possible the socio-cultural phenomenon of bottle-feeding mothers' experiences. Patton (1990) describes the mix of creativity and rigour behind successful qualitative inquiry methods as follows:

The validity and reliability of qualitative data depend to a great extent on the methodological skill, sensitivity, and integrity of the researcher. Systematic and rigorous observation involves far more than just being present and looking around. Skilful interviewing involves much more than just asking questions. Content analysis requires much more than reading to see what is there. Generating useful and credible qualitative findings through observation, interviewing, and content analysis requires discipline, knowledge, training, practice, creativity and hard work.

(Patton, 1990, p. 11)

The present chapter will elucidate the methodology for the research and then the step-by-step methods undertaken in reaching the research findings.

## Section 1: Methodology

### Reflections on presenting the Methodology

Writing, or reporting the thesis, has been demanding and complex, and of itself has raised hermeneutic questions of the extent to which language allows truth, and the role of my "self" in attempting to find and report truth. The study's commitment to a critical discussion of Midwifery discourses and infant-feeding discourses has drawn on a field that, like qualitative research in general, suggests self-reflective concern is owed to such matters. Foucault's discussion of discourses describes the deep problem as well as the reason for persevering:

Ought we not to admit that, since language is here once more, man [sic] will return to that serene non-existence in which he was formerly maintained by the imperious unity of Discourse? ... [Such issues of language and Discourse] are at most questions to which it is not possible to reply; they must be left in suspense, where they pose themselves, only with the knowledge that the possibility of posing them may well open the way to a future thought.

(Foucault, 1972, p. 386)

Three contentious aspects of reporting qualitative research methodology that have concerned me in a pragmatic sense are: the writing's time orientation, the visibility of the researcher, and the writing's assumed "ideal reader". This methodology section, will address each of these issues before describing the research methods employed to reveal the experiences of bottle-feeding mothers in Western Australia.

Firstly, the time orientation should account for the evolving and unfolding nature of the qualitative research process. This is unlike studies that conform to experimental designs that present methodology in the future tense as an initial blue-print or directive to which the research process will closely adhere. The iterative process in this study means that this study is not reported solely in the future tense but also refers back to specific stages in the process. The account offered in this chapter makes transparent how the research evolved through cycles of analysis and interpretation that led to further data collection, further analysis and further interpretation. If there is one guiding statement that best underpins this mammoth task it is Porter's advice to, "Consider whether the supporting evidence in the literature really is supporting your analysis or if it is just expressing the same cultural background as yourself" (Porter, 1993). Ahern points out that, "In qualitative research, the substantive literature review often comes after the analysis. The form of research literature is just as much the result of convention as any other cultural artefact" (1999, p.410). Although the substantive review will not be presented after the analysis in the present thesis, it was significantly re-shaped and drew on many other sources after the initial interviews. It was, in fact, the last chapter to be substantively shaped in the reporting processes but still plays that conventional role of

foregrounding the questions, analyses and findings of the study. However, the language of the time-frames becomes blurred by the complexity of the reporting process.

Secondly, the visibility of the researcher is significant. For example, the study's range of research methods called for the researcher to be sometimes bracketed out in a phenomenological stance and at other times to be visibly situated within the research context in a participant observation stance (Patton, 1990; Streubert & Carpenter, 1999). Ahern (1999, p. 409) poses the following challenge to nursing researchers, "Porter (1993) suggests that researchers' use of the third person reflects their assumption of objectivity. Does this apply to you?" The researcher's level of visibility will be made as transparent as possible through use of personal pronouns which mainly are used in this chapter but not in the analytic chapters where the focus is intended to be on infant-feeding practices. This will situate me, the researcher, in terms of the research context and results. In so doing, it is important to document the values and principles on which this study is based. It is my belief that it would be misrepresentative to exclude myself from an account of the methods. Even at the points of consciously taming my subjectivity — from the conception of the research question to the final interpretation and reporting — the research process involved me in a great deal of soul-searching and thinking about who I am, who I was, who I should be and sometimes burying my own perspective and other times strongly drawing on it. It is important to note that I am a midwife and a former breastfeeding mother. Further, the original aim of this study was to better understand bottle-feeding mothers in order to persuade them to breastfeed. That aim changed, it was redirected to a critique about the production of specific infant-feeding practices in hospitals. As such, questions of "who I am" have become unsettled in the research process. Certainly the analytic chapters have depended upon me as 'interpreter'.

Thirdly, in presenting this chapter with a time-frame that can shift back into the past tense, and with an overt inclusion of myself, the intention is to offer a clear and accurate account to a notional reader. I have envisaged the Ideal-Reader as a professional peer concerned with the issue of infant-feeding practices, not only interested in judging for herself or himself the rigour of this piece of research but also deeply interested in the practical details of the qualitative research process. (Foucault, 1972, in his preface, refers to an Ideal Reader, described as one at the same level of philosophical thinking underlying his thesis, and therefore ideally able to avoid being detracted into solved issues. For instance, in this study, a single "best" method of infant feeding is untenable, but "best" comes to be understood as the term supporting a discursive strategy for policy-making.) I have aimed for a level of detail that may have been useful to me to guide my study had it appeared in someone else's thesis. Therefore, rather than aiming to impress the inevitable Examiner-Readers with false allusions to my having had a



smooth and unproblematic engagement with the finer nuances of qualitative research methods, I have chosen the riskier path of aiming to disclose my unexpected difficulties and my untangling of problems underlying some of the study's major methodological choices. Thus, this chapter's narrative is intended to describe authentically how I developed the study's research directions, what I found when I conducted the research, and what was involved in the journey towards my understanding of the research problem as it is finally presented in this thesis.

## **Summary of Research Background**

The research is located within the context of Western Australia (WA) in an era when the dominant Midwifery professional attitude towards infant-feeding is strongly pro-breastfeeding. That attitude accords with the World Health Organisation (WHO) and other local professional organisations that have set breastfeeding targets of at least 90% of mothers, and that would therefore reduce levels of mothers initiating bottle-feeding to 10% or less.

The field of Midwifery in recent decades has made substantial efforts to claim the status of a recognised and skilled profession, including emphasising the promotion of knowledge that is specifically useful to nurses and midwives. The profession has tended to be sceptical about the previous scientific-medical findings of an earlier era that uncritically supported bottle-feeding as a suitable form of infant nutrition. As well as increases in breastfeeding rates being a great achievement that improves the health status of infants, an effect of achieving change towards the targeted goals can also be seen as establishing the value of professional Midwifery knowledge, since, arguably, midwives have always known that "breast is best" but more recently the profession has developed improved knowledge about how to influence clients to make healthy choices<sup>1</sup>.

Even though there have been considerable recent advances in implementing pro-breastfeeding policy and practices, bottle-feeding continues, in fact, to be the practice of a significant percentage of the field's clientele. 17-23% of mothers in WA have continued to choose to bottle-feed their babies at birth. This is problematic for Midwifery as a field of health care that is entrusted with the establishment of adequate nutrition for all newborn infants.

It was against a fiercely pro-breastfeeding backdrop that this study began. It stepped back to consider the perspectives, of mothers positioned outside of the dominant Midwifery advice, who have chosen to bottle-feed their infants.

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<sup>1</sup> Prior to the more recent widespread recognition of mother-child transmission of HIV in poorer parts of Africa in particular, the midwifery knowledge that "breast is best" had wide support on a global scale.

## Research Purpose

The aim of this study is to add to the knowledge of infant feeding by:

1. Developing a descriptive understanding of the experiences of bottle-feeding, specifically incorporating the perspectives of mothers.
2. Exploring how Midwifery professional knowledge might be enhanced by the study's findings about how mothers feel about their choice to bottle-feed, how they cope with the task, and their perceptions of the influences on them of their family, health professionals, and wider society.
3. Examining the relevance of current theories of health decision-making to the infant-feeding choice.

## Research Questions

The broad research question is:

- **Broad Question:** *What are the experiences of bottle-feeding mothers?*

The research sub-questions reflect two competing professional goals for Midwifery with regard to bottle-feeding practices, as well as the broader theoretical underpinnings of health decision-making:

- **Sub-Question A:** *How might understanding these mothers' experiences lead to improved methods of encouraging future mothers to make the feeding choice of breastfeeding for their infants?*
- **Sub-Question B:** *How might understanding these mothers' experiences suggest solutions to the professional Midwifery dilemmas of when, and in what ways, a mother's choice to bottle-feed should be accepted and supported?*
- **Sub-Question C:** *To what extent do current theories about health decision-making account for the decision to bottle-feed?*

This study's first question aims to gain insight into the broad "experience" of bottle-feeding from the perspective of bottle-feeding mothers. Additionally, the underlying research questions a, b and c indicate my initial research hunch that the way forward in the Midwifery profession's understanding of the issues lies in improving the field's understanding of "choices". Furthermore, the study's underlying research goals were to turn the findings about the mothers' experiences into explanations of value and relevance for guiding the "professional practice" of Midwifery. The range of research approaches ultimately applied in this study allowed for consideration of all three of those issues: experiences, choices and professional practice.

## Selecting Appropriate Research Methods

This section provides a general rationale for the selection of research methods used in this study. It explains in broad terms how the choice of approaches from amongst various alternatives suited the research goals, and briefly narrates how those decisions to use a variety of research approaches evolved.

The research stance needs to be clarified because the study has a contentious topic. Although superficially the present study may appear to have departed from the dominant Midwifery concerns about infant-feeding both globally and in Australia, I believe that even within Midwifery's current pro-breastfeeding context this study into bottle-feeding poses relevant and timely questions. Any research study, especially one investigating a new, neglected or troublesome topic, should aim to be both open-minded and rigorous in its methods, allowing for flexibility in its research directions and for validity in its asserted findings. This study has attempted to allow for both of those research tensions by choosing a variety of qualitative research approaches that are relevant to the research questions.

Experiences and choices are best explored by using qualitative research orientations from fields that explain thinking. Typically, philosophy and psychology provide methods for understanding or explaining inner intuitive feelings, logic and motivations, and anthropology and sociology provide methods for understanding and explaining how choices are made according to and within social contexts. Philosophy's branch of phenomenology seemed most appropriate for me as an Outsider to understand the mothers' perspectives on their choice to bottle-feed and their experiences of nurturing their babies in this way. The intention was to take an adapted, "soft" approach to the phenomenological study, allowing the use of interviews to elicit the mothers' rational accounts of their experiences rather than taking a more "hard-line" phenomenological approach, such as aiming to capture the mothers' pre-rational intuitive feelings. Patton describes the approach I adopted in this study as follows: "Phenomenologists focus on how we put together the phenomena we experience in such a way as to make sense of the world and, in so doing, develop a worldview." (1990, p. 69). In this thesis, the worldview of bottle-feeding mothers was elicited through interviews. Patton adds, "There is no separate (or objective) reality for people. There is only what they know their experience is and means. The subjective experience incorporates the objective thing and a person's reality." (p. 69). Thus the approach in interviews for this study was to listen very carefully to what the mothers described as their experiences, and especially what those experiences meant to them.

Another aspect of phenomenology relevant to the approach in this study concerns what Patton has said is the method's defining quality: "the assumption that there is a shared essence or

essences to shared experience". (p. 70). Thus, phenomenology accepts participants' perspectives on their experiences as being true for them and shaping of their experiences and future actions. Such a consideration needs to be taken seriously by professionals aiming to serve their full clientele. The interviews were insightful, not least of all because many of the patterns of responses elicited from the mothers were completely unexpected. Those patterns are treated in this thesis as "themes" that have aimed to capture the "essences" of the women's shared experiences. For example, an essential shared experience is dissatisfaction and frustration with Midwifery's information standards and the pressure tactics of some pro-breastfeeding midwives; that underlies what I have thematised as "marginalisation". Marginalisation is not a word used by any of the mothers but it interprets their experiences in terms of the power relationships at play. Husserl discussed methodological issues of capturing phenomenological expression:

The hearer perceives the speaker as manifesting certain inner experiences, and to that extent he [sic] also perceives these experiences themselves; he does not, however, himself experience them, he has not an 'inner' but an 'outer' percept of them. Here we have the big difference between the real grasp of what is inadequate intuition, and the putative grasp of what is on a basis of inadequate, though intuitive, presentation. In the former case we have to do with an experienced, in the latter case with a presumed being, to which no truth corresponds at all. Mutual understanding demands a certain correlation among the mental acts mutually unfolded in intimation and in the receipt of such intimation, but not at all their exact resemblance."

(Husserl, 1986, p. 173)

Although intellectually exciting, the unexpected perspectives gained from this phenomenological aspect of the study posed several inter-related problems. The analyses were based on one group's perspectives alone and tended to produce polemical, binary explanations. For instance, the phenomenological explanations of this study tended to polemically situate mothers in opposition to professionals. This outcome is important to the study and has been maintained in the analyses; however, the phenomenological approach's compelling privileging of the mothers' perceptions had little explanatory power for the Midwifery field within its current professional constraints. In other words, the analytic outcomes from phenomenology did not seem to adequately fit the research problem and were too incomplete.

Despite the strengths of data collected on the mothers' perspectives, I was extremely uncomfortable about the unsolved loose ends that had been created; the previously identified professional perspectives underlying the interview structure fitted very poorly with the phenomenological research findings. Researchers working on the Outside have to make an effort to not directly reinterpret back into their own experiences. One technique for avoiding this outcome is called Bracketing. Using a phenomenological approach as the most appropriate orientation for gaining insight as an Outsider into the perspectives of the bottle-feeding mothers, the interviews and initial analyses benefited by bracketing out my researcher's perspective. Bracketing, according to Streubert and Carpenter, is:

A methodological device of phenomenological inquiry that requires deliberate identification and suspension of all judgments or ideas about the phenomenon under investigation or what one already knows about the subject prior to and throughout the phenomenological investigation.

(Streubert & Carpenter, 1999, p. 329)

The techniques include writing down the researcher's beliefs and thoughts to suspend, especially before entering interviews with participants to try to ensure "pure" descriptions of data (Carpenter, 1999, p. 61).

Nevertheless, after developing themes based on data of the bottle-feeding mothers' essentially shared experiences and their worldview, I considered that the pre-existing professional perspective could not viably be simply dismissed on the basis of this one small study without any further exploration and explanation. But the phenomenological method in itself did not offer ways to more fully investigate these problems-arising. I will borrow once again from Foucault's discussion of his postmodern methodology, as his profound work influenced my awareness of the implausibility of relying entirely on the data of interviews with bottle-feeding mothers.

... I should not like the effort I have made in one direction to be taken as a rejection of any other possible approach. Discourse in general, and scientific discourse in particular, is so complex a reality that we not only can, but should, approach it at different levels and with different methods. If there is one approach that I do reject, however, it is that (one might call it, broadly speaking, the phenomenological approach) which gives absolute priority to the observing subject, ... which places its own point of view at the origin ... It seems to me that the historical analysis of scientific discourse should, in the last resort, be subject, not to a theory of the knowing subject, but rather to a theory of discursive practice."

(Foucault, 1972, p. xiv)

Thus, after a period involving despair, discussion and angst about the problem, I came to see the research as having been too naively modernist in its assumptions, and that my findings had only reached a first phase. The study needed to include other ways of thinking so that an adequate analysis of the phenomenon of bottle-feeding could be developed. In other words, even if my bracketing efforts had been sufficient for me to simply concede to the bottle-feeding mothers' views suggesting that Midwifery may have been substantially mistaken about breast being best, I felt that for my research to have credibility I needed to provide fuller explanations. In particular, the analyses needed also to account for the mismatch between the perspectives of bottle-feeding mothers and Midwifery, and needed to explain how such an intense divide in perspective had occurred. Thus, from the first insightful step via a phenomenological approach eliciting the bottle-feeding mothers' perceptions, I broadened the research focus so that it could consider other perspectives and could more clearly contextualise the issue of bottle-feeding in terms of current "professional practice" as discourses.

The second phase of data collection for the study introduced a number of additional qualitative research approaches, these were: participant observation, postmodern analysis and hermeneutic

analysis. This stage of data collection arose from a critical stance – that is, it was used to investigate Midwifery's stance on bottle-feeding stemming from concerns among bottle-feeding mothers about the deficiencies of Midwifery's practices. It is unlikely that, as a researcher, even using the same techniques, I would have investigated these issues without having previously explored the mothers' concerns. Thus, the critical, qualitative research approaches for both phases of data collection and the study's analyses were inter-related.

Triangulation is a qualitative set of techniques that can be used to broaden the research base. Rice and Ezzy (1999, p. 38) describe triangulation as follows,

Recent qualitative researchers have cautioned against seeing triangulation as a way of discovering what is actually going on by comparing one method against another and deciding which one represents the truth (Mason, 1996, p. 149). Rather, triangulation allows the research to develop a complex picture of the phenomenon being studied, which might otherwise be unavailable if only one method were utilised.

(Flick, 1992; Lucchini, 1996)

Furthermore, they describe four distinct types of triangulation: Data Source Triangulation, Methods Triangulation, Researcher Triangulation, and Theory Triangulation. Apart from Researcher Triangulation which was not systematically applied (apart from the ways that all research projects have input from others) all of those forms of triangulation have been used in the present study. The point being made here applies particularly to Data Source Triangulation which involves the use of multiple information sources, firstly the bottle-feeding mothers and secondly the Midwifery profession.

Participant observation is an ethnographic technique that allows insight into procedures and activities, usually with the goal of developing insight into the perspective of Insiders of a given social group. Typically, a participant observer begins as an Outsider and spends considerable time coming to understand the culture of the group being observed because they are uninformed about what seems natural and meaningful to members of the group. Goodenow (1971, pp. 21-22) describes the "standards" built out of and into the practices and beliefs of a culture, in ways that are applicable to my intention of developing a voice for a notional group of "Midwifery" regarding bottle-feeding, as follows:

A cultural group will have shared standards for deciding what is, standards for deciding what can be, standards for deciding how one feels about it, standards for deciding what to do about it, and standards for deciding how to go about doing it.

(cited in Patton, 1990, p. 68)

For this study, however, the methods were adapted to the research situation since I was an Insider to the Midwifery profession but at that point loaded with an Outsider's perspective and questions. In this instance bracketing techniques again needed to be used to create a suitably astute observing frame of mind. The advantage of having access to the Outsider perspective was that it overcame the typical disadvantage of a purely Insider's insight, that is, a lack of

comparative perspectives. This part of the research took the form of participating in professional fora, holding discussions with people in key professional positions, scrutinising the professional literature, and working and observing on a range of maternity wards in Perth hospitals. From my observations I developed descriptions of the Midwifery profession and some comparable composites of different types of maternity ward. Max Weber's work suggests that "ideal types" are a starting point for research and provide a framework for specific instances. In more recent critical thinking the interpretive, heuristic act of the researcher in constructing these has been noted, for instance Gordon Marshall says,

Perhaps the best way of thinking about ideal types: that is, something which the sociologist works out in his or her head with reference to the real world, but selecting those elements that are most rational or which fit together in the most rational way.

(Marshall, 1998, p. 292)

Comparisons were made of the everyday experience of staff as well as provisions of equipment needed by bottle-feeding mothers, adherence to BFHI's preference for exclusive breastfeeding, and each hospital's nursery services.

Since I felt that the background literature already reflected dominant Midwifery perspectives, the purpose of the second phase of the research was to be able to generate a "voice" for Midwifery that would be much broader than my own opinion and conjecture, and that would be developed in the light of serious criticisms that had been levelled at the Midwifery field by the bottle-feeding mothers. In this way the research data was broadened and became more able to account for the differences in perspectives of the mothers and health professionals. The resultant investigation of differences in perspective aimed to incorporate an understanding of the specific socio-historical context for bottle-feeding mothers and Midwifery professionals in Western Australia. It is theoretically problematic to assert finding a single "voice of dominant Midwifery", but it is useful to re-examine the patterns of Midwifery actions and inactions identified by the bottle-feeding mothers in order to extrapolate that, what appeared deficient to the bottle-feeding mothers did not necessarily also appear deficient to midwives. The analysis therefore aims to explain typical underlying circumstances and reasoning for particular Midwifery actions. Nevertheless, my participant observations revealed that when members of the profession were representing themselves as a group, their voice was highly unified, closely mirrored BFHI policy and was explicitly antagonistic towards alternative ideas. Whereas, individually, (such as in phone conversations with the same office bearers representing themselves in professional roles, such as in Director of Nursing positions of particular hospitals), the midwives' voices varied. They were more likely to draw my attention to concerns they had about one or more aspects of the BFHI policy and difficulties related to the complex responsibilities won by the profession to oversee it. Both of these tensions were drawn upon in discussing the notional "dominant Midwifery profession" and "Midwifery voice". The study took shape as it is presented in this thesis within an analytic framework drawing on postmodernism and critical hermeneutics.

Postmodernism and critical hermeneutics were selected because of the temporary 'hiatus' position reached by the research that posed questions about the nature of its research methods. For example, was everything in the Midwifery field merely ideological; and why were there discrepancies between the study's background research assumptions and the responses of the mothers; and why had the professional literature not previously been aware of or answerable to some of the strong criticisms levelled against the Midwifery profession that were consistently expressed by the interviewed mothers?

Postmodernism allows for the temporary suspension of a notion of "truth", as well as allowing for the possibility of multiple truths for clients and professionals whilst examining issues of institutional power and practices. It is also a view that allows status of thinking and possible action to more than one group in a relationship, and I propose this can assist in an examination of the relationship between bottle-feeding mothers and Midwifery. Foucault explains this interdependence of discourses as follows:

Power comes from below; that is, there is no binary and all-encompassing opposition between rulers and ruled at the root of power relations, and serving as a general matrix — no such duality extending from the top down and reacting on more and more limited groups to the very depths of the social body. One must suppose rather that the manifold relationships of force that take shape and come into play in the machinery of production, in families, limited groups, and institutions, are the basis for wide-ranging effects of cleavage that run through the social body as a whole.

(Foucault, 1981, p. 94)

Thus it is important to understand the intricacies and effects of an institution's policies at various levels. According to Patton:

Hermeneutics is the study of interpretive understanding, or meaning, with special attention to context and original purpose. The term hermeneutics refers to a Greek technique for interpreting legends, stories and other texts. To make sense of and interpret a text, it is important to know what the author wanted to communicate, to understand intended meanings, and to place documents in a historical and cultural context.

(Patton, 1990, p. 84)

The hermeneutic approach, therefore, allows an exploration of the multiple truth positions of the different groups, bottle-feeding mothers and professional midwives, from the assumption that they will be situated differently but nevertheless will both have rational lines of thinking leading to the differences. Eichelberger (1989, p. 9, cited in Patton, 1990, p. 85) argued that for researchers adopting this technique it is vital to be aware that, "they are constructing the "reality" on the basis of their interpretations of data with the help of the participants who provided the data in the study." It is a method for establishing the context and meaning for what a cultural group does and thus openly recognises truth as a "perspective" and therefore is open to including and comparing other perspectives. From the shared assumption of there being multiple truth positions, postmodernism and critical hermeneutics can be combined to form a powerful analytic strategy: Postmodernism can be used to examine the contextualised material



practices such as the constraints of working within professional hierarchies, and hermeneutics can explain the group's tacit meanings and interpret the role of their texts. For example, Foucault's thinking has suggested to me that midwives, and not only their clients, also have their position created and maintained by Midwifery's discourses. While the mothers' experiences felt to them like marginalisation, most midwives are likely to be unaware of that and instead would see themselves as responsible helpers, bound by deliberate professionalism that they may have come to strongly believe has, without question, values applicable to everyone. Foucault discussed power, but not as being part of an individual project:

Let us not, therefore, ask why certain people want to dominate, what they seek, what is their overall strategy. Let us ask, instead, how things work at the level of those continuous and uninterrupted processes which subject our bodies, govern our gestures, and dictate our behaviours etc. In other words, rather than ask ourselves how the sovereign appears to us in his lofty isolation, we should try to discover how it is that subjects are gradually, progressively, really and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts etc. We should try to grasp subjection in its material instance as a constitution of subjects.

(Foucault, 1980, p. 97)

Thus a postmodernist hermeneutics can assist the task of analysing a profession by interpreting texts such as professional journals and policy documents that describe the socialised position of members of an institution (in this case the Midwifery profession) in order to explain how members of that group make sense of their own roles. As a consequence of employing this research strategy the study will be able to develop an identifiable, professional perspective for Midwifery, as well as being better placed to explain the differences between professional perspectives and those of the client group of bottle-feeding mothers.

To summarise, the methodology included two broad research approaches, the modernism underlying the interview questions and the postmodernism underlying the critique of the Midwifery field that would ordinarily be considered to be oppositional. However, they were combined in a hermeneutic goal that each approach of phenomenology and participant observation would elicit useful perspectives — of bottle-feeding mothers and midwives, respectively. The hermeneutic analysis of meanings allowed for both of those perspectives to be taken into account, and their triangulation lent a powerful level of interrogation to the analyses before allowing the researcher any confidence to assert the validity of the results.

## Section 2 - Methods

The purposes of this methods section is to explain reflexively the actual steps taken, to specify the study's parameters, and to demonstrate the particular considerations given to validity and reliability. Nursing research sometimes uses the term "trustworthiness" in reference to issues of validity and reliability (for example, Streubert & Carpenter, 1999, use this term). Without sufficient measures to ensure trustworthiness, research activity cannot progress beyond mere speculation. The various qualitative approaches used in this study were applied systematically to generate accurate and credible explanations, and to extend the findings where possible to useful recommendations relevant to contemporary Midwifery.

### Phase One – Description of method and techniques

#### *Research Sample for Interview*

I interviewed twelve bottle-feeding mothers. Ten participants were recruited from a one-off advertisement in the local newspapers covering the full Perth Metropolitan area and a request on a local radio channel seeking mothers who had a baby under 12 months who they had completely bottle-fed. Of the ten mothers recruited by advertisement, two had breast-fed their infant for a short while. Another two participants were recruited by word-of-mouth snowball sampling and I had never previously met the latter two volunteer interviewees. A total of thirty-six women responded to the requests. Of the full cohort of responding women, most were found to not meet the criteria: sixteen breastfed their babies for under a week, with some changing to bottle-feeding before leaving hospital, sometimes for as short as half-a-day; and eight mothers who responded to the advertisement had babies over one year old. The twelve women, comprising the full sample of recruited mothers who at the time of recruitment appeared to have met the criteria, were chosen for in-depth interview.

Patti Lather (1991, p. 98) advises about research participants, "Rather than her demographics, let us focus on the desire that shapes her". Neither the recruitment advertisement, nor the paperwork for the study, nor the interview techniques sought or systematically collected demographic data such as age, level of education, marital status, or occupation and income of the mother or any male relative or partner. Although discussion of some of those issues in terms of the women's expression of their experiences occurs naturally in the interview transcripts, the decision to not systematically collect demographic data was based on two assumptions:

1. deliberate intention to break down the patriarchal traditions of demographic categories for females and, thereby, allow for each of the women's voices to be heard with equal status; and

2. To support the main methods used which were informed by phenomenology that intended to uncover 'experience' rather than sociological 'indicators'.

Qualitative research methods allow for the recruitment cycle to continue until saturation levels have been achieved in the responses. The discovery of sufficient overlap in the mothers' responses, which ultimately have been collated and reported in this thesis, were used as an indication that saturation was achieved, and that interviewing additional participants would be unnecessary. However, I considered that the data set needed to be broadened, not by interviewing more mothers but instead by investigating aspects of the Midwifery profession.

### *Issues and Problems with Interview Research Sample*

- a) Relevant to the decision to retain interview data from the two women who had briefly breastfed their infants are a number of factors. Unlike the majority of controlled studies which investigate primiparous women only, and which convey a different view compared to this data set — that individual women either only ever breastfeed or only ever bottle-feed — I was inspired to retain an angle demonstrated by this cohort of women that, more than the literature would suggest, some mothers who have previously breastfed one or more babies for a short time then choose to bottle-feed at initiation with later births. Of five women who also referred to experiences feeding previous babies, three had only bottle-fed their last baby but had breastfed their previous babies, and they brought into the discussion their previous breastfeeding experiences during the interview; so it seemed unnecessary to exclude those other two mothers who had fed their most recent baby for a short time and were anxious to offer their perspective to the study. The strongest findings of this study were consistent across the cohort, including criticisms of the Midwifery profession, and strongly defined reasons for preferring bottle-feeding. To have mothers who could personally compare their experience of both breastfeeding and bottle-feeding the same baby was an additional strength to their confidence in describing their attitudes towards infant feeding.
- b) A notable problem with the sample is that in spite of publishing the criteria and checking over the telephone with applicants that they met the criteria, two of the interviewees still had breastfed for a short time. If faced with an unexpected turn of events in qualitative research, a decision has to be made. Most often the data sets would be excluded for not meeting criteria, but if the data are valuable they can be retained with an explanation, such as in this instance. Unanticipated issues were at stake. As a consequence, I decided to retain both of those mothers' transcripts because they were useful to the data set. In the interests of transparency, I am disclosing here which of the interviewees had breastfed their

infant: The pseudonyms and transcript numbers were Erica, (Mother 03), who breastfed the baby for a short time changing to bottle feeds when she caught influenza and changing earlier than with her previous children, and Anne, Mother (04), who breastfed for a few days. The two women's short-term breastfeeding experiences still left them with common experiences with the exclusively bottle-feeding mothers that appeared to be consistent with the other women's views and together those views have informed the arguments in this thesis.

- c) In one of the interviews the father of the interviewee's baby joined in. At the time the interview was progressing well and the interviewee seemed happy for her husband to join the conversation, so I chose not to ask him to leave and anticipated later possibly needing to ignore his comments in the transcript. However, qualitative research methods allow for the incorporation of unexpected but useful twists, and this one father's voice serves as a very strong illustration of his belief that bottle-feeding had benefited him. That view accords strongly with those of several mothers regarding the advantages of bottle-feeding to their babies' fathers. Sarah Earle (2000) shows that she too found that amongst bottle-feeding mothers, "bottle feeding was perceived as a means of sharing their baby with the baby's father" (p. 327). She concluded, however, that, "it is not clear whether fathers wished to be involved or whether only the women in the study perceived this as important" (p. 328). The inclusion of this one father's comments begins to address that question.
- d) Thirty-four women responded to the advertisements for volunteer interviewees. It is astounding to think that only ten of the responding women completely met the criteria for interview, not counting the two who inadvertently were recruited to the study. When I explained the criterion of needing a baby under 12 months which the mothers had never breastfed, several of the respondents pointed out that -- to them, only half-a-day, one day or several weeks was relatively little in the overall role of feeding. They did not think of themselves as breastfeeding mothers but strongly self-identified as bottle-feeding mothers. The haunting sense I carry that there are many mothers out there who wanted their voices heard is partly placated by the knowledge that mothers Erica 03 and Anne 04 have been able to speak on behalf of women who have unsatisfactorily tried to breastfeed. The only major differences between these two women and the others were their descriptions of pressure by a husband and a mother-in-law to breastfeed and their sense of failure, whereas the exclusively bottle-feeding mothers did not appear to see themselves as "failed breastfeeders".
- e) There was a sense of authenticity to use all of the data I had collected. Removing a proportion of the interviews, those of Erica (03) and Anne (04), would have felt as if I was suppressing potential findings.

## **Phase 1 data collection - Interviews with bottle-feeding mothers**

### ***Phenomenology influence on techniques***

Since the present study's broad aims were to understand experiences, phenomenology as an approach offered a number of useful techniques. Phenomenology requires a very open attitude on the part of the researcher. In aiming to be open to the sense conveyed by interviewees, I used methods of bracketing (Patton, 1990). The use of bracketing is contentious; contradicting its many proponents, it is criticised on the grounds that it is impossible for a researcher to bracket out their true feelings and that, indeed, to bracket those out is not really positive for developing intuitive and authentic qualitative research results. Nevertheless, in this instance, I found it useful and did feel that I could bracket my own prejudices in order to listen sincerely to the interviewees. For sceptics who doubt that bracketing can work, the principle of the bracketing technique can also be understood in terms of consciousness-raising – writing down my thoughts allowed me to be aware of my feelings and prejudices and was useful in preparing me to listen openly to the interviewees. Of itself, it did not and could not have fully prepared me to deal with points of view that I had never encountered before, but it certainly played an important part in preparing me for open-mindedness in interviewing and analysing the transcripts.

### ***Interview questions and approach***

In qualitative interviewing it is important to have open-ended questions. Patton (1990) suggests, "The task for the interviewer is to make it possible for the person being interviewed to bring the interviewer into his or her world" (p. 279). Furthermore, "qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable, and able to be made explicit" (p. 278). Nevertheless open-ended interviews vary from being fully informal to being incorporated into standardised open-ended questions (Patton, p. 280). My questions took a middle ground within the spectrum of what Patton describes as the general interview guide approach.

The *general interview guide approach* involves outlining a set of issues that are to be explored with each respondent before interviewing begins. The issues in the outline need not be taken in any particular order and the actual wording of questions to elicit responses about those issues is not determined in advance. The interview guide simply serves as a basic checklist during the interview to make sure that all the relevant topics are covered. The interview guide presumed that there is common information that should be obtained from each person interviewed, but no set of standardised questions are written in advance. The interviewer is thus required to adapt both the wording and the sequence of questions to specific respondents in the context of the actual interview.

(Patton, 1990, p. 280)

The interview questions were based on a number of broad themes that were asked in open-ended ways. The interview themes were:

- What the experience of bottle-feeding felt like for the mothers;
- When, how and why the decision to bottle-feed was made;
- The influence of health professionals, including midwives, the hospital experience, General Practitioners (GP's), and Health visitors or Clinic Child health nurses; and
- Family, friends and wider society's influences and pressures.

Most of the interview themes were related to the literature arising from dominant Midwifery texts and general discussion within professional forums. Those themes appear innocuous at face value, but they generated surprising answers.

### *Interview data collection procedure*

The interview procedure included three meetings with the mothers. The first was to establish rapport, explain what the study was about and ensure that interviewees understood their ethical rights concerning informed consent. The second meeting used open-ended interviews that were audio-recorded. A week prior to the third meeting I posted out the transcript of the interview to each participant so they would have an opportunity to verify or change the transcript. In the third meeting I collected the transcripts. Seven of the participants had made changes, mainly to overcome the "um's and er's" that had been included during transcription and to complete some of the gaps that had been marked up as "inaudible". One mother added examples of her experiences. The transcripts were later adjusted accordingly. During our third and final meeting, I spoke to each participant in order to convey the importance to the study of their research, and I also tried to make it a confirming experience by briefly stating what some of the study's main themes were likely to be — thereby confirming to participants that points they had raised were shared by other women and had been heard.

A point about method that I would like to emphasise strongly is — open-ended interviews have the potential to be extremely confronting, pushing beyond the anticipated boundaries of open-mindedness for which techniques such as bracketing can only partly prepare the researcher. Open-mindedly listening to the interviewees and analysing their concerns led to my pursuing further research questions in the form of a critical review and participant observation of the Midwifery field.

### ***Transcript Preparation***

The audiotapes were outsourced for transcription and coded 01 - 12. I then made changes from the verification stage by interviewees and entered pseudonyms into each of the transcripts.

## **Phase I - Analysis of transcripts**

### ***Using NUD:IST program***

The QSR Non-numerical Unstructured Data: Indexing, Searching and Theorising (NUD:IST) program allows researchers to build a data-base of transcript data; this study combines the technical efficiency of NUD:IST for indexing and searching within transcript responses with the researcher's analytic categorising decisions to develop the thematic results. The data is organised under various headings (nodes), in this case the tentative "themes" for the study's analysis. NUD:IST allows the relationships of all nodes to be visible and to be manipulated at any point of the analysis. I methodically went through each transcript line-by-line with the analytic question of, "What does this best illustrate?" I was developing various themes via this nominating process, based partly in terms of the interview organisation, and also partly in terms of my emerging hypotheses of what the interview data was showing. This stage of the analysis creatively drew together and extended both the interview framework and my insights about the analytic findings. Although not finalised at this point in time, several of the categories developed for the NUD:IST analysis were maintained as significant themes in the results.

The study's themes organised into NUD:IST 'branches' and additional 'nodes' were:

- *What the experience of bottle-feeding felt like:*  
Wonderful; best thing I did; bonding; no responsibility/ share; father cared for baby; family involvement; never tired.
- *The decision to bottle-feed:*
- *The influence of health professionals, including midwives, the hospital experience, GP's and Health visitors or Clinic Child health nurses:*  
No trust in midwife; no choice; pressure from midwives; no pressure; differences in staff approaches to breastfeeding mothers and bottle-feeding mothers; GP; child health nurse.
- *Family, friends and wider society's influences and pressures:*  
Family/ socialise; back to work; 100% dependence on mum; restaurants and shopping.
- *Other issues:*  
Future babies/ next baby; post natal depression; media; weaning.

### ***Discussion about NUD:IST transcript analysis – its uses and limitations***

The NUD:IST themes eventually seemed too limited, especially once I began developing more critical methods of explaining the data. I continually referred back to the full transcript sets.

This meant that I was able to analyse beyond the original NUD:IST themes, identify new responses, and double-check the prevalence of any patterned response. Further, I was able to locate contradictions, and, to continue checking and confirming that individual statements were conveyed by the results in ways that I remembered to be their intended sense. Often research method sections describe the use of programs such as NUD:IST as part of the justification for a study's validity and reliability. However, all analysis is creative, including the process of choice in nominating themes for the NUD:IST program's indexes. To rely overly on the technology could lead to missing out on the special flexibility of studying participants' responses in-depth, which is the main advantage of qualitative research techniques.

### ***Potential problems with de-contextualised transcript data that were avoided***

At the same time as seeking to expand on creativity by using in-depth analyses, it is important to remain objective by not abusing opportunities for persuasive exaggeration. When using transcript data outside of linguistic fields, typically transcripts are not marked up for intonation and expression and this also opens opportunities for misinterpretation. For example, during the progress of this project, in showing written transcript excerpts to peers I became aware of the power of some isolated excerpts to convey powerful emotional sentiments that just did not fit with my recollection of the discussion. Although sometimes others have assisted me in noticing patterns or effects more poignantly than I had done at first, it raises an important issue of method — that there is the potential danger and temptation to let excerpts be used analytically in ways that distort the meaning. For instance, one mother's statements, read out of context, struck a cord with some of my research peers who saw the excerpt as illustrating timidity, self-consciousness and deep personal angst. However, the particular discussion had seemed to me to show that she was exceptionally confident to do what she felt was right. Separated from its linguistic context, the woman's confidence and laconic sense of humour were not properly conveyed; this meant that the flavour was of the very point that she was making was lost. To overcome this methodological issue of misrepresentation, useful techniques I developed in reporting the study's results included: frequently referring back to the full transcripts, consciously monitoring the use of excerpts in the analyses through very careful selection of stand-alone excerpts, and careful framing of excerpts.



## **Phase Two - Description of method and techniques**

### ***Data collection: Participant observation and document analysis of "Midwifery field"***

Still in relation to the main research questions, based on themes analysed from the interview responses by bottle-feeding mothers, a new secondary-level set of themes to investigate was generated:

- Pressure by midwives.
- Mothers' bottle-centric beliefs and post-decision attitudes on their choice.
- Mothers' decision-making processes.
- Standards of ante-natal and post-natal education.
- Variations in levels of hospital services.

These secondary-level themes in themselves can illustrate why open-ended questions are very important for capturing the "essence of thinking" from a group different to that of a researcher. The second set of investigations also defines the foci in the analytic chapters of the thesis.

I developed a systematic approach to follow-up these research issues arising from the bottle-feeding mothers' responses which involved developing adequate "Midwifery Data". The data set was based on participant observation including document (re-)analysis of relevant documents to the field, and bringing in relevant techniques and procedures to shift the research perspective towards investigating the issues thematised from the interviews' analyses; the goal was to develop a Midwifery voice about those themes. Ethnographic techniques of participant observation allow the researcher to collect data from a number of situations in order to describe the culture of the group being observed, and those strategies were similar to grounded theory in which the researcher draws on, "Interviews, Field Notes, Documents, Journals, Participant Observation, and Literature" (Streibert & Carpenter, 1999, p. 101).

### ***Insider document analysis data selection***

The documents used were wide-ranging and included: published studies; high-level official policy documents; professional newsletters and editorials; very unofficial documents that existed in my own and colleagues' professional collections, on noticeboards and even on staff-room fridges. Specific sources included:

- Baby Friendly Hospital Initiative (BFHI) documents including guides for assessing, and monitoring and re-assessing.
- Professional newsletters, including BFHI Australia News, BFHI Victoria, Australian Midwifery News, International Lactation Consultant Association literature.
- Nursing Mothers' Association literature (now Breastfeeding Association).

- The UNICEF web site.
- Textbooks from university library with nursing programs.
- Public and staff noticeboards in hospitals.
- Undated, author-unknown documents in circulation in maternity ward staffrooms.
- Regionally developed maternity hospital protocols.

In addressing the new questions, re-analysing field literature was a useful source, usually more readily accessible, less intrusive and easier to verify than other forms of participant observations. However, it is impossible to fully separate approaches, for example the two sources of document analysis and participant observations were combined when many of the documents were supplied by peers or gleaned from participating in professional forums. The goal in analysing the texts was to articulate the sense Midwifery was making for itself of infant feeding issues. Published documents such as journals were used in re-examining the broad approach to the field as well as to interrogate the way Midwifery approached various of the identified themes. The professional literature also provided a broad overview, but especially allowed me to examine in depth BFHI issues which had become more prevalent than initially realised. Documents in hospitals such as forms for mothers to sign added further insight into how the policy document was effected as practices in particular hospital settings.

### ***Insider participant observation data collection***

I undertook participant observation and kept field notes for meetings, telephone conversations and other activities that took place in professional circles. The following is a summary of the contexts and underlying issues of the observations made:

#### ***1. Attending meetings:***

Meetings that were attended:

- Various professional association meetings.

Specific questions by observation:

- What is the dominant discourse for infant feeding?
- What are the key documents for these professionals? (BFHI identified.)
- How relevant is the BFHI to the Midwifery profession?

#### ***2. Asking key health-care professionals:***

Professionals who were approached:

- Individual collegial discussions with office-bearing members of Midwifery professional associations and individuals occupying positions equivalent to Director of Midwifery Care in hospitals.

Specific direct questions:

- How relevant is the BFHI to the Midwifery profession?
- Are there provisions for bottle-feeding mothers and their babies in the current system?
- What makes the BFHI policy appealing to hospitals?
- What problems do hospitals have with the BFHI?

3. Telephoning hospitals to indirectly uncover differences in mothers' experiences of service between public hospitals and private hospitals:
  - a) Telephone questions to Midwifery Nurse Managers, 4 public, 4 private hospitals:  
Specific questions:
    - "Is this hospital BFHI or not?"
    - "Is this hospital striving towards the BFHI accreditation?"
    - "What percentage of mothers leave this hospital breastfeeding their babies?"
  - b) Telephone questions to Admissions, 2 public, 2 private hospitals:  
Specific questions (anonymous as if from intending bottle-feeding, ante-natal mother):
    - "If I am bottle-feeding my baby what will I need to bring to hospital?"
    - (and where relevant to response:) "What kind of formula would you recommend?"
4. Agency work placements on maternity wards for observational purposes:  
Hospitals observed:
  - Private 1; Private 2; Private 3; Government 1 — near-BFHI; Government 2 — near-BFHI (pseudo-codes).
 Specific questions by observation:
  - Are public government run hospitals more pro-breastfeeding than private hospitals?; Can any differences be accounted for in terms of resourcing levels?;
  - What are the bottle-feeding procedures, staff attitudes towards mothers, and staff resource levels?

### ***Rationale for data selection***

The participant observation data had to be sufficient to triangulate specific issues from the data collected in the bottle-feeding mothers' interviews, and collected in ways that would assist in understanding how those issues were practiced by health providers, who were mainly Midwives, and how the issues were understood by the Midwifery group. It was not always necessary to use large samples because the study was not conducting a full-scale investigation into hospital practices or effectiveness, but merely adding a dimension to an existing set of data. In addition, this phase of the research sought to follow-up a hunch arising from the interviews that the private and public sectors of hospitals interpreted infant feeding policies differently, and so both of those sectors had to be included in the research samples.

### ***Observational inquiry procedures***

For observations it is important not to ask direct questions or appear absorbed by factors outside of one's assigned participant role when entering a cultural group setting such as a hospital or meeting. For example, probing questions about the reasons and beliefs behind policies and procedures would sound unusual for a new, casual staff member. However, when participating in professional forums or when talking to professional colleagues it could be appropriate. Thus,

each opportunity for participant observation of Midwifery settings was conducted in a manner as close to how I would normally act as possible. The major differences were that I knew what my research intentions were and I followed up interactions by writing up field notes, usually away from the premises as soon as I returned home.

I organised my hospital placements through a nursing agency. This became more complicated than I had initially expected. I needed to be sent to a range of hospitals and difficulties arose when the agency would offer me work in a hospital I did not need to observe any further. Agencies and hospitals generally prefer to return staff to placements that have gone well previously, and so it became quite awkward refusing opportunities and I must have appeared very difficult. This had short-term consequences of embarrassment and of course it worried me that I might have developed a long-term reputation as being difficult with an agency that I might need for employment opportunities in the future. Additionally, agencies assume that staff are willing to take any kind of work, and it was sometimes disappointing and frustrating to be placed on a surgical ward rather than a maternity ward since it held up the research.

### *Second phase validity issues*

I will offer here a very brief reiteration of the methodological rationale behind this second phase, before describing the techniques employed. Qualitative research deals with people's perceptions and social situations and acknowledges that the findings to some extent will reflect the socio-cultural beliefs of the information source. To increase the reliability in describing social phenomena, there are a number of research techniques that in essence integrate reflexivity and triangulation of specific findings to decrease the subjective effects of the researcher's and the observees' world-views in reaching findings. It has strengthened the observational power by developing a postmodern hermeneutic strategy of supplementing the interviews with participant observations of the 'described phenomena' arising from the interview analyses.

Patton observes that there are a number of qualitative techniques available to address the validity of and confidence of the findings: "Triangulation options, multiple data sources, multiple methods, multiple perspectives, and multiple investigators" (1990, p. 197). In various ways all of those options were incorporated into the research design of the present study; the latter option, however, was not systematically incorporated into the research design, but certainly the nature of literature research, collegial discussion and PhD supervision lends a vicarious dimension of "multiple investigators" to this study.

Participant Observation is an ethnographic technique described by Leininger as:

The systematic process of observing, detailing, describing, documenting, and analysing the lifeways or particular patterns of a culture (or subculture), in order to grasp the lifeways or patterns of the people in their familiar environment.

(Leininger, cited in Baillie, 1995, p. 6)

It is common in participant observation to less formally inform other participants of the research process and goals. I obtained special ethics approval from the university to do this on the grounds that when colleagues know they are being observed this may change their behaviour, and so the researcher tries to "infiltrate" unobtrusively. It is impossible to self-assess the extent to which I would have achieved this in the hospital settings, or indeed any of the other professional fora such as when attending committee meetings. The active Midwifery professional group in Perth is relatively small and so during several of the placements people seemed aware of my research interests because there were comments and questions about my research. In two of the settings on my first day I already knew some of the other staff and was quizzed about a paper I was giving with a very provocative title, "Qualitative evidence-based health care: Milk Mafia or Best Practice?" that had been advertised in a recent professional association mail-out. Understandably, then, it seemed at first as if my colleagues were suspicious and somewhat guarded in their behaviour towards me. Sam Porter (1993) refers to this phenomenon as the researcher being regarded as a "spy in the camp", a role he denies, and with which I do not fully identify either since I was there to develop an accurate but broad "voice" for Midwifery in light of the charges made against it. However, apart from the initial coolness, hospitals are usually very busy workplaces and, of necessity, it quickly becomes business-as-usual, with everyone, including me, obliged to do the best job they can. My observations took place mostly incidentally as I would become highly involved in the shift, and it was later that I would write-up field notes and reflect on the extent to which remaining questions were being answered.

When I attended meetings, or spoke to colleagues from the Midwifery field, or if it came up whilst working on maternity wards, I was open about the fact that I was writing a PhD thesis and I usually described it as investigating mothers' perceptions. The majority of my professional colleagues were very supportive and efficient in answering my questions about the BFHI; policies of accountability and openness in administration made it ethical for information to be obtained this way by individuals who were prepared to cooperate. In general, I noticed that discussion in meetings was rigidly supportive and protective of documented Midwifery policy, that is the BFHI, whereas in one-on-one individual discussions, midwives were more likely to respond to questions I raised and several were very open in discussing their concerns and difficulties in implementing this policy. Goffman (1959) describes different on-stage and off-stage behaviours. Even though these comparisons were of "performances" that in neither

case occurred in front of clients, the meeting situation would have been a performance in front of other key players of the profession, and the individual discussions more clearly opportunities for off-stage consideration of the policy and the actual performance that they experienced. For some of the basic information about hospitals' procedures, I would telephone, and on one aspect this was done anonymously to gauge how they dealt with providing information to prospective clients.

### **Limitations of Study**

The findings are based on a Western Australian sample, which as Hauck (2001) identified, is a unique environment with, at the time, some of the world's highest breastfeeding rates for developed countries. Therefore, it is a context where the key pro-breastfeeding / anti-bottle-feeding attitudes in Midwifery surrounding infant feeding choice may be more extreme than in other developed countries. As identified by Donahue (1998, p. 62), this research follows the trend in the nursing field of incorporating inquiry approaches from the social sciences. The study uses its findings to suggest improvements in Midwifery. This responds to the criticisms of too large a gap between theory and practice in the new field of nursing (Donahue, p. 63). However, since the recommendations did not originate from identified concerns within the Midwifery field, a limitation of the study may be that the suggestions will not easily be taken up constructively.

The topic "experiences" is very broad, and therefore was appropriate to researching a neglected area as well as being effective in opening the study to new and unexpected findings. However, the breadth of issues addressed in the study are such that they only sketch a general description of various inter-related investigations in the thesis that mothers' bottle-feeding experiences included having to cope with being marginalised. In addressing the theme of marginalisation, insufficient justice is done to the dedicated professionals who do the very best job they can, especially those trying to overcome the apparent contradictions of the system.

Typical of qualitative research, and constrained by the time and resource limitations of a PhD study, all of the issues have relied on relatively small data samples. The transcript data did reach saturation point in terms of the main thesis of women coping well with bottle-feeding other than their being marginalised. It was more difficult to build the second part of the data set. In re-reading the field literature critically, there was a sense of reaching saturation in describing the relevant policies, given their cross-referencing and the "fit" with what the mothers had described. The most limited part of the study, however, is that the sample in accessing professional forums and hospitals was very small, and it was not possible to cover all

hospital shifts. I believe it was sufficient for the triangulating purpose, especially to confirm as a researcher that the analyses were based on more than just my own reaction having listened to the mothers. However, my observations leading to a comparison of hospitals and inferring different orientations, did rely on a small data sample. As such, those classifications may not generalise to a larger sample, and since specialist attention is usually offered during day shifts, undoubtedly the thesis has not been able to present a full view of infant feeding care in Perth maternity hospitals.

## **Ethical considerations**

### ***Formal ethics procedures***

The process was cleared by the university's ethical committee that follows National Health and Medical Research Council (NHMRC) guidelines that specifically demands informed consent and confidentiality.

Informed consent applied to Phase One. Letters were given to all participants explaining briefly what the research was about and informing them of their right to withdraw at any point in time of the data collection. For Phase Two, special ethics approval was granted by the University's Ethics Committee. No informed consent was sought because the methodology, participant observation, is more effective without going through such formalities. Special permission was gained from the university to take the latter approach: the ethical principle of informed consent in protecting the Observed against possible abuses of the Observer's social power was less relevant to this phase of data collection than the previous phase. (One researcher doing non-intrusive observation while working alongside professional colleagues and for sizeable organisations who have recourse to libel laws, is less socially threatening than the researcher on an official visit from the university entering an individual's home.)

Privacy was protected, and all names of individuals from Phase One's interviews and Phase Two's participant observation are referred to in the thesis through systems of pseudonyms and coding.

### ***Problematisation of study's ethical position***

Within Midwifery, bottle-feeding is a contentious area to research. The extent of this was made very clear to me due to the ill-feeling it aroused amongst a few key people in the health-care field from all levels — from a medical general practitioner (GP) telephoning in response to my interview recruitment advertisement and demanding I explain why I was doing this project, to some influential professional colleagues implying that it was an unworthy topic that would only

be contemplated by someone totally ignorant about the field, to a less hostile but wary stance amongst some general Midwifery colleagues. Some comments suggested I was suspected of being a "turn-coat" — my previous professional and research involvement had always been with breastfeeding, and so the change to researching "mothers' perceptions of bottle-feeding" was very upsetting to some people. I did agonise over this to the point of realising that ethical positions can be found to suggest it is both wrong and right to do this study<sup>2</sup>. However, a compelling ethical position that I took-up for myself was that attempts to undermine anything other than the dominant discourse underlined the fact that I owed it to the mothers, who had so sincerely and intensely participated in the interviews, to complete the study so that their broader perspective would be available to the field.

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<sup>2</sup> For a full discussion about the complexities of nursing ethics, which in this case applies also to research ethics, see Veatch and Fry (1995).



## **CHAPTER 3 - Summary of Interview Responses, and Introduction to Analytic Findings Chapters**

This chapter begins with an outline of the bottle-feeding mothers' responses to the interview questions. That summary is followed by an introduction to three emergent general themes typifying the experiences and perceptions of bottle-feeding mothers. The themes identified are the mothers' sense of being marginalised for bottle-feeding; the mothers' ongoing satisfaction with their decision to bottle-feed; and the mothers' concerns about inadequacies in the health care services for bottle-feeding mothers and infants. It is those themes that will be addressed in-depth as the main findings of the study.

### **Summary of interview responses**

This summary addresses each of the categories for the open-ended interview questions. Within each category, the bottle-feeding mothers' interview responses will be juxtaposed with the dominant literature of the field. It is intended that issues highlighted in the summary will also serve as part of the rationale for framing the analytic chapters of the thesis into themes reflecting the most notable, broadly-shared perspectives of the bottle-feeding mothers. Because there is so little literature specifically on the issue of bottle-feeding apart from the composition of infant-formula feeds (Hennessy, 1994), the open-ended interviews included topics based largely on the literature from breastfeeding research. As such, many of the responses by bottle-feeding mothers allow new insights into their experiences that are not well documented in the existing infant-feeding literature.

#### ***What the experience of bottle-feeding felt like***

Generally, the interviewed mothers were content with having made the decision to bottle-feed and the outcomes of it. The expectation from the dominant Midwifery discourse was that mothers would feel very strong disappointment and guilt at having failed at breastfeeding. The interview responses, however, strongly contradicted this expectation. There has been extensive literature debating the role of guilt among bottle-feeding mothers, and suggesting that professional health workers need to protect women from the inevitable guilt they feel should they fail at breastfeeding. For example:

Probably 95 per cent of women are physiologically capable of breastfeeding their babies successfully; but where women attempt to breastfeed and fail, they are often blamed for their failure, subtly or otherwise, the explanations ranging from selfishness to psychological inhibitions.

In an attempt to relieve mothers of the burden of guilt which those judgements impose, professionals everywhere have joined in a conspiracy of silence: we mustn't say too much about the intractable differences between breast and bottle, because those mothers who've tried and failed to breastfeed, or who 'choose' to bottle-feed, will feel guilty.

(Minchin, 1985)

However, the mothers in this study reported that they enjoyed bottle-feeding, even to the extent of finding it "wonderful".

Findings were also that bottle-feeding mothers perceived themselves to be comparatively much happier and more organised than breastfeeding mothers. Therefore, it is worth considering the opposite findings by Dracup & Sanderson (1994) that it is women who breastfeed that have lower anxiety, greater confidence, greater ability to relax, and greater flexibility<sup>1</sup>. Since these bottle-feeding mothers expressed considerable contentment and confidence, and explained how their choice of infant feeding method allowed them to relax more and be more flexible regarding interacting with others, it would seem that those qualities are not related to any particular choice of infant feeding. As such, the literature, contradicting Bowlby's attachment theories<sup>2</sup> and supporting the importance of women forming better attachments if they freely choose the method of infant feeding, appears to be upheld by this finding. Martone and Nash's (1988, p. 213) conclusion proposed that, "Health-care professionals can best promote maternal-infant attachment by supporting a mother's chosen method of feeding." Their point of view is supported by Casey (1996, p. 1) who argues that, "Coercing [mothers to breastfeed, as was allegedly happening due to the UK Baby Friendly Initiative] is dangerous and potentially damaging to both mother and baby."

An interesting related finding was that many of the mothers in the present study described themselves as more than typically strong and able to stand up for their choice whereas they were concerned for other women who wanted to bottle-feed but who were more easily pushed around. This points to the need to consider how confidence, particularly self-efficacy (Bandura, 1997), is affected in preparing bottle-feeding mothers in a context with pro-breastfeeding policies. Gigliotti (1995, p. 315) made this point, stating, "While nurses must continue to promote the benefits of breastfeeding we must question what effect our efforts have on the self-esteem of those women who choose not to breast-feed or opt to bottle-feed after a short time."

<sup>1</sup> Dracup and Sanderson (1994) found as well that breastfeeding mothers had higher social class, longer education and greater support from a partner or other family members.

<sup>2</sup> For a full discussion on attachment theories and their socio-political origins and implications see Blaffer Hrdy (2000).

The bottle-feeding mothers were emphatic in the interviews about their awareness of breastfeeding currently being expected and preferred by hospitals - and to some extent by the wider society. However, their attitudes were pro-choice and they felt frustrated and hurt that respect for their choice had been withheld from them. The tensions produced by this difference between the pro-breastfeeding professional stance and the mothers' needs for professional support in bottle-feeding will be explored in depth in the analytic chapters. Additionally, both the mothers' positive feelings and experiences of enjoying bottle-feeding and their negative feelings and experiences of being marginalised and excluded from adequate professional support will be explicated.

### ***When, how and why the bottle-feeding decision was made***

Dominant midwifery discourse highlights midwifery's role via antenatal education through to postnatal care and the establishment of infant feeding as crucial periods for influencing mothers in their decision on whether to breastfeed or bottle-feed. However, much of the literature suggests that the decision timing varied from pre-pregnancy, to early pregnancy, to later in pregnancy. Most women decide either before they become pregnant, or by the first three months of pregnancy, with only 20% of women deciding during the remainder of their pregnancy (Midwives, 1991; Oakley, 1993; OPCS, 1991; Purtell, 1994). The survey by Purtell (1994) of 40 schoolgirls between the ages of 16 and 17 suggests that attitudes to breastfeeding are already established in girls in their teens. It is also important to consider the work of Oxy, (1994), who, in a study of 67 women, examined feeding intentions in relation to eventual practices. She found that women who had already chosen their feeding method were unlikely to change their minds. A UK survey supported those findings where 45% of women said there had been some discussion of feeding during antenatal visits, although the survey found no evidence that this affected the outcome (Scowen, 1993).

In accordance with that literature, the interview responses suggest that for the ten mothers who bottle-fed at initiation, the bottle-feeding decision was made firmly and early in the pregnancy, with three mothers stating that they had always disliked the idea of breastfeeding, and of the four of these mothers with previous babies, three reported wanting to avoid difficulties they had experienced with attempting to breastfeed those babies. Examples of such responses included:

#### **An early decision, based on dislike of idea of breastfeeding:**

Imogen (01): Ever since I can remember I've never wanted to breastfeed. Physically it repulses me the thought of doing it. It's great if people want to do that, but for me, the thought sickens my stomach. So I've always known I'd bottle-feed.

*An early decision, based on feeling suited to bottle-feeding:*

Terri (12): [My reasoning is, do] whatever suits you, just feed your baby whatever way suits you, after all you are the one looking after the baby, not the hospital staff. I think you have to be happy doing what you are doing, and confident, otherwise you all end up a mess.

*An early decision based on avoiding prior bad outcomes of breastfeeding:*

Francine (08): I started breastfeeding [elder daughter, now three and a half years old] for a while, for about 6 weeks, and she lost a dramatic amount of weight and wasn't sleeping at all. So we eventually turned to bottle-feeding and that was it, she was fine.

Interviewer: So did you make the decision then that if you had another baby you'd bottle-feed?

Francine: Yep, almost that very day (laugh).

Interviewer: Oh really?

Francine: After the horrible experience of being so frightened, because she was so small when she was born to start with, and then having her lose weight and we were all so worried, like the whole family were worried. So when we first gave that bottle and she started to put on weight and stuff I thought that's it, no more breastfeeding.

These findings accord with the literature on early decision-making by some women.

While it points to the need for sensitivity amongst midwives in understanding the reasons underlying the women's infant feeding choices, it also raises the problem of dilemmas for midwifery. What is considered to be the most professional current approach, as exemplified by Baby Friendly Hospital Initiative policies, is for midwives to use various opportunities when working with mothers to persuade mothers to make the "healthy choice" of breastfeeding. In doing that professional work, however, this study has found that midwives offend mothers who have already firmly decided to bottle-feed. The example above, for instance, illustrates the depth of feeling underlying Francine's choice based on her sense that she has empirically discovered that for her babies, bottle-feeding is best whereas breastfeeding has serious and frightening health risks.

Of the two mothers in the study who counted themselves as bottle-feeding but had failed at breastfeeding their babies, it was difficulties with breastfeeding that led to them making the decision, with a strong sense of relief, that bottle-feeding would be less stressful and physically draining.

### ***Bottle-feeding decision following careful consideration***

How the decision to bottle-feed was made, was frequently prefaced by the mothers with a statement that they knew about the professional and medical opinion of "breast is best" and some even volunteered examples of the knowledge they had on this. The International Lactation Consultants Association (ILCA, 1996) believes that the predisposing factor of a woman's knowledge of infant feeding is significantly linked with a decision to breastfeed, and therefore, almost all women would choose to breastfeed their infants if they were fully informed (Hanson & Bergstrom, 1990; Tamagond, 1992). However, in many of the interviews it transpired that the mothers considered the evidence and claims about breastfeeding's benefits to be overstated and the disadvantages to be understated. Several mothers described the decision as having been made jointly with the baby's father, or in consideration of the opportunity for allowing father-and-baby bonding, with the baby's father supporting whatever the mother chose. There was strong evidence that the mothers went through processes of weighing up the advantages and disadvantages of both feeding methods (C.F. Becker (1974); Rosenstock, Strecher & Becker, (1988) on health decision-making), which will be fully explored in the thesis.

### ***Bottle-feeding chosen for a number of reasons, especially for involving baby's father***

The reasons given for why the decision was made by these mothers were also interesting. The responses suggest that unlike the literature, issues of privacy or embarrassment were strong factors for only two mothers, and the issue of returning to outside paid work early, whilst relevant was a factor affecting only two mothers (Bryant, Coreil, & D'Angelo, 1992; Hawthorne, 1994). One very strongly reported reason was the mother wanting to include the father – not primarily for convenience but to "include" and "involve" the father. Earle (2000) also found that mothers stated this as a reason, but she re-framed that finding as their legitimisation for preferring the choice of bottle-feeding despite acknowledging that they knew that breast was best. Black, Blair, Jones, & DuRant (1990) found in high socio-economic families that the method preferred by the father was the second most important variable influencing the decision on infant feeding method. The mothers of this study who initiated bottle-feeding expected the support of their baby's father, sometimes stating that whatever they chose they knew their partner would support them. The support of the baby's father by the mother, and the mother's self-sacrifice to optimise the involvement of the father appeared to be an important aspect of their enjoyment of child rearing. This finding raises questions about the role midwifery plays in encouraging fathers to influence mothers to breastfeed their baby if the mothers are against that method, or if the mothers consider that there are important advantages in involving the baby's father by bottle-feeding.

In terms of satisfaction with their choice, many mothers mentioned being able to have social support with the feeding demands and being more organised than their breastfeeding friends. Indicative of many of the mothers' attitudes about their decision was the following statement:

Penny (07): It was a conscious decision, and that decision had reasons behind it. It wasn't something that I just plucked out of the air and decided to do.

The women thus found any challenges to their decision near the time of the birth or even afterwards to be patronising, offensive and damaging to their relationship with the health care providers.

Based on these findings of what the experience of bottle-feeding felt like to the mothers, the analytic chapters to follow will explicate in more detail how these mothers hold "bottle-centric" views. That understanding will be used as a platform for then reconsidering the field's health belief models and their relative power or lack of power to explain the non-disease consumer health choices made by the mothers.

### *The influence of health professionals*

The interviews included questions about the influence of midwives, hospitals, general practitioners (GP's) and Child Clinic Health Nurses on the mothers' infant-feeding choice.

#### Midwives

It was notable that amongst all of the health professionals, midwives were described as having a qualitatively different influence on a more significant level than all of the other health professionals. In general, there was actually strong criticism of midwives for the pressure that they placed on the mothers, especially new mothers, and many stories emerged either of other women they knew being forced to breastfeed against their will or of the pressure on themselves even after they were quite firm in their decision to bottle-feed. The pressure on breastfeeding mothers to persist in spite of difficulties was widely witnessed in hospitals, and this pressure generated negative perceptions of midwives as having no compassion for the mothers or the babies for whom obtaining a bottle of formula in some hospitals took an overly long time. Another aspect of midwives' professionalism that was consistently questioned by the mothers was that antenatal education is biased. For example, it offers only positive views and practical advice for breastfeeding. Only negative views and warnings to sterilise equipment, rather than practical advice, were given about bottle-feeding. Such bias was strongly objected to by ten out of the twelve mothers. Of itself this illustrated the mothers' perception of a lack of

professionalism within midwifery by the use of unfair pressure that causes marginalisation of bottle-feeding.

A clear finding was that midwives were particularly criticised for their insistence in breast feeding. They were targeted in mothers' comments much more than GPs, other health professionals, family members or people in wider society. Midwives are in the front-line of health care when it comes to establishing infant feeding, and part of the problem, as this thesis argues, is that their anti-bottle-feeding stance, based on research findings that breastfeeding is superior, have become naturalised through professional discourse and policy. It is fascinating that many of the women describe what are, to them, obvious improvements that could be made for bottle-feeding mothers, and suggest, for example, simple steps that might help to remove its "stigma".

The thesis will demonstrate that many of the details provided by the bottle-feeding mothers – of the lack of services and stigma for bottle-feeding – accord with current policy, and therefore, are unfortunate negative consequences of implementing a pro-breastfeeding policy. The analytic chapters in this thesis will address in more detail those issues of: the mothers' stated experiences of pressure by midwives; the experiences by mothers of inadequacies in ante-natal information; and; their varying satisfaction with hospital services that will be illustrated and then examined in relation to policy. Whilst it is understandable that midwives follow policy guidelines which accord with their knowledge that breastfeeding is best, it is disturbing to contemplate negative effects on the women who bottle-feed in terms of the inconveniences and stigmatisation they experienced. The thesis will argue the case for midwifery to better take into consideration these mothers' feelings, choices and practical needs.

### Hospitals

The Baby Friendly Hospital Initiative (BFHI) policies strongly define procedures for promoting breastfeeding. While most Western Australian hospitals have not met the criteria for accreditation, the BFHI document illustrates the professional goal in hospitals to remove or limit accessibility to bottle-feeding options. Initial interview analyses suggest that hospitals had a reputation amongst the respondents as pressurising mothers at unwelcome and intrusive levels. This was raised by ten out of twelve of the mothers. Interestingly, however, less than half of these mothers said that they had experienced this pressure themselves (partly because they knew how to stand up for themselves), and some of the mothers gave high praise to their hospitals as being highly supportive of their wishes and not pressuring them at all. Some of these latter mothers brought up the issues of pressure in accounts of the many horror stories they had heard and their dread in anticipating what would happen to them. They reported being pleasantly

surprised and impressed by the professionalism by which they had been spared the anticipated ordeal. Some mothers reported that their strong personalities, determined nature, and being known to staff as capable of making their own decisions, had set them apart from the pressure to breastfeed that they believed was standard treatment for most other mothers, especially first-time mothers. Nevertheless, some of the mothers gave concerning anecdotes of bad experiences of their own, such as refusal by a hospital to supply formula when the mother had not brought any in, apparently without previous warning of this policy, and various strategies whereby staff ignored a mother's stated "choice" when she elected bottle-feeding.

An inference hypothesised from the interview data was a discrepancy between public and private hospitals, especially with a lesser emphasis on breastfeeding and greater support for bottle-feeding in private hospitals. This hunch was followed up in Phase Two of the data collection.

The experience in hospital was also referred to by some of the interviewees as their evidence for comparing the success of bottle-feeding and breastfeeding, as here they had observed differences in the establishing phases for themselves and breastfeeding women. Nearly all felt that they were much happier, more comfortable and more organised due to their choice of bottle-feeding. Some mothers pointed out that they received less attention from midwives than breastfeeding mothers, but they found this reasonable considering that they needed less care.

Several interviewees offered anecdotes about their friends who breastfed in hospital only by way of giving-in to the midwives' pressure. They fully intended to change to bottle-feeding once home, which, on the Early Discharge Program, can be as soon as one day after the birth. The point made by these anecdotes is that resentment of the pressure is widespread and includes a significant proportion of mothers who may appear to midwives to be content but they are not.

### General Practitioners

The literature suggests that GP's can be highly influential in mothers' decision to breastfeed or bottle-feed but few mothers receive advice to breastfeed from this source (Lawrence, 1994; Scowen, 1993). Although the mothers discussed at length disagreements with midwives in particular, they generally did not report any attempt by GP's to influence them. In terms of general practice, the sample size of this study makes it impossible to draw strong conclusions about typical doctor-patient antenatal discussions. That these women's GP's did not directly advocate breastfeeding might suggest that GP's in general do not. Alternatively it might accord with infant feeding literature – that an absence of advice to breastfeed leads to mothers bottle-feeding, however, the mothers themselves did not see this as an omission. Notably, some of the



mothers spoke of their GP's professionalism, stating that it would have been unprofessional for the doctor to do anything other than ask what their feeding intentions were. They expected their doctor to then support them in that choice. There is a changing doctor-client relationship where the doctor is consulted, but ultimately the patient makes decisions.

Interviewer: So how did you feel when your doctor said nothing?

Terri (12): Well as I say I wasn't expecting her to say anything to me, I just expected her to act in a professional way and respect my decision. I suppose I would have been disappointed in her and maybe lost trust in her if she had criticised me for bottle-feeding.

The thesis will demonstrate that the bottle-feeding mothers considered that the infant feeding decision was theirs, and that professional advice should be a consultancy service advising them on their options and how best to achieve and cope with their choice. The dominant midwifery approach, which is to promote breastfeeding and meet policy target percentages, is therefore seen by mothers as unprofessional. Although not developed further in the thesis, it should be noted here that the contrast between the mothers' judgements of experiences with GP's and with Midwives suggests that midwifery risks a reputation of being pushy and unprofessional.

#### Child Clinic Health Nurses

The interview responses suggest that the role of Child health nurses was very limited in comparison to that of Midwives. This is understandable because breastfeeding is usually established in the hospital setting. Even on the Early Discharge Program it would be late to introduce breastfeeding or expressing breast milk. The mothers in this study would have used the services of Child Clinic Health Nurses (the equivalent to UK Health visitors) once a practice of only bottle-feeding had already been established. The mothers' reported experiences with these health-care professionals varied. Some of the mothers reported an unsupportive attitude towards bottle-feeding and others reported actually having been assisted by the Child Health Nurse. For some, Child health nurses were an information source. In some cases, this was presented as criticism of the fact that help had been left so late and mothers were already at home before knowing how to prepare formula and equipment adequately. Some mothers stated quite adamantly that they deliberately avoided the anti-bottle feeding attitudes of these health professionals by not attending the clinic. Many mothers found substitute lay help that, in their view, was superior in providing information and assistance for bottle-feeding. Amongst those found helpful were the "girls at the chemist", who could weigh the baby. Chemist assistants were particularly praised for their role in averting or spotting potentially harmful choices of formula. Knowledgeable and pro-active mothers, sisters, and neighbours were also mentioned. Several mothers were convinced that health nurses did not know the facts about formula or bottle-feeding and were critical of the expectation that, as bottle-feeding mothers, they had to

find information by making mistakes in feeding their babies. Other mothers, however, seemed happy with the service of these health nurses, either reporting no pressure, or recounting simple bits of advice that they had found useful. Indeed, in some cases they were surprisingly impressed and pleased with small bits of practical advice they had been given.

### *The influence of and reactions of family and friends*

Generally, the mothers found others in their family and current peer group quite supportive of their choice. However, for some, they recalled initial disapproval by two of the partners, and partner's mothers who had themselves breastfed. One aunt, who was working interstate as a midwife, also expressed disapproval but, in most cases, the same people, especially partners, were won over, but not the aunt-midwife.

It was interesting that several mothers saw themselves as doing a welcomed favour to others in the community, for example, neighbours enjoyed the opportunity to bottle-feed these babies especially when their own grandchildren were not accessible.

Donna (02): And everyone else [was able to participate] as well. Like grandparents and even the children, they wanted to help by bottle-feeding, and that was giving them time to get to know him as well.

Erica (03): I think (older people) they get a lot of joy out of holding a baby and doing something like feeding, it's not something they do all the time, especially if they haven't got their own grandchildren ... or haven't seen their grandchildren for a while I think they really get a lot out of it.

Many of the interviewees also stated that most other mothers they knew had breastfed, which is to be expected given current statistics of breastfeeding. They stated that it had not been a problem affecting their acceptance into the group of their peers. Furthermore, when the babies from the peer group were a bit bigger and reached the weaning phase, the bottle-feeding mothers' experience put them ahead of breastfeeding mothers, and they became valued and sought after for providing advice about milk formulas, equipment, sterilisation and other feeding techniques. This is an additional element of interest in these finding together with (Scowen, 1993) highlighting that many mothers wanted information on both breastfeeding and preparation of bottles and formula.

Another aspect emphasised by the mothers, was their concern for friends and associates who were breastfeeding. They saw women suffer in hospital, or had friends or neighbours not coping well in comparison to them. For example, Lisa described how she was observed to have coped better from bottle-feeding:

Lisa (11): ... the mothers in the room where I was were all breastfeeding ... Some of them had so much trouble .... They were ringing the bell for help and the baby would be screaming and then the mother would be all uptight and then she wouldn't be able to feed as the milk wouldn't let down. I know one of the mothers was going to bottle-feed when she got home. She couldn't believe how good my baby was, and hers was screaming all the time.

Interviewer: Did you talk to her about bottle-feeding?

Lisa: No, I didn't, but she could see my baby sleeping and she could see how organised and relaxed I was. And when my husband came in we could enjoy the baby, whereas she was stressed out and was always glad when her visitors left.

Additionally, they felt in some cases that other women's or couple's decisions to breastfeed could be harmful to babies that did not thrive, and that bottle-feeding had the advantage of being adjusted to boost a child's intake if required.

### *Other issues*

The wider community was perceived as supportive and helpful, and some of the mothers seemed well informed about which places to go for assistance. Morse & Harrison (1987), whose research focussed on breastfeeding, contended that it was a dynamic, open relationship occurring within a social context, and that it is the attitude of others towards breastfeeding that modifies the mother's choice of how the infant is fed, where the infant is fed and how long breastfeeding is maintained. In relation to bottle-feeding, it is interesting to consider the contrast between some of the hospitals' lack of provisions, with the dynamic of shopping centres and restaurants that seemed happy to provide whatever assistance they could to bottle-feeding mothers. Warming bottles was discussed by many of the mothers, and some described shopping centres' facilities for infant care, which catered well for bottle-feeding mothers' needs, by including microwave ovens to warm formula.

Unexpectedly, several of the mothers had strong opinions that breastfeeding caused post-natal depression. They appeared to attribute to breast-feeding the physical discomfort of breast pain; lack of sleep; anxiety from generally not coping; inability to maintain a normal sense of efficiency; and no time for other family members. They described these effects in breast-feeding women and noted how they were pleased to have avoided those outcomes.

The general media, including magazines, were criticised for only supporting and providing information about breastfeeding. This contrasts with the findings of Henderson (1999) which said "breastfeeding is painful", "you may need to give up [breastfeeding]", and "babies are

unsettled, ... [and] cry a lot". However, the mothers' discussion of mass media referred mostly to their need for practical information, of which there is apparently a scarcity.

Roughly half of the bottle-feeding mothers noted that they were motivated to participate in this study to advocate for mothers and to provide midwives with an opportunity to understand that the choice of infant-feeding method should be made freely, not to suit a midwife, but to suit the mother and her circumstances.

An overview of their opinions has been provided in this section which has described the influences of a range of other people, GP's, health visitors and child clinic health nurses, family and friends. This summary of Phase One of the study gives me a number of analytical theories which will be introduced in the next section.

## **Introduction to main themes of study's findings**

The summary above has outlined the interview findings (Phase One of the research). The interviewees, by the fact that they bottle-feed in an era where breastfeeding dominates for midwifery, are clients with relationships that cause dilemmas for midwifery -- this point is readily apparent in the main research questions. However, the mothers' perspectives, which were extremely critical of midwifery, create further dilemmas that deserve consideration. The research questions, therefore, have been broadened to allow investigation of their concerns to be incorporated as the main focus of the study. A paradigm of interpretism guides the inquiry of this thesis. It allows for the inclusion of empathetic human feelings, intentions and beliefs (Burns & Grove, 1987; Guba & Lincoln, 1985; Leininger, 1985). The findings of the interview which have been summarised in the present chapter, are taken up in the following three broad themes that emerged from bottle-feeding mothers accounts of their experiences.

- ***The mothers' sense of being marginalised, especially by midwives***

Chapter Four describes the ways in which mothers felt marginalised by midwifery's attitudes towards them. It describes the negative emotional impact of that marginalisation upon the bottle-feeding mothers and discusses some of their coping strategies. It offers a constructive comparison of the different points-of-view of bottle-feeding mothers and midwives on the ideal client-midwife relationship during the establishment of infant feeding.

- *The mothers' ongoing satisfaction with their decision to bottle-feed*

Chapter Five describes the mothers' "bottle-centric" views on both breastfeeding and bottle-feeding, many of which are not widely recognised in the professional literature. It describes how concepts of emotions, especially around "bonding", have symbolically meanings that have marginalised bottle-feeding mothers. Chapter Six considers the mothers' health decision-making processes in relation to how well the current health decision-making theories in nursing allow for midwifery to meet this client group's needs.

- *The mothers' concerns about inadequacies in their health care services*

Chapter Seven explicates how developments in policy can account for bottle-feeding mothers' perceived inadequacies in standards of information. Chapter Eight focuses on the mothers' varying levels of satisfaction with hospital services. The participant observation findings of the study's investigation into midwifery's professional practices and policies are particularly pertinent to these chapters.

The analytical chapters of the thesis encompass concerns from both Phase One of the study, the interviews with bottle-feeding mothers, and Phase Two, participant observation of midwifery. The thesis aims to interpret the important message from this client-group and highlight opportunities for enhancing midwifery services. Given the pro-breastfeeding policies that guide midwifery and hospital practices, the decision by mothers to bottle-feed may be defined as a problem for midwives. Professionally, midwives face a dilemma; they are required to "protect, promote and support breastfeeding" by BFHI guidelines, but at the same time they are encouraged to empower women and to help them exercise choice and control by NHMRC guidelines on patient care. There is no easy solution to this problem. In this context, the study is timely in presenting the issues in ways that consider the largely neglected perspective and experiences of bottle-feeding mothers.

## **CHAPTER 4 - Bottle-feeding Mothers' Experiences of Marginalisation Within Midwifery's Pro-breastfeeding Policy**

This chapter begins to address the most pervasive of all the analytic themes of this thesis regarding the sense these mothers gave to their bottle-feeding experiences - the problem of being marginalised. Marginalisation can occur in a number of ways, often unconsciously, because institutional practices and discourses aim to naturalise relations of dominance and subjugation, privilege and marginalisation (Fairclough, 1995). As such, the term "Baby Friendly" from current pro-breastfeeding hospital policies sounds harmlessly neutral, if not desirable. What is not immediately revealed in the dominant Midwifery discourse is the extent to which baby-friendly policies are 'friendly' to bottle-feeding mothers. Marginalisation occurred in the educational and hospital resourcing the bottle-feeding mothers received which they felt were not as relevant to their needs as to those of breastfeeding mothers, and marginalisation also occurred through the inter-related negative attitudes displayed by the midwives caring for the mothers. Therefore, the focus of this present chapter is on the negative interpersonal experiences bottle-feeding mothers had with midwives.

Whilst it is of primary importance in this thesis to understand the perspective of these mothers, it is also important to understand and critically interrogate the perspective of midwives. The underlying position of this thesis is that pro-breastfeeding midwives are not contrarily or opportunistically abusing institutional power in their interactions with bottle-feeding mothers. Rather, they are located in powerful institutional discourses and constrained by formal policies, and often may be unaware of the negative impact they have on this client group. In this regard, Patti Lather's rationale for professionals to analyse the discourses that constitute their practices, especially their privilege in hierarchies with non-expert clients<sup>1</sup>, applies to questioning the midwifery profession's attitudes about bottle-feeding:

[We should be] trying to unlearn that privilege ... not for working through more effective transmission strategies but for helping us learn to analyze the discourses available to us, which ones we are invested in, how we are inscribed by the dominant, how we are outside of, other than the dominant, consciously/unconsciously, always partially, contradictorily.

(Lather, 1991, pp. 98-100)

Although Lather did not relate this imperative to health institutions, it appears to be wise advice for health professionals, because in health care empathy is paramount.

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<sup>1</sup> Patti Lather (1991) was examining the power relationships in her field of adult education, and exploring the possibilities of emancipatory pedagogy. However, the sentiment applies well to this thesis' exploration of the power relationship between health provider and health client, in relation to Midwifery's educational role, and in this instance, in relation to the midwifery profession's attitudes towards clients whose choices differ from their preference.

The present chapter will provide transcript evidence of the sense of marginalisation amongst the bottle-feeding mothers and damaged trust in client relations, evident even during childbirth experiences, and it analyses mothers' ways of coping. It also discusses why midwives, in comparison to general practitioners and other health providers, were perceived as unhelpful and antagonistic towards this client group. The chapter includes a Midwifery perspective, pointing out that policy directives presently drive the profession. A final section explicates the differences of perspectives in terms of clients' right to choice between bottle-feeding mothers' and Midwives.

### **Bottle-feeding mothers' sense of marginalisation**

The women explained that their decision to bottle-feed was undermined and not given adequate support by midwives. Marginalisation as a concept implies being unfairly subjected to fewer rights or less importance than a dominant group through the use or abuse of power. It is qualitatively different to recognition of being in the wrong, and has greater ramifications than a simple acceptance of different opinions.

It is important to note that the general categorising of 'health professionals' is inadequate because, many of the bottle-feeding mothers had different positive or negative experiences according to the different professional groupings. In general, doctors, especially general practitioners (GP's) were found to be non-judgemental and/or supportive of each mother's decision to bottle-feed. Most of the mothers' criticism was levelled at midwives, and to some extent child health nurses.

### **No marginalisation by general practitioners, & little from child health nurses**

All twelve mothers in this study made positive comments about the doctor with whom they came into contact. No doctor questioned these mothers' decisions to bottle-feed their babies. The following comments were typical of how the mothers felt happy and relaxed following meetings with these professionals.

*Francine appreciated receiving supportive approval and positive recognition from her doctor.*

Francine (08): ...she (doctor) supports you in what you are doing (bottle-feeding); she never makes you feel guilty, she just makes you feel good and that you are coping, I liked her (doctor).

Lisa's felt her doctor was supportive in advising her to find what suited her.

Lisa (11): My doctor was very supportive, he just said feed her (baby) whatever way is best for you, and then you will be more content.

Terri felt at ease with her doctor who did not question her choice to bottle-feed.

Terri (12): He didn't question me at all, I think he just accepted that this was my decision. He (doctor) said just come and see me if you have any problems. I felt at ease, and felt happy going back to see him after that.

What can be seen by the above comments is, that as well as the mothers feeling supported and unchallenged by their doctors, the comments reveal the appreciation by the mother of being able to feel comfortable.

Fewer mothers commented negatively on the child health nurses' attitudes. Typically, the mothers expected to encounter a negative attitude when they knew the child health nurse was pro-breastfeeding (often child health nurses teach ante-natal classes, as a consequence their reputation is widespread amongst the new mothers). However, mostly they found the child health nurses accepting with varying degrees of helpfulness. For example, Lisa reported she was afraid to tell her community-based, clinic nurse that she was bottle-feeding:

Lisa (11): Before we went to see the clinic nurse, ... we were a bit scared to tell her we were bottle-feeding... we were pretty nervous about it actually. But the baby was doing well, sleeping well, and everything was going fine. But we felt we were letting her down.

Jackie noted her child health nurse did not discuss infant feeding with her.

Jackie (10): (The child health nurse) never mentioned it, so...just accepted that that was my choice (to bottle-feed).

In this case, the absence of any comment was taken to be acceptance.

These findings serve as a reminder of the need for any health provider to provide support of the mother's decision and build a good rapport to ensure ongoing consultations should problems arise.

### **Marginalisation by midwives in particular**

Midwives are in sustained contact with new mothers in hospital at the critical time when infant feeding practices are being established. Midwives are also constrained by pro-breastfeeding hospital policies. In this context, it should not be surprising to find that the majority of negative events described by the bottle-feeding mothers referred to midwives. The BFHI puts the onus on the hospital to set target goals for their breastfeeding policy. Although the goals specify aspects of the hospital environment, education programs and marketing materials, rather than



women's uptake of breastfeeding, the target goals often mean that hospital staff will persist in trying to change the mother's decision if she chooses to bottle-feed. Implicit in the dominant, professional world-view is the belief that the role of the professional is to diagnose, prescribe and treat (Playle & Keeley, 1998). The role of the mother is to comply. Non-compliance can be seen as a behaviour that challenges the professional and this led to the mothers feeling unfairly treated. The findings were that midwives use a number of approaches that the bottle-feeding mothers found objectionable.

### ***Guilt tactics***

The bottle-feeding mothers did not feel guilt about their choice, but they did feel that midwives' attitudes were meant to make them feel guilty. Terri explained how new mothers are made to feel they are 'doing wrong' in their decision to bottle-feed.

Terri (12): ...if you listen to the midwives, ... they make you feel that you are doing wrong by choosing bottle-feeding.

Claire also talked about how she was made to 'feel bad' about her decision to bottle-feed her baby:

Claire (06): They make you feel bad about bottle-feeding, like you're not doing right by the baby. That's what came across to me when I was in hospital.

Lisa extended the suggestions that she had made a wrong decision about bottle-feeding to feeling that she was being regarded as a 'bad mother'.

Lisa (11): They look on you as a bad mother because you have decided to bottle-feed, as if you are doing some harm to the baby. But I knew I wasn't because she was putting on weight and (she) was a very happy baby.

### ***Midwifery's prejudice against bottle-feeding option***

The women felt that information about bottle-feeding was neglected. This was interpreted as bias on the part of health-professionals and evidence of a lack of support to bottle-feeding mothers. The predominantly negative attitudes towards bottle-feeding and lack of useful and relevant information from health professionals was seen, at best, as ineffectiveness and, at worst, as a form of coercion. To these mothers the choices were equal and deserved equal consideration and prior training.

Sandy (09): At the ante-natal class they should say there are two ways of feeding, there's breast-feeding and there's bottle-feeding, and then tell you about both. It's okay to say that breast-feeding is better, but they never tell you anything about bottle-feeding except to say how bad it is.

Bottle-feeding mothers' criticisms about the poor quality of information consistently occurred in the interviews and itself was a significant strategy in midwifery's marginalisation of bottle-feeding.

The mothers felt that no respect was afforded to their choice of bottle-feeding. For example, Sandy said it was given second class status:

Sandy (09): It shouldn't be bottle is the second class [choice] ... I really feel that that's the way that ... you walk into a hospital that's how it's looked at. And the Nursing Mothers' Association, that's big pressure towards breastfeeding, and how dare you bottle-feed. I'd like to see it treated as an equal [choice].

Many bottle-feeding mothers felt that midwives did not respect or support their choice. Rather they were disapproving towards the mother.

For example, the negative attitude bothered Lisa.

Lisa (11): A few of the midwives were not very nice to me when they knew I was bottle-feeding ...no, not very nice at all.

It also bothered Claire.

Claire (06): So they weren't very happy when they knew I was really going to bottle-feed. Not one person was happy with me.

### ***Pressure to breastfeed***

Several mothers spoke of how midwives tried to force women to breastfeed. Donna, who had been able to resist the pressure with her current baby, told of how she had succumbed to the pressure with previous babies.

Donna (02) [referring to her prior experiences]: They made me breastfeed the twins, I really didn't want to, I stopped when I got home from hospital.

Claire felt that the hospital tried to ignore her choice.

Claire (06): They asked me what I wanted to do, I think that was when I went to the hospital first. I said I wanted to bottle-feed him, and they gave me all these pamphlets on breast-feeding and just said, 'Think about it', and I said, 'No, I want to bottle-feed him', and they said, 'No [unclear]' and I said, 'No, I want to bottle-feed'. So on the slip they have they put nothing down. They didn't put bottle-feeding they just left it blank as if to say I was thinking about it.

The ignoring of Claire's choice at admission to any health provider aware of Midwifery policy in relation to the NHMRC Guidelines for Patient Choice (1987) is disturbing.

The lack of acknowledgment of a client's decision can result in the woman feeling challenged and unsupported at a time when she is emotionally vulnerable. Whilst such effects are not normally compatible with midwifery's goals of caring holistically for women and babies, some hospitals must be unclear about the point at which hospitals must accept a mother's choice to

bottle-feed. This may well be due to the contradictory role of persuasion afforded midwives and also due to BFHI policy guidelines that include the baby being put to the breast at birth.

### ***Criticisms and disapproval of bottle-feeding***

The mothers felt that their bottle-feeding choice was criticised, and that they were treated badly because of it.

Imogen (01): The midwife said, 'Oh you want to bottle feed, oh no, you can't. It's like you're not a natural mother then.' Well no, I AM a natural mother, I'm just not a breastfeeding mother.

Francine (08): And they make you feel like because you're not getting that skin on skin contact that you're not bonding. And that's the big thing. People are constantly saying that. How can you bond with your baby if you're not breastfeeding it. And I say well he grew inside me for 9 months, I think we're bonded (laugh), we're pretty much bonded now.

The mothers felt unjustly treated. In their view that they did not deserve the negative attitudes of midwives in whose care they had been placed. They resented all attempts to make them feel guilty or like bad mothers.

### **Case study of emotional impact when values are marginalised**

The following case study illustrates the depth of emotional experience of one mother:

A key point for practise arising from the case study is that momentary and transitory encounters for health professionals become lifetime memories for mothers.

#### **Jackie (10): A case study**

The single encounter between professional and patient can be very important. Individuals are in the patient role for only a minute fraction of their lives, yet the influence of these passing, brief encounters with the professional world is of prime importance. Unfortunately for Jackie, it was a negative encounter and the long-term influence of her first negative encounter had a devastating effect on future encounters with this very same midwife.

Jackie outlined the whole process of encounters with the midwife that she first met in the antenatal clinic. She felt that the midwife, at the first meeting, made a negative judgment about her decision to bottle-feed. This left her lacking in trust for the midwife at subsequent meetings. In this emotional extract from Jackie's narrative she recalls how the midwife questioned her values:

I had an interview with the midwife at (the hospital name), and she asked me how I was going to feed (my baby) and I said that I would be bottle-feeding. And she (midwife) said, 'can I ask you why?'. And I said, because I was quite successful bottle-feeding my other children, and I really had no interest to breastfeed. And then she asked me again, 'why?', you know, and I said, 'that's all I can really say'.

The implication for Jackie was that she had to justify her values while the midwife, assuming superior knowledge, did not have to justify her professional values.

There is a taken-for-granted notion that when a discrepancy occurs the burden is on the mother to clarify her values. Jackie had to justify her decision to bottle-feed. There was an unquestioned assumption that the midwife's knowledge of the best way to feed babies reduced the probability that her beliefs were the source of the problem. In addition, the inference is that the standards of what constitutes healthy and unhealthy actions, that is, breastfeeding and bottle-feeding, are objective and not culturally bound. In other words, these standards are value-free. Thus, resolution of conflicting beliefs rests primarily with the mother's ability to adapt to the dominant value system, which is breastfeeding. The focus appears more about being right rather than being effective. Jackie continued her narrative about this same midwife when she met her again in the delivery suite:

It was horrible, she (the midwife) came in and I thought...I recognised her from the interview, and she came up and she grabbed my hand and she said, 'now, we'll get through this (the birth)', because it was really painful and his (the baby's) heart rate had dropped. And she (the midwife) grabbed my hand and she said, 'we'll get through this'. And I looked at her and I didn't trust her, because she'd questioned me about my feeding (decision). And I just ...I didn't say anything, I just ignored her.

Trust is a two-sided relationship and arises from what health professionals and clients do and how those actions are perceived. Good intentions can be misinterpreted and unsupportive behaviour or comments can hinder positive relationships. Jackie felt an extreme lack of trust for this midwife, at a time when she desperately needed the support and expertise of the midwife. Jackie explained this lack of trust:

I didn't trust that she (the midwife) could get me through it (the birth). Do you know what I mean?... She grabbed my hand and she said, 'okay we'll get through this'. Because I was 10 cms and I had to push as the baby's head was high, ...and I didn't trust that she would be able to get me through it because ...I guess because she was so positive about breastfeeding, and so, ...you know, everyone should sort of do it... and she didn't respect the decision I made. And when she said to me, 'I'll get you through this, when you start pushing, when we get there I'll talk you through it', ... whatever, I just didn't trust her.

Visibly upset Jackie continued,

I thought, 'you won't get me through this'. I just felt, ...no, ...I didn't really want her to. And while she was in the room, I felt very uncomfortable, but I never said anything. I felt very uncomfortable. And I saw her a couple of times on the ward and I ...you know, I'm very jolly and happy, and I'd always say hello to everyone, and I didn't want to look at her, I don't know if I could even talk to her again.

Conflict has an emotional cost that remains after the battle is over. Win or lose the scars may be with the individual for the rest of their life. People affected by conflict constantly refer to the event; it pervades their memory as if it happened yesterday. Jackie became visibly upset when she related these events of nine months before. It was clear that this encounter had an emotional cost for her, damaging her relationship with the midwife, and indeed her impression of the midwifery profession, as well as scarring her memories of her childbirth experience.

## **Coping strategies**

Reactions to negative encounters varied. This chapter has shown how Jackie suffered lasting emotional pain following the birth experience with a midwife who she did not trust. Despite such emotional pain caused by the women having to defend their choice against current policy,

many of the women spoke about how they coped with the perceived antagonism of the midwives. Their strategies included reconstructions of good mothering, avoidance, passive resistance, standing up for themselves and having others advocate for their rights.

One of the consequences of encouraging breastfeeding is that bottle-feeding mothers feel that they are told they are doing wrong since they are given little encouragement. This is significant because infant feeding is intricately intertwined with cultural and personal notions about good mothering. As a consequence, negative messages about bottle-feeding become negative messages about mothering. The health message, therefore, became ineffective because bottle-feeding mothers simply 'dig in at the trenches' and develop strategies to justify and sustain their position on bottle-feeding. The outcome is frustrated health professionals and miserable mothers who feel unsupported and who often continue in their plans to bottle-feed. This might be classified as a lose-lose situation where neither the health profession nor the mother benefit.

### *Reconstructing definitions of good mothering*

The mothers' reactions were to construct their own ideas of good mothering, incorporating the importance of bottle-feeding. However, they struggled to do this because they were on the defensive against professionally defined care practices for infant-feeding. As Jackie explained, the struggle arose from such external pressure. She knew what good mothering meant to her and she wanted to get it right:

Jackie (10): While I was pregnant with my first, I knew that I did not want to breastfeed. So ...I struggled a bit because I knew that the pressure was there to breastfeed, and breastfeeding being the best way, but, ... I felt that I wanted to bottle-feed, it was very important for me to be able to...it was my first time at mothering, I just wanted to do it right.

Thus they appear to regard mothering in a broad sense that doing it right can include bottle-feeding.

### *Avoidance*

Some mothers simply avoided the battle by quietly ignoring midwives and keeping as silent as they could. Francine, for example:

Francine (08): It's like a little conspiracy secret. I didn't want them to know, but I've got to feed him somehow (laugh). Yeah. You feel like you're keeping a bit of a secret ... it just felt like, ... you know, I was being a bit naughty (laugh) ... a bit deviant. I thought they might think that I was trying to get the easy way out, but it didn't really concern me that much about what everybody thought. It only matters what the baby needs, so I was going to do it (bottle-feed) anyway.

Francine talked about how she felt she was deviant, although it did not appear to upset her too much since she was light-hearted in her response.

### ***Passive resistance***

However, when lay determination encountered professional imperatives and hospital breast-feeding policies, the outcome was sometimes passive resistance. Women complied with breast-feeding in hospital only to change to bottle-feeding when regaining autonomy in their own homes. Earlier in the chapter Donna was quoted as doing just this with her previous newborns, and Penny was quoted as having heard many stories of women doing this.

### ***Standing up for themselves***

Mothers in this study were aware of the possible coercion they could face and this made them all the more adamant that they would feed their baby the way it suited them. They had made a conscious decision to bottle-feed. Natasha, like all the other mothers, was very definite in her decision:

Notasha (05): I know there's a lot of pressure here (Australia) to breastfeed, and that would nearly make me go the other way and really stand up and say I'm not doing it, and I don't want to do it and nobody's going to make me do it either. It just was never really a choice for me, I never considered breastfeeding.

The classification of Natasha's response as resistance or opposition depends somewhat on the perspective taken; from her point-of-view she was being self-determined and positive in her choice to bottle-feed. Nevertheless, in the hospital context, resistance or "standing up" to authority was often a necessary strategy to sustain the personal choice to bottle-feed.

### ***Use of advocates***

For some, use of advocates became necessary, as Imogen indicated. She gained the support of her baby's father and her doctor to overcome the pressure from the midwife to breastfeed:

Imogen(01): Well, the midwife that was in the delivery room, she said, 'do you want to give him a feed?', and I said, 'no, I don't, I'm bottle-feeding'. And then I think it was (baby's father's name) who said again, 'she's going to bottle-feed', and that's when the midwife said, 'well, have you thought about that, do you know the advantages of breastfeeding?'. Then the doctor (name) who was stitching me said, 'no, Imogen's made up her mind, she's bottle-feeding'.

In summary, the mothers' reactions to professional negative attitudes and negative encounters were reconstruction of good mothering, avoidance, passive resistance, standing-up for themselves and having advocates to defend their decision. The reactions to some of these

encounters with health professionals left some mothers lacking in self-confidence, but because many of these women were self-determined they were unpersuaded by the many negative events. However, the women were left on the outskirts of midwifery care and lacking confidence, not in themselves but in the health professionals' ability to care for, and support them.

## **International differences**

The importance of this study is that it explores a particular zone of the line drawn in battle between professional and client interests. One implication of the findings of this study is that Western Australian bottle-feeding mothers face particular difficulty in their determination to exercise choice in infant feeding practices. Some of the mothers with international experience noted the strength of the breastfeeding messages in Australia. Sandy had experience of midwifery care in each of the United Kingdom and Australia.

Sandy (09)      There's a big thing going on towards breastfeeding over here, (in Australia) whereas in the UK it doesn't seem to be so forthright ... really the midwives here are very pushy ...trying to make everyone breastfeed.

Natasha gave further evidence of this different international experience.

Natasha (05):    In Ireland all my family bottle-feed their babies, so no one even asked me how I was feeding her (the baby). It seems there is such a push for breastfeeding here (in Australia), but they wouldn't need to push me (laugh).

This international comparison suggests the influence of local culture on professional care practices. Although the WHO Code was the result of international effort and pro-breastfeeding policies apply globally, Australia is noted in the literature for having comparatively high breastfeeding rates for developed countries (Hauck, 2000). Another relevant contextual point is that attitudes towards infant feeding change over time. Even during one of the most marked periods of pro-breastfeeding attitudes, the use of artificial feeding has not been eliminated and is the method of choice of a sizeable minority of about 23% of new mothers in Australia. In brief, policies and practices are culture-bound as well as evidence-based. What is made culturally can be changed culturally. Policies and their implementation are not immutable.

## **Comparison of different points-of-view in relation to feeding choice**

For midwifery, having a strong policy directive with support materials, such as the BFHI, is a useful step for developing professionalism. The prospect of having accrediting power has also

been welcomed as an opportunity for the profession to establish its goals in hospitals. The negative outcomes described in this study are, in general, an unintended consequence of the pro-breastfeeding stance.

A particularly common label applied to patients in health care settings is that of compliance. Many professional health promotion messages favour personal responsibility in decision-making. The paradox is that what is really expected is compliance with health information. Failure to do so is interpreted as non-compliance. Bottle-feeding mothers are not compliant<sup>2</sup> but they are self-determined. What is important here is that mothers who choose to bottle-feed are labelled non-compliant (Marsch, 1998). Defining and assessing compliance in health care has been defined as "the extent to which the patient's behaviour coincides with medical or health care advice" (Haynes, 1979, p. 2). Fletcher (1989, p. 453) puts it in a more simplistic form, suggesting that compliance really means "patients doing what the health professionals want them to do". The term 'coincides' used in the definition offered by Haynes (1979) seems less judgmental than the language used in the definition by Fletcher (1989) which emphasises the power relationship between health professionals and patients. Despite the differing terminology used, the issue of power is central to the definitions.

Moore (1995) suggested that mothers, who were non-compliant with professional advice and pressure, leave health care professionals feeling exasperated and concerned. Waller and Altschuler (1986, p. 492) described such mothers as having 'thwarted the best medical efforts to help them'. Davis (1968, p.274) reinforced this professional view implying that the mother was to blame for not following professional advice. The literature (Barklay, 1994) focuses on how the health professional felt in these situations. The mothers' feelings were not discussed. Common terms used to refer to mothers who do not breastfeed include: non-adherence, non-compliance, failure, refusal, unwillingness, reluctance, and non-cooperation (Fawcett, 1995).

In Australia, administrative hospital policies set targets for the number of new mothers who leave hospital breastfeeding after the birth of their baby. This raises a number of interesting questions about parental autonomy in deciding infant feeding practices and professional control. There is a view that health professionals have been accorded a powerful, pivotal role in institutions (Saks, 1983) and that there is a constant need to consolidate professional status. (Freidson, 1970). Power accorded to health professionals gives them the authority to define the mother as a client or patient, and to determine what is best for her. In brief, the professional

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<sup>2</sup> Strictly speaking, bottle-feeding mothers merely pose a "problem" for midwifery by not taking up the profession's preferred advice. However, since bottle-feeding is a legal option, those clients are simply difficult, a disappointment and sometimes accepted. "Non-compliance" is a term more often applied to extreme cases where people are not protecting themselves against immediate and serious health risks, such as not adequately caring for post-operative wounds or refusing medicine for severe mental illnesses. Occasionally, debates are sparked but rarely progress over more nebulous concepts of non-compliance, such as propositions to refuse health care to obese people or smokers.



judges the appropriateness of the mother's infant feeding decision thereby undermining her autonomy. Where the focus is on the mother's behaviour as being problematic, and the implications are that it is because she has chosen to bottle-feed, this interferes with the midwives ability to provide good health care because not all mothers share the same values, or find themselves in similar contexts.

It was obvious from the findings of this study that there were many episodes of powerful relationships between mothers and health professionals, invariably, the professionals were in the dominant role. However, the interesting thing is that these mothers were not influenced by the power of the professionals to alter their decision to bottle-feed. These women were strong in their own knowledge. In this context, the concept of 'knowing' is interesting as many mothers in this study said they knew that bottle-feeding was right for them. This knowledge arose from their understanding of their own personal space (Hunt, 1994) and how bottle-feeding would fit into that space. The concept of one knowing oneself best is integral to self-responsibility. What is at stake here is the direction that self-responsibility takes. The problem occurs at the contested boundary between an individual's choice and policy that seeks to direct that choice.

There are many policies to which midwives should adhere, in addition to the BFHI. One that outlines five basic patient's rights is the National Health and Medical Research Council (NHMRC)'s (1987) guidelines. For illustrative purposes, the differences in point-of-view of the mothers' and midwifery's will be compared in the following table in terms of those guidelines:

Table 1

## Differing perspectives on client/midwifery relations regarding infant-feeding choice

Points of View (p.o.v.)		
NHMRC Patient Choice <sup>3</sup> p.o.v. <sup>3</sup>	Bottle-feeding mothers' p.o.v. <sup>4</sup>	Midwifery's p.o.v.
Choices in health care	By midwives pushing breastfeeding, the choice of bottle-feeding is misrepresented as being uncaring, non-viable, and always a health risk.	Mothers will not be able to make an informed choice until we have explained the benefits of breastfeeding and the risks of bottle-feeding <sup>5</sup> .
The right to be informed	Mothers have a right to be given full information about both options, breast and bottle. Midwives should support mothers' choices and should assist bottle-feeding mothers to cope optimally, not just breastfeeding mothers.	We have a duty to inform mothers that breast milk is best. It is detrimental to public health to display the formula companies' perspectives. <sup>6</sup>
The right to safety	Compared to the ante-natal focus on breastfeeding, bottle-feeding mothers are not sufficiently trained about formula and sterilising bottles to be really confident. Breastfeeding mothers are not routinely taught how to prepare formula.	Every maternity hospital has a "Care Plan for Post-natal Mothers" whereby essential basics must be taught before discharge, and there is a section for bottle-feeding education that is taught to bottle-feeding mothers.
The right to be heard	Once the choice to bottle-feed is made, midwives should respect our reasons for deciding it suits us, and respect our experiences of coping well with our babies.	Strict guidelines ensure that all patients receive adequate levels of care. Midwives follow WHO-led professional policy to promote breastfeeding.
The right to redress	Mothers in this study did not discuss issues but they did complain of learning about formula by trial and error due to poor Child Health Clinic advice about formula. This was revealed when given advice at the chemist...	Aiming to be "Baby Friendly", our priority is to promote infants' rights to be given optimal nutrition. BFHI guidelines require that only necessary information about formula is provided to those who need to use it.

This comparison highlights how bottle-feeding mothers have an expectation that they have a right to be provided with full information about both breastfeeding and bottle-feeding and to be supported in their own choice. Most of their criticisms stemmed from these unmet expectations.

<sup>3</sup> The NHMRC's Point of View column takes the five main points from NHMRC (1987) guidelines for patient choice.

<sup>4</sup> The Bottle-feeding Mothers' Point of View column reconstructs some issues arising in the interview data. Each issue is fully illustrated and discussed at various points of the thesis but not necessarily in this present chapter.

<sup>5</sup> The Midwifery Point of View column is a re-construction of various policy documents. This point-of-view on Patient Choice is taken from: WHO/UNICEF's Ten Steps to Successful Breastfeeding.

<sup>6</sup> WHO International Code of Marketing of Breast Milk Substitutes.

<sup>7</sup> The BFHI slogan is to "Promote, protect and support breastfeeding".

<sup>8</sup> Public criticism of the BFHI policy occurred more widely when it was new. For example, a UK editorial in 1996 in *Nursing Standard* argued,

[An] area that must worry nurses and midwives is that they could well be breaching the UKCC Code of Professional Conduct by withholding important information. If a baby became seriously ill or died because the mother did not have the necessary information about formula feeds who would be responsible - the [BFHI] trust or the individual health visitor?

... Nurses, midwives and health visitors are professionally accountable as individuals.

... Whatever good intentions are behind the Baby Friendly campaign, the drive towards breastfeeding has gone too far.

(Casey, 1996, p. 42)

The policy driven stance of Midwifery, when considered from the perspective of bottle-feeding mothers, aims to narrow the options of mothers towards only choosing breastfeeding, and postpones taking a mother's choice of bottle-feeding as a definite decision until as late as possible, usually undertaking basic bottle-feeding training in a post-natal risk-management style. As such, disapproval and negative attitudes of professional to client are the likely result, and this can be very upsetting to bottle-feeding mothers and damaging to their rapport with health providers, as this chapter has shown.

The evidence so far has demonstrated the extent and nature of bottle-feeding mothers' sense of marginalisation which rested on their assumption that the differences between bottle-feeding and breastfeeding were not sufficient to make their choice wrong. They perceived everything to be organised to suit breastfeeding. This not only put them at odds with health professionals in whose care they were placed for child-birth, and meant they received considerably worse service than the breastfeeding group.

## **Conclusion**

This chapter has documented concerns by bottle-feeding mothers that they are marginalised by the negative attitudes of midwives towards them. An examination of professional directions such as the BFHI policy documents would suggest that the promotion of breastfeeding has indeed resulted in a lower priority being given to developing services for this group of clients, even though they have been a formally researched group of arguably non-compliant clients. Many professionals might consider this to be an inevitable result of continuing attempts to meet the WHO breastfeeding targets of 90%. However, in a democratic and egalitarian society such as Australia, and within caring models of nursing, the implications for the midwifery profession is that marginalising any group may be unacceptable because within the Australian health care system, midwives are the health-care-providers with responsibility for establishing *all* infant feeding.

The implication is that more complex professional strategies, models and guidelines may be needed to cope more sensitively with clients choosing to bottle-feed. In order to achieve this it is important to understand the decision-making process that led mothers to bottle-feed. This is the subject matter of the next two chapters.

## **CHAPTER 5 - The Mothers' Bottle-centric Comparisons of Breastfeeding and Bottle-feeding**

It is of concern in Midwifery that, despite advice to breastfeed, many women still choose to bottle-feed. Typically the focus of research into this concern is on 'deficit' theories suggesting that women who choose to bottle-feed are lacking in some way. Factors identified have included intelligence, lower levels of education, being unmarried, smoking, or being young and immature. Recommendations arising from deficit theory research normal feature the need for better persuasion about the benefits of breastfeeding and the risks of bottle-feeding. However, in such studies usually the goal is to analyse the mothers' faulty reasoning. From those deficits which get identified, researchers then propose interventions to educate mothers, or fathers or young girls and boys, so future clients can meet their needs in more appropriate ways - that is, complying to their advice by choosing breastfeeding rather than bottle-feeding<sup>1</sup>. In contemporary Midwifery literature on infant feeding, both pro-breastfeeding<sup>2</sup> and pro-choice<sup>3</sup> publications have referred to such research as victim-blaming. Women are either too stupid, too ignorant or too selfish to do 'the right thing'. What they need is better marketing of breastfeeding. The Australian College of Midwives Incorporated (ACMI)'s professional Midwifery journal, like its overseas counterparts, frequently carries editorial opinions, letters and some research articles that openly or subtly support the marketing approach<sup>4</sup>. Positive discussion about the Baby Friendly Hospital Initiative (BFHI) has regularly been published in the ACMI journals. Indeed, recently an additional ACMI newsletter has been produced, called the BFHI Australia News, that is entirely promotional in the sense of it acting as professional development for the hospital policy.

The present study, however, considers the perspective of bottle-feeding mothers by really listening to them, and argues that the mothers in this study proffered some important considerations about their choice to bottle-feed, which are rarely reflected in the recent professional literature. Bottle-feeding mothers' experiences left most of them feeling frustrated

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<sup>1</sup> For example, Durdle (1996, p. 188) wrote, "In just over 20 years, most peoples' attitudes to smoking and to drink-driving have moved from complacency or indifference to positive condemnation. The challenge for us is to turn around the negative attitudes to breastfeeding in our society."

<sup>2</sup> In recent Australian literature, for example, Maureen Minchin has mentioned the problem of such deficit models of mothers, claiming that in fact it is professionals who are at fault for not properly informing mothers in not wanting to make them feel guilty about bottle-feeding. Sarah Blaffer Hrdy (2000) details this issue with examples of researchers' so-called wisdom being shaped by and shaping of ideologies of motherhood.

<sup>3</sup> In recent Australian literature, Leslie Cannold (1995) critiques the deficit model of bottle-feeding mothers, claiming many mothers have good reasons to choose bottle-feeding that get overlooked.

<sup>4</sup> The marketing approach to breastfeeding typically occurs in its promotion from editorials to letters. However, the slightest hint of bottle-feeding mothers having needs will typically spark responding letters defending breastfeeding and often expressing outrage.

that the midwives who cared for them seemed to be oblivious to their perspectives and needs. For example, Sandy described how she felt ignored:

Sandy (09):            They (Midwives) make you feel that you are second class, they never consider why you might have chosen bottle-feeding.

The sense of being unheard (or heard but always considered to be wrong) is one dimension of how bottle-feeding mothers felt marginalised by dominant Midwifery discourses.

This chapter will examine some key terms about infant feeding that frequently occur in ideological battles over which is the correct way to feed infants. Then the mothers' bottle-centric views of the disadvantages of breastfeeding and advantages of bottle-feeding will be described. The final section of chapter will investigate and theorise the mothers' beliefs that bottle-feeding leads to enhanced father-baby "bonding" and involvement.

### **Nebulous, slippery concepts in infant feeding discourses**

Current and historical concerns about infant feeding go beyond nutritional concerns. Medical and biologic reasons for breast-feeding (Hartmann, 1997) are especially well established in Midwifery discourse. For example, the antibodies in breastmilk enhance babies' ability to resist infection (Howie, Forsyth, Ogston, Clarke & Forey, 1990). This generalisation is now complicated by the transmission of HIV/AIDS through breast milk. Further, in lactating mothers, the release of oxytocin minimises postpartum blood loss (Du v Florey, Leech & Blackhall, 1995; Newcomb, Storer & Longnecker, 1994). Nevertheless, in a society with high standards of medical care, to some mothers the balance of risks and benefits on medical grounds still points them towards opting for bottle-feeding.

Other key areas of concern in infant feeding encompass emotional and interpersonal relational aspects. However, these aspects of health are removed from direct observation. As a consequence, there is considerable scope for dogmatic assertion about what is taking place in regard to total health. Several of the bottle-feeding mothers in the study were frustrated that their babies were obviously thriving by observably gaining weight and being content, yet they felt that their success was overlooked by midwives and wider society who continued to regard them as not giving their baby the best. Midwives know that oxytocin dilates blood vessels creating the pleasurable glow that in breast-feeding women which can reinforce their feeding efforts. This has led to cultural beliefs about this being the ingredient of mother-love (Blaffer Hrdy, 2000). However, many mothers have sufficient confidence in their resolve to care for their infant and to develop the appropriate emotions without such biologic reminders. To the

mothers in this study successful interpersonal relationships were very important, but they regarded involvement as the key.

Another key concern in infant feeding, that may sound quaint, is morality. Whilst the word itself was not raised by the mothers, as a concept, it permeated their perceptions. There were underlying moral judgements in how they felt about bottle-feeding as well as their experiences of midwives' and other people's attitude towards them, and in what they said about mothers that breastfeed. The field knowledge of infant feeding raises such issues in a number of ways. For example, the pairing of guilt with bottle-feeding mothers' feelings occurs and re-occurs in the literature, blame is debated and reassigned, surfacing less as sound reflections of data and more as an indicator of heated opinion and ideology.

An overview of the literature matched with those concerns raised by the mothers suggests that several key concepts relevant to emotional and interpersonal relational aspects of infant feeding frequently occur. The issues of bonding, attachment, emotional needs of the parent and morals in infant feeding choice are inter-related, and will now be outlined.

### ***Bonding***

Bonding is a contentious issue, but it was a term used by the mothers that had meaning for them. The consistent manner in which it was discussed formed the basis for this study's finding that it was a shared belief amongst the mothers. The term has wide popular usage, even amongst many health professionals who often speak of nebulous issues such as maternal instincts or mysteriously powerful mother-love occurring instantaneously following birth. However, even Maureen Minchin warns against the use of "the hypothetical bonding period" suggesting that it is a "useful but unscientific concept, very useful in its day" (1985, pp. 173-174), and quoting the following:

Early experience, far from being *all important*, is no more than a link in the developmental chain, shaping behaviour less and less powerfully as age increases. Contrary to a variety of strongly held beliefs, there is no clear-cut evidence that events around and soon after the time of birth can readily or seriously distort either the development of the infant's personality or interfere with the growth of maternal love and attachment.

(Sluckin, Herbert and Sluckin, 1983, cited in Minchin, 1985, p. 173)

Sarah Blaffer Hrdy vividly critiques the ideological drives behind research into human theories of maternal instincts, and describes scientific evidence of bonding as:

[Being] derived from studies of sheep and goats, whose mothers imprint on their smells while licking off the amniotic fluid right after birth... . None of the research on bonding came from primates, who are far more flexible in this respect. In stark contrast to primates, sheep are intransigently discriminating about which babies they will accept. Unless the baby smells just like the baby whose scent the mother imprinted on moments after she gave birth, she rejects all overtures.

(Blaffer Hrdy, 2000, p. 487)

Bonding has come to be used in terms of infants bonding with their mothers. More recently, it is used in terms of fathers 'bonding' with their children. This is discussed by Barclay and Lupton (1999) who describe it as a recent discourse of western society, central to some men's symbolic meanings of 'new fatherhood' along with ideas of 'being there' and 'involved fatherhood'.

The mothers interviewed for this thesis do not support notions of "bonding" in its strictest sense, which is that chemical imprinting during early lactation is essential if a human mother and baby are to form a close attachment. Blaffer Hrdy offers a similar critique of the notion that there is a "critical period" for so-called bonding to take place. There is some evidence that the rare cases of "at risk" mothers, not especially capable or committed to caring for their infant, fare better in developing the commitment if contact is not delayed more than 72 hours. However, while early contact may be helpful and is preferable, in normal and stable mothers delayed contact does not preclude or limit the development of appropriate emotions for maternal caring. As such, the theory of bonding as a time-limited effect of breastfeeding essential to developing proper maternal feelings in humans has not been proved. However, as the mothers in this study used it, bonding has come to stand for the forming of special emotionally close relationships and this can be achieved as much through bottle-feeding as breast-feeding.

### ***Attachment***

Despite confusion in the use of the word bonding, something less dramatically sudden and more sustained is considered to develop the special feelings between mother and baby. It is termed maternal attachment behaviour, or shortened to 'attachment'.

Bowlby (1958) in the late 1950's early 1960's suggested that satisfaction with breastfeeding fostered closer mother-infant ties. He conducted the classic studies of maternal eye-contact during breastfeeding in the first months of a baby's life. With ongoing research, it turned out that achieving successful mother-infant attachment was more varied than Bowlby at first realised and not necessarily reliant on breastfeeding, and Blaffer Hrdy suggests that Bowlby's most relevant contribution was to define what is important in the superseding theory of attachment. He identified commitment and security as the most important factors:

A securely attached infant is an infant secure about his [sic] world in general, present and future. A secure infant is far more comfortable, even in his mother's absence, than an infant in doubt about his mother's commitment.

(Blaffer Hrdy, 2000, p. 534)

There is a biologic basis shared by all mammals for a symbiotic mother-infant feeding relationship to develop. However, humans have the capacity to develop equivalent mutual social bonds such as through adoption. Those social bonds are also symbiotic, not only from the mother's drive to nurture the infant but also in the baby being "cute" and responding to care (Blaffer Hrdy, 2000). Klaus and Kennell (1976), the more contemporary authorities on maternal attachment, also identify that sustained contact rather than breastfeeding is the key variable for success. The mother gets to know her infant by repeated returns to enact care, and the child feels secure that the mother will provide care often coming to display behaviours of enjoying and choosing the mother, and arguably 'needing' her, above all others.

Variations of the maternal attachment theory developed along the lines that infants' emotional attachment depended upon breastfeeding. Some implied that infants learn to trust their mother only through breastfeeding and if they are not offered the breast they can tell that their mother does not love them. Martone and Nash (1988) describe how public sentiment tying bottle-feeding with deficient mothering behaviours became so strong that in the early 1980's a Task Force on the Assessment of Infant Feeding Practices and Infant Health issued a statement, "a mother should not feel that she is doing psychological harm to her child if she is unable or unwilling to breastfeed."

Involved mothering compared to non-involved mothering is the important difference regarding the success of attachment. If there is such a thing as bonding in humans its function is reciprocated emotional "attachment". Breastfeeding and or early contact may be helpful for this but neither is essential, whereas positive, involved and sustained contact is essential and is the key to successful attachment.

The late 1980s marked a high point of optimism for breastfeeding advocates, and studies comparing postpartum attachment behaviour in breastfeeding and bottle-feeding mothers were attempted. It is notable that some of that professional literature suggests that mother may be negatively affected if pressure is applied by health professionals proposing a particular feeding method. For example, Martone and Nash cautiously presented their finding that:

Overemphasis on either feeding method by health professionals and others tends to create additional stress for mothers who are trying to form relationships with their newborns...health care professionals can best promote maternal-infant attachment by supporting a mother's chosen method of feeding.

(Martone & Nash, 1987, p. 213)

It is in relation to the concept of attachment that much of the attitudinal marginalisation of bottle-feeding permeated the experiences described by the mothers. It appears that the notion of attachment through breastfeeding can be twisted to imply that the reverse happens in bottle-feeding. Usually false assumptions are drawn or persuasive arguments are developed that



*typically* bottle-feeding mothers love their babies less, and may even go further to suggest that *typically* bottle-feeding mothers will reject or abuse their off-spring. As Martone and Nash point out, despite official debunking of the notion that bottle-feeding is equated to bad mothering, the link between enhanced attachment and breastfeeding remains a strong belief.

### ***Emotional needs of the parent***

Breastfeeding is argued to be emotionally satisfying to both mother and baby. That the mother develops her own emotional needs for contact with her child and receives physical pleasure from the relationship is applauded. The socio-biologic explanation is of oxytocin let-down being reinforcing to the mother, to the extent that she becomes addicted to caring for the infant for whom she develops instincts and feelings of life-long, unconditional love. However, when it comes to bottle-feeding, the focus on emotional needs is often a denial that the baby can be emotionally satisfied due to being deprived of the breast and the mother's real love. In such anti-bottle-feeding views, there is frequently too little sympathy for the mother to even consider that she has emotional needs. Discussion about emotional needs in relation to people deemed to have made the wrong decision nearly always introduces a moral judgement concerning whose needs are primarily being met and whose are subjugated. Suspicion is cast on what selfish, neurotic or sinister motives must underlie the emotional needs of parents who, by preferring to bottle-feed, allegedly place their needs above those of their babies.

Maureen Minchin's work is typical in regard to her pro-breastfeeding stance that infers unless parents breastfeed, they will be incapable of forming proper emotional relationships with their infants. Postmodernism has a technique of 'de-constructing' powerful discourses, to show them as fictions or effects of ideological positions more than representing the truth of objects. An analysis of nebulous concepts such as emotions and needs will be applied to the following paragraph of published literature.

1. In the area of psychological effects of breastfeeding we should mention other family relationships.
2. No one suggests weaning in those rare cases where other children feel left out when the mother breastfeeds.
3. Rather, they suggest practical ways for the mother to cope without excluding the siblings.
4. But if a father has problems with the fact of his partner breastfeeding, or if the mother's sexual urge is diminished, weaning is all too often accepted as reasonable.
5. Such people need help to change.
6. They are adults who have (we hope) chosen to be parents. Having done so, they have undertaken a responsibility to another person, their child.
7. I personally believe that no adult has the right deliberately to put his/her wishes ahead of a child's most basic needs.

8. and breastfeeding is a basic need.

9. Adult sexual gratification, or male jealousy and immaturity, is not a good enough reason to deprive an infant of the only suitable food for the first half-year.

(Minchin, 1985, p. 175, numbering added)

The following analysis will show that claims are made very easily about unobservable issues such as emotions. The various accusations made about people's emotions may seem natural but are actually cultural construction. They do not reflect real evidence about the people, but are developed through the author's opinion and moralising statements.

1. Linking psychological effects to breastfeeding already sets in place the prejudice against bottle-feeding. The opening sentence suggests that a broad general topic will be discussed, which is family relationships.
2. That the mother should meet the infant's needs to be breastfed above previous children's rare feelings of being left out is established.
3. The small problem of the rare ill feelings of siblings in #2 is removed by slipping into being easily solved in practical ways. Without saying so, that strategy suggests that in good breastfeeding families all the emotions are stable apart from some rare and easily solved childish fears and mothers cope. It hides the fact that in reality, however, not all breastfeeding households are calm.
4. Without even mentioning the words preferring bottle-feeding, a dramatically contrasting picture is given of those families. The discourse introduces some well known topics from the field about how new parenting can involve temporary disappointment about changes in adult partners' intimate relations, and assumes a situation of the father wanting more sex than the mother wants to give. Notice the contrast with #3, so that the discourse assumes that parents who do not want to breastfeed are much less happy and experience problems with their sexual relationship, without pointing out that is not the case for all people who want to bottle-feed. The word weaning evokes an image of a distraught baby and there is no mention of the possibility that some babies find formula milk quite satisfying.
5. The parents' believed emotional problems are now further alleged to be abnormally deep-seated. The construction, in the best of Freudian traditions, is that the bottle-feeding choice was not discussed as ordinary parents who feed differently, but instead was introduced in terms of the author's opinion as an emotional issue through creating fictional sexually imbalanced parents. To claim people need help is to suggest their emotional problems are so bad they cannot be resolved alone.

6. From this point, bottle-feeding parents are being constructed as entirely sinister, as the focus changes from emotions to moral judgements. Instead of talking about them as normal people who do provide for their baby by buying and preparing formula, their choice to bottle-feed is discussed as forgetting their responsibility as adults.
7. The author positions herself as upholding high principles, as someone who defends the child against the adult. Once again, the author's construction is denying that bottle-feeding parents feed and care for their children.
8. Asserting an opinion to back up previously falsely premised assertions does not make the author any less incorrect, but it might make her sound right. Nevertheless, what is hidden is that being fed is a basic need and bottle-fed babies do get fed. Thus it is an opinion not a fact to call breastfeeding a basic need.
9. The fact that a baby may be fed formula milk is denied by not being mentioned except where discussed as the author's opinion of the baby being deprived. To call it that, twists the meaning of deprived children who would get too little or no food, and it is misleading to describe breastmilk as the only suitable food. In the final sentence, the former unfounded facts about the emotions of bottle-feeding parents are reiterated in another fiction. Disguised as a wise comment about moral values, the author prioritises the importance of an infant being able to breastfeed for six months against adult sexual and emotional traits. Thus, if the fiction succeeds in its work to hide the fact that bottle-feeding can be nutritious and to hide the fact that preferring it is not a mental illness, crime or mortal sin as apparently alleged, it is almost impossible not to feel appalled about bottle-feeding parents by believing what she describes. The sentence suggests that parents who think breastfeeding is a problem are so immoral they think that wanting adult sexual gratification is a good enough reason to deliberately deprive a child of suitable food for half a year. This construction is not describing normal bottle-feeding parents, but it is very sinister in pretending that it does so.

The deconstruction illustrates how the allusions to emotional problems, underlying sexual issues, and other aspects of parental selfishness made by the author did not arise from clearly reporting research findings but arose simply by being placed into her argument. They are an outcome of an exercise in ideological mythologising rather than of real observation of parental emotions and needs, or of bottle-feeding facts. The deconstruction should also show the power of discourse for perpetuating myths through a compelling mixture of salacious detail and moralising. As such, it is the published literature that is sinister, not the topic of bottle-feeding parents. It is deceptive and marginalises people who bottle-feed. This deconstruction, in

refuting such opinions and moralising statements, re-opens the possibility, that is better aligned with research, that all committed parents, whether they breastfeed or bottle-feed, have quite similar emotions towards their babies and similar problems in adjusting to changed family relationships.

### *Morals in infant feeding choice*

Morality is pertinent to the field in a range of open and subtle ways. It has immense relevance to forming opinion and promoting directions for professionalism. For midwives, the imperative to be caring carries with it a concern to know what is the right thing to do. This section suggests that morality is yet another nebulous, slippery concept that is applied to the contested domain of infant feeding.

A pertinent example to this study's findings is that Midwifery moralises about mothers who choose bottle-feeding and about what the father should be doing. Earle's discussion of mothers wanting to involve fathers in feeding the baby accords with the patterns in this study's data:

The data suggest that the role of the father is becoming increasingly significant in women's baby-feeding decisions.

(Earle, 2000, p. 328)

Yet she dismisses her interviewee's stated desire for fathers' involvement in bottle-feeding as a 'justification' (that is, claiming a morally good reason for having chosen to do something wrong or immoral). Earle referred to a particular pattern found in her study's data: Many bottle-feeding mothers would say something about Breast is Best substantiating it with reasons during pregnancy but then choose to bottle-feed which, in follow-up postnatal interviews, they explained as their having wanted to involve the baby's father. Earle's analysis develops a modernist argument about the women as behaving in inconsistent and irrational ways when choosing what they know is the 'bad' option of bottle-feeding, and the following demonstrates her dismissal of the desire to involve the father:

Other studies have also pointed out that women can justify their decision to bottle-feed by suggesting that it is a way in which to involve the father in the baby's care (Murphy, 1999).

(Earle, 2000, p. 328)

Earle's data collection methods and data from bottle-feeding mothers are similar to data in this study. Her findings fit closely to something I had anticipated finding. That is that bottle-

feeding mothers felt guilty. Instead, they felt marginalised by midwives wanting to make them feel guilty<sup>5</sup>.

In the present study, differing markedly from the dominant Midwifery approach, the bottle-feeding mothers' expressed desire for the role of the father 'bonding' is analysed as being sincere and meaningful to them. Moral judgement is avoided. The mothers' arguments about bottle-feeding being better are accepted as simply being stronger truths for the mothers than their co-existing knowledge of breast being best. The mothers' articulation of co-existing truths (knowing that breast is best; believing that bottle is better) does not illustrate irrationality or wilful selfishness. Instead, it means that these mothers have "truth positions" that can see more than one truth simultaneously. Furthermore, it is likely that the bottle-feeding mothers wanted to indicate to me as the interviewer that they had not acted out of ignorance of the dominant advice but out of their own judgement and insight that was different. Their awareness of their marginalised position would likely have made these bottle-feeding mothers try to sound "neutral" about infant feeding at the beginning of the interviews. Patterns in the data suggest that as the interview situation settled and trust developed, the interviewees became more confident, and in some instances outright keen, to drop their deference to the conservative position of the dominant discourse and to speak openly as if it were one bottle-feeding mother to another. In other words, because I was not being judgemental in the interviews but was asking genuinely open-minded questions, the mothers eventually relaxed and opened up to me as if I were pro-bottle-feeding like them.

Issues of morality are also raised outside of judging the parents' motives. A compelling argument widely circulated in dominant Midwifery is that it is 'immoral' of midwives to let mothers bottle-feed. For example, Minchin (1985) claimed that to save mothers' from feeling guilty by not specifying the risks of bottle-feeding was morally wrong, and any guilt should lie completely with professionals not prepared to emphasise that information. A Midwifery Studies lecturer forwarded a similar argument but suggested that women who fail to breastfeed blame themselves and midwives therefore take the moral responsibility for making them suffer damaged self-esteem.

If women believe themselves to be failures in this most basic female function, they must surely suffer considerable damage to their self-esteem. This is all the more poignant when we consider that it is not the women who have failed. It is the midwives who have failed them. ... We cannot shrug away the burden of moral responsibility for the way we contribute to the failure of breastfeeding. We have claimed breastfeeding as a Midwifery skill - it is our professional and moral duty to exercise it. (Rachel Clarke, 1995)

(cited in Carter, 1996, p. 151)

<sup>5</sup> Carter (1996, p. 150) warned against Midwifery's growing "dogmatic" approach in favour of breastfeeding. In what he termed a "backlash", which would be against what this present study terms marginalisation, he cites a bottle-feeding mother's published letter, "I don't like breast-feeding. ... [Midwives make our bottle-feeding experience] worse [in] the message that, if you bottle-feed, you are monstrous and unnatural. ... So why did I feel guilty when all my girl friends were breast-feeding and I wasn't? Because I had been bombarded with propaganda."

Another issue, that is not uncommon in the literature on infant feeding, is allusions to the public good, generally in the form of proposing that breastfeeding will save society the cost of attending to the illnesses bottle-feeding causes in both the baby and the mother. This is a moral proposition undermining the right to individual choice, showing the encroachment of individual's rights to bottle-feed into burdening society.

A technique for exploring moral judgements is to assess areas of contention in terms of who benefits. The opinions and morals of those benefiting are deemed worthy of further analysis. For example, Gabrielle Palmer's (1998) calculations of the economics of milk substitute formula in the Philippines sought to show that its detrimental effect on the national economy because of high import costs. In this case, the USA benefited. Looking at a monthly budget of low-income families, based on a single sample derived in discussion with a villager, Palmer argued that family units fared poorly due to large percentages of total income expended on formula costs and related expenses of cleaning, equipment and transport to hospital and doctors' fees. The picture emerging was of collusion between the main beneficiaries, formula companies and doctors at the financial expense of poor families, not forgetting the tragic health costs to infants. In particular, Palmer depicted doctors as self-serving in their support of bottle-feeding.

While the notion of questioning who benefits can be useful up to a point, accusations about being self-serving can be made about anyone benefiting from a situation. Simply to benefit may not necessarily make it morally wrong. For example, few breastfeeding proponents would see the hard won policy money to support breastfeeding as automatically transforming pro-breastfeeding societies as self-serving. Beneficiary organisations would need to maintain themselves but would also continue with the purpose of improving infant and maternal health by supporting breastfeeding.

This section examining key concepts around infant feeding choices has shown how many of the beliefs have an ideological basis. It has shown how concepts in Midwifery professional literature so easily 'slip' from one point into something else based on asserting moral positions or assuming particular underlying emotions. This is not to say that the literature is completely devoid of mentioning what this present study has found about the mothers' sense of marginalisation with regard to their bottle-feeding. There is some literature that points to the negative emotional consequences of current practices for bottle-feeding mothers. For example, there is additional stress on mothers who are pressured to feed either way (Martone & Nash, 1987). A problem for bottle-feeding mothers is feeling unsupported and desiring social confirmation of their feeding choice (Hauck, 2000). There is evidence that Midwifery dogma in suppressing milk formula information can result in a "backlash" (Akre [unreferenced] cited in

Carter, 1996), and knowledge that proposed total bans on marketing are met with the disapproval of bottle-feeding and breastfeeding mothers alike (Market Trends, 1994 cited in Carter, 1996). However, even those research reports do not fully address the problems faced by bottle-feeding mothers. Frequently they are framed by or conclude something about needing better ways to promote *breastfeeding*. Certainly if breastfeeding were promoted so infallibly that no one wanted to bottle-feed, this would remove immediate dilemmas over patient choice and rights faced by midwives. However, such a proposal fails to address what ordinarily would be considered serious issues for parents choosing to or needing to bottle-feed. At the most, such research findings of negative consequences for bottle-feeding mothers are mentioned as signalling the dangers of 'dogma' in Midwifery. James Carter, for example, states that midwives need better guidance on how to avoid compromising their professional responsibilities to bottle-feeding clients. He warns that professionals need to become aware of the need to remain objective and dispassionate around "the siren voices from both [pro-breastfeeding] activist groups and [bottle-feeding] industry" pointing out that each group has vested interests but they fight against each other and leave the true interests of mother and child on the sidelines (1996, p. 153, clarification added). But no specific suggestions of how professional midwives can learn to remain objective and dispassionate in serving bottle-feeding mothers appear to have been suggested or developed by Carter or anyone. It would seem that part of the problem is that it is largely the siren voices of activists such as Palmer (1998) and Minchin (1995) that have framed much of the dominant Midwifery discourse. Contemporary Midwifery has generated and is being generated by an anti-bottle-feeding, pro-breastfeeding movement that currently has become almost impervious to other perspectives.

### **Mothers' perspectives of bottle-feeding being a viable and preferable option**

This section will present the mothers' perspectives for preferring bottle-feeding by highlighting their perceptions of advantages of bottle-feeding and disadvantages of breastfeeding. Advantages and disadvantages are neither stable nor consistent descriptions but depend upon subjective judgements. For example, these bottle-feeding mothers made the same argument about portability and convenience of bottles when going out as the pro-breast-feeding arguments make about breast-milk being 'on-tap'. This suggests that views of whether particular aspects are considered to be advantages or disadvantages will depend upon the women's perspectives more than any aspect being specifically an advantage or disadvantage.

Notably, this study found several perceived disadvantages and advantages that are not widely recognised in the literature, such as considering that women breastfeed for selfish reasons or

that bottle-fed babies can be healthier. In other words, a finding is that the views on infant feeding expressed by the mothers in this study were "bottle-centric".

### **Bottle-centric disadvantages of breastfeeding**

Some of the best known disadvantages of breastfeeding come from previous literature in the field. Gibney (1994, p. 10), for example, lists possible disadvantages of demands on the mothers' time, breast discomfort, inability to see the volume of milk taken, bad reactions to the mothers' diet, jealousy by husbands and siblings, embarrassment in some cultures, and incompatibility with the mother's return to work. Other research has identified the fear of feeling tied down (for example, Byrant, Coreil, & D'Angelo et al, 1992), and recently the relationship between return to work and infant feeding facilities is even emerging in some Australian political commentaries<sup>6</sup>. Dominant contemporary Midwifery literature is loath to acknowledge any disadvantages of breastfeeding. For example, Minchin states, "The usual adverse effects cited by bottle-feeding advocates include maternal fatigue, nutritional depletion, exhaustion from broken nights, restriction of mobility, and so on. These are specious arguments, hardly worth dignifying with a reply." (Minchin, 1985, p. 176)

Even so, underlying some of the bottle-feeding mothers' discussion of their experiences with bottle-feeding were some anti-breastfeeding arguments. Those arguments were based on the women's discussions with other mothers, or in some instances, based on their own former experiences.

The following section will describe how bottle-feeding mothers questioned the impact of breastfeeding in respect of physical disadvantages, over-tiredness, disturbed sleep, depressive disorders, difficulties in having peace of mind about the babies' food intake, and how breastfeeding can be chosen for the wrong reasons.

### ***Needing to avoid the physical impact of breast pain***

The physical impact was questioned, for example by Sandy who had noticed breastfeeding mothers in the same maternity ward were dreading feed time.

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<sup>6</sup> Like many developed countries, Australia has a declining birth rate, and the trend of women's earlier return to work is seen as part of the reason for this. Recent public discussion of this problem sometimes refers to the WHO recommendations for six months of breastfeeding. Some commentators are proposing supporting mothers' dual roles, for example, by taking up a radical feminist calls to restructure society "to support women in their productive and reproductive lives" (van Estemick, 1981).



Sandy (09): One experience that sticks in my mind was when I had my daughter and I was in a six-bedded area, and there was two people opposite me and who obviously had problems with breastfeeding, and they were in tears. Absolutely crying their hearts out, and it was like there's a feed due, and it was, "Please I just can't handle it". The one was young, I've got to be honest, but I know your hormones and everything else can do this, but they were so upset, just at feed time. They had problems, they had cracked nipples and all sorts of things like that.

Bottle-feeding was seen as a way of avoiding physical pain, cracked nipples and problems like these which could make feed time an upsetting experience.

### ***Questioning the health and contentment of breastfed babies***

The health of breastfed babies was questioned by some of the bottle-feeding mothers. For example, Jackie noted that breastfed babies she knew were not happy.

Jackie (10): All my friends, all the mothers that breastfeed, and I would honestly say none of them... this is just around me, so you know it's not generalised, none of them have happy babies (laugh). ... oh, they've got colic, oh they've got this, and I look at them and I think, they're starving or something (laugh)...I've had three perfectly, you know, wonderful babies. You know, no problems with any of them, they slept... very content. And I don't know if that's due to the fact that I'm bottle-feeding, and I've bottle-fed all of them, but I have a pretty good feeling that that has quite a lot to do with it.

Thus, Jackie not only believed that breastfed babies were less healthy, but she believed they were not as content and did not sleep as well as bottle-fed babies.

### ***Needing to avoid emotional strain of breastfeeding***

Some of the concerns bottle-feeding mothers raised regarding the disadvantages of breastfeeding related to issues of emotional health. For example, these mothers felt that breast-feeders suffered insecurity in never knowing how much breastmilk their babies were getting, and they felt breastfeeding mothers were at risk of over-responsibility. They were concerned that mothering in a sleep-deprived state had inherent emotional dangers. Penny claimed that these effects may be linked to the post-natal depression suffered by breast-feeders:

Penny (07): I wonder about post natal depression, whether... you know because feeding has gone in phases, you know, suddenly breastfeeding is very in in the last decade or so. Prior to that bottle-feeding was quite acceptable. And we're seeing this marked increase in post natal depression. Whether the fact that a mother is expected to do so much with the child, you know, they're not getting the support and assistance from the family as in fathers and in that sort of thing, being able to feed, and mums being able to get enough sleep. Because sleep deprivation is atrocious. And you know, perhaps if mums that are suffering post natal depression, if they looked at perhaps bottle-feeding, whether it would assist with their recovery and that sort of thing.

Bottle-feeding mothers also felt that it was more worrying monitoring the health of babies who are breastfed. Donna had breastfed her first twin babies but not her present baby, and compared the two experiences:

Donna (02): When you're breastfeeding I don't think you know exactly how much they've had, whether they're still hungry or anything like that. At least you know that, from the side of the tin, that that amount for their age... taking that amount should be sufficient enough to keep them full, and then you can go to other areas where if they're just wet or if they're just in a grizzly mood. At least with the bottle you know that they're full.

Francine discussed the worry she perceived her breastfeeding friend suffered, and she also felt confident about keeping her bottle-fed baby strong in comparison to breastfed babies:

Francine (08): I saw a friend the other night who's breastfeeding and her baby's the same age, nine and a half months, and she was so stressed out because he'd lost 200 grams. And he'd had a cold for a week so you'd put it down to that, but because it was 200 grams and because she's breastfeeding, now she has to stress about that. I would just be able to give him a few more bottles and build him back up sort of thing.

Some mothers saw a definite advantage in being advanced in experience and knowledge at the weaning stage, and were concerned that breastfeeding mothers had little idea about how to prepare formula or the required and normal amounts of milk. They also felt that weaning was less stressful on infants if they had been bottle-fed.

As such, there were widespread perceptions amongst the bottle-feeding mothers that in various ways and to various degrees breastfeeding had the disadvantage of introducing avoidable additional anxiety into the tasks of caring for a baby.

### *Immaturity, moral weakness and selfishness perceived to underlie breastfeeding choice*

The motivations behind the breastfeeding mothers' choice were criticised, with many of the interviewees suggesting weakness by the breastfeeding mothers in succumbing to the pressure of the Midwives and "society". For example, Lisa inferred that her neighbour had not been definite enough in stating her choice to bottle-feed, and that her immaturity had allowed Midwives to pressurise her.

Lisa (11): ... a neighbour of mine, she was young and she was a bit immature so she hadn't really said what way she was going to feed her baby and the next thing she knew the Midwives put the baby to her breast in the labour ward. She said it was a bit of a shock to her and she wasn't ready for it so she changed to bottle-feeding the next day.

Some of the interviewees suggested that breast-feeders were motivated by dishonesty about their true feelings, or even negative feelings such as possessiveness. For example, Francine said:

Francine (08): It's like people breastfeed to keep the baby a baby. I like the closeness with my babies too .... Once they lose that bond of the breastfeeding, they [breastfeeding mothers] feel almost useless, they feel like you know anyone can do it now, anyone can feed my child.

A reason for breastfeeding that is often promoted by Midwifery is that "It helps uterine involution and uses the surplus body fat deposited in pregnancy." (Gibney, 1994, p.10). However, Penny interpreted this as a "wrong reason" being chosen for quick and easy weight loss:

Penny (07): I also think that a few mums actually breastfeed for the wrong reasons. They opt for the quick weight loss and things like that after the pregnancy, whereas I've had to take a lot longer to actually get back to my weight pre-pregnancy. But a lot of mums that I know that are breastfeeding just figure that .... it's an easy option for weight loss.

Penny was probably making the point that far from breastfeeding being a heroic act of putting their babies first, breastfeeding could be chosen for self-centred reasons. She also appeared to be suggesting that she had made a sacrifice by taking the difficult option by forgoing use of breastfeeding to aid faster re-adjustment to pre-pregnancy weight.

Often the bottle-feeding mothers' discussions of their observations of women who breastfed identified what they considered to be the disadvantages of breastfeeding - discomfort, anxiety and so on - and they seemed to hold quite strong feelings about this. To the bottle-feeding mothers the problems were obviously avoidable because they had avoided it. They expressed sympathy where they felt that breastfeeding women were suffering with no understanding of how bottle-feeding might be beneficial. It was also interesting that from their bottle-centric

perspective the choice of breastfeeding was considered to reflect poorly on the breastfeeding mothers' characters or morality. The avoidance of problems can allow for more positive outcomes, which will be explored next in the context of the mothers' bottle-centric attitudes.

### **Bottle-centric advantages of bottle-feeding**

The mothers' perceived advantages of bottle-feeding, categorised as being more organised, sharing the joy with the extended social circle, better eye-contact to enhance bonding and creating preferred role/s for the father, will be described.

#### ***Being more organised***

Some mothers commented that bottle-feeding enabled them to be more organised and to enjoy time with their family. For example, as described in Chapter 3, Lisa considered that right from the start of mothering, her experiences were notably better than those of breastfeeding mothers.

Lisa (11): I know one of the mothers [in hospital] was going to bottle-feed when she got home. She couldn't believe how good my baby was, and hers was screaming all the time.

Interviewer: Did you talk to her about bottle-feeding?

Lisa: No, I didn't, but she could see my baby sleeping and she could see how organised and relaxed I was. And when my husband came in we could enjoy the baby, whereas she was stressed out and was always glad when her visitors left.

The perception of breastfeeding as being incompatible with organisation is implicitly supported by Midwives who often advise mothers not to worry about untidiness or developing a routine. However, the Midwifery profession and pro-breastfeeding literature rarely acknowledge that organisation may be more easily facilitated by bottle-feeding.<sup>7</sup> The Australian Breastfeeding Association, for example, correctly claims that a number of aspects of childcare can make life disorganised, but it does not suggest that breastfeeding takes extra time or explain clearly that feeding on demand can create more frequent interruptions.

Your time can appear very disorganised when there are little ones in the house. Instead of starting and completing one task at a time, you probably find yourself starting two or three amidst unpredictable interruptions for feeding, soothing, playing, changing nappies, and rocking to sleep. By the end of the day you may look back and wonder just what you've achieved. Don't worry - it's the way all mothers work, at least some of the time.

Australian Breastfeeding Association (2002a)

<sup>7</sup> The implementation of the WHO Code of marketing practices of 1996 marks a distinct decrease in publications that try to compare breastfeeding and bottle-feeding without bias. However, prior to that, it was more common to see publications such as Gibney (1994, p. 10), who gave seven common disadvantages of breastfeeding, for example that "breastfeeding is demanding on the mother's time".

Many of the mothers in this study, however, explained that bottle-feeding suited their personalities that thrived on organisation. Lisa's comments about being visibly more organised than breastfeeding mothers right from the start were typical. Many of the mothers in this study saw organisation as essential groundwork for avoiding unnecessary distress and creating optimal conditions for enjoying the baby, enjoying sharing the baby with its father and enjoying time with other children. Therefore, it is noteworthy that the mothers perceived their overall experience to be relaxed and calm rather than stressed, and they attributed this state to the advantages of bottle-feeding.

### ***Sharing the joy with the extended social circle***

Some advantages noted by the women are not as well documented in the literature. For example, many of the mothers also commented on the joy of others, such as siblings, grandparents and neighbours, being fully involved with the baby. Terri was happy for her baby and extended family to exchange love:

Terri (12):      My own parents are great and they just love (baby), and also my husband's family are very involved with him as well, he gets so much love from them all. Sometimes it's a fight to see who gets feeding him. It's lovely to see everyone involved with him.

Lisa's perception was similar of the broad social role her baby played:

Lisa (11):      She will stay quite happily with anyone who will play with her. Also (baby's father's) parents loved feeding her when she was a baby, she just got so much love from them. It was really nice to see his mum feeding her and chatting away to her and she was just loving it.

This perspective is different from that of the simple convenience of others' involvement. It suggests that these mothers discussed joy as a social reason for bottle-feeding. It is a point of view that expressed the mothers' altruistic concern for others.

### ***Better eye contact to enhance bonding***

One of the mothers who failed at breastfeeding and had breastfed previous babies stated that bottle-feeding allowed the same bonding as breastfeeding except that bottle-feeding enhanced "bonding" by allowing better eye-contact:

Erica (03):

I don't think there's any difference, no, I mean, you still hold the baby against your body while you're bottle-feeding, so they can still smell you and they can still feel your heart beating and all that sort of thing. Yeah, the only difference I found is with bottle-feeding you can hold them up a little higher, a little closer to your face, so they have more visual contact with you, whereas when you're breastfeeding they're lower down, they're facing your body, so they can't really look at you in the eye. So I found it really good to that effect. And as I said, I still held their hand, I was still able to stroke their face or their arm or whatever. So the bonding didn't make any difference to me either way. It was still the same, it was still there. It was good.

This mother's claim of better eye-contact from bottle-feeding is an interesting interpretation that is similar to claims made in early attachment theory studies by John Bowlby in which he indicated that breastfeeding leads to better eye-contact. According to Blaffer Hrdy, Bowlby sought to explain the dread of infants "when they fail to detect "the meeting eyes of love"" (p. 535), but she states that has less to do with breastfeeding or how basic needs are met than ongoing interaction with the mother and the quality of that interaction for creating the infant's sense of security.

Although Erica's description of breastfed babies facing the body and therefore being deterred from the best eye-contact is a viable and interesting proposition, its importance here is in terms of noticing how many concepts have an arbitrary basis. This is an example of how the term "bonding" in relation to human infant feeding can be misunderstood and over-sold in apparently endless ways because of the enduring belief in it. Similarly to Erica, several mothers commented that due to breast pain from breastfeeding they believed it would be easier to "bond" with a baby under conditions of pain-free bottle-feeding.

Discussions about mother-and-infant bonding have typically envisaged a particular behaviour or demeanour for the mother of the infant, argued by some researchers such as Bowlby to make their interaction special. As shown here, the mother's own perspective will decide what makes her interaction with her baby special.

### ***Creating preferred role/s for the father***

The literature suggests that fathers' attitudes strongly influence women's infant-feeding decisions (Black, Blair, Jones & Du Rant, 1990). The present study found that women did not speak of conforming to the baby's father's infant-feeding preference. Rather they spoke about how their choice was part of their expectations of the relationship dynamics of infant-feeding. Two notable patterns emerged that concerned the father's role positioning with the baby's mother and the father's role with the baby, which will now be discussed.

### The united and equal parenting couple

When I interviewed the bottle-feeding mothers about how influential and supportive the baby's father had been in the decision to bottle-feed, many of them found the question odd. For example, Jackie explained that in their relationship she would always receive support:

Jackie (10): ... my husband is very supportive in anything I do. He would just... if I chose to (breast)feed he would say great, if I chose to bottle-feed, whatever you think.

Penny also explained that she had considered how the method of feeding would affect the family relationship dynamics, implying that she wanted to equally share the joy of feeding the baby with her partner:

Penny (07): We'd discussed the fact that it's [breastfeeding is] quite a selfish method of feeding, the fact that he wouldn't be too involved in the feeding as such.

Imogen returned to work quite early, partly as a strategy to overcome post-natal depression. She stated that expressing milk could be impractical and intimated that she would only have trusted the baby's father to also parent the baby:

Imogen (01): I didn't have to worry that he was in day care or anything like that. Knowing that he was safe and (baby's father) was dealing with it all was wonderful.

Imogen's partner was also extremely positive about being able to help her care for her health by saving her from suffering broken nights. Bottle-feeding allowed him, the parent with the better health at the time, to feed the baby at night:

Brett (Father 01): I really liked being able to help feed at two o'clock in the morning. I didn't really like it, but it was good to be able to do it because then Imogen didn't have to do it all the time. Even though she did it most of the time, but it was just good that I could do it. And it helped Imogen get unbroken sleep.

For a few of the mothers who were averse to the thought of breastfeeding, the support of their babies' fathers, who believed breast was best, came later. The women spoke of how, in the end, the babies' fathers were glad about the bottle-feeding.

Natasha (05): But then as soon as she was born, as soon as he was feeding her as well, he said I'm glad now that you didn't [breastfeed] because he could do it too. And it is nice doing it and for him to do it as well, because even if she's been crabby and all the rest of it, give her the bottle and she's like an angel.

In many of the interviews, a sense of both parents caring for each other, trusting each other to make the best choices and having each other as the best other person to care for their baby, was an underlying message of what had been positive in the bottle-feeding experience.

Of the two mothers who gave up breastfeeding early (or failed to establish it early), it appears that for one, Anne (04), an additional stress to having no milk-flow was having to persuade her husband that she needed to stop trying. The other mother, Erica (03) previously had suffered a bad experience breastfeeding her first baby. She was, therefore, supported by her partner in giving up breastfeeding fairly early with the next three babies, including the baby that included her in this study. Erica, too, said that the baby's father enjoyed bottle-feeding this last baby as it allowed him to experience what a mother experienced.

Thus, in the mothers' perceptions, bottle-feeding usually had the effects of strengthening the quality of relationships, such as developing strong parental trust and enhancing the quality of emotional depth for the baby's father. This part of the findings therefore also suggests that the Midwifery field should not overlook long term consequences of its influence, for example, parental relationship dynamics may be harmed if one parent is encouraged to put pressure on the other.

#### Father bonded to the baby

Bottle-feeding mothers took father bonding into consideration when discussing their infant-feeding choice. Yet, 'father-baby bonding' is an alien term in Midwifery literature, although the desire by mothers or fathers for the father's involvement is recognised. The results of this study, however, showed that mothers saw bottle-feeding as creating a special baby-and-father relationship, unattainable in breastfeeding situations. Claire spoke about her baby's father himself not wanting to miss out.

Claire (06): He was happy that he could participate. Yeah. He didn't want me to breastfeed at all.

Interviewer: Oh did he not?

Claire: No.

Interviewer: Why was that do you think?

Claire: Because otherwise he couldn't be involved.

Several mothers described the act of feeding the baby in terms of it leading to a privileged involvement, that captures the sense of closeness and attachment, and they emphasised the emotional experience in nurturing. Some mothers spoke of their choice as if it were an honour for their baby's father to experience giving bottles to the baby and as something they would not have wanted the father to miss out on. For example, Terry was enthusiastic that her baby's father had "bonded" so well the baby did not show a preference for either parent.



Terry (12):

He would have missed out on all of that if I had been breastfeeding. He may not have bonded as well with him if he hadn't the opportunity to feed him. He is very confident in looking after him now, I can go out and leave him with his dad and he can take as good care of him as I can. (Baby) knows no difference, he's not always looking for me the way breastfed babies always look for their mothers and the dad doesn't get much of a look in.

Some of the mothers indicated that the closeness between father and baby was what they valued most highly about their bottle-feeding choice. The mothers' perceived advantageous qualities to the fathers' experiences and closeness to their babies would seem to be highly desirable outcomes.

Considering the bottle-centric perspective overall, it is interesting to notice the consistency and coherence of the bottle-feeding mothers' perspectives. They had little or nothing positive to say about breastfeeding and therefore would have had few regrets to have not chosen it, and they were extremely positive about the impact of bottle-feeding that can largely be summarised as helping the mothers create optimal conditions for the home environment they felt affected interpersonal relationships for the baby, both parents and other important people. The depth of feeling about feeding methods and the ongoing satisfaction with bottle-feeding found in this study is absent from the literature and is a significant outcome of the present study.

### **Theorising the recently emerging concept of father-bonding**

The phenomenon of the father's increased involvement through bottle-feeding is recognised in the literature (for example by Earle, 2000). This accords with this study's finding that an advantage perceived by bottle-feeding mothers is the enhanced involvement of fathers. However, this is constructed in Midwifery as a barrier to successful breastfeeding. For example, one of the manuals for a government hospital in Western Australia has this to say:

The physical and emotional closeness the breastfeeding mother and baby share can be threatening to the father at a time when he is feeling significant loss of time alone with his partner and attention from her. He may have ambivalent feelings about breastfeeding and want to join in feeding times by giving baby milk formula by bottle. He needs to understand that to do this may undermine the success of breastfeeding.

[Undisclosed Perth metropolitan district] Health Service, 1993, 1994, 1998, p. 11)

The desire by fathers to be involved by bottle-feeding the baby is also recognised, but is framed as being a failure on the part of fathers due to putting their emotional needs ahead of the needs of the baby. The following cartoon shows a bewildered breastfeeding mother having to allow the father to take over the feeding of their infant.

**Fig.3**

**Bottle-feeding shown as a childish father's crime against mother-love**

From "Father's emotional needs (cartoon by Chris Mann)" in Palmer (1988, p. 61)



In the present study, the mothers, and apparently some of the fathers too, saw breastfeeding rather than bottle-feeding as a selfish mothering option and obstacle to successful family relationships. It is notable that in Midwifery literature on the preference for bottle-feeding, mothers' desires for practical assistance and fathers' desires for emotional involvement are recognised (even if typically refuted), but little attention has been paid to the *mothers' desires for the baby's father to become emotionally attached to the baby*. That concept which is evident from this study's analysis will be further explored in the present theorisation of 'father-bonding'.

### *Competing positioning of fathers*

An interesting finding in this study was that many of the mothers valued the father's involvement by bottle-feeding. This does not fit with dominant Midwifery discourse. Typically incorporating feeding into father involvement desired by either parent is dismissed, for example as a justification (Murphy, 1999; Earle, 2000), or as inappropriately targeting the wrong person's emotional needs (Palmer, 1988), or as being derived from sinister and immoral intentions (Minchin, 1985). Barclay and Lupton (1999), from the perspective of cultural studies of new fatherhood, sympathetically argue that hegemonic discourses of breastfeeding can negatively impact on fathers' profound emotional experiences of changing family dynamics.

### *Mother's equal counterpart*

The mothers in this study spoke enthusiastically about various ways in which fathers were their equals in parenting. For example, bottle-feeding had allowed the baby's father to experience what a mother feels, the baby to be just as happy if left with 'Dad' as with the mother, a closeness to develop between baby and father, the father to be confident with the baby and so on. Some mothers criticised breastfeeding for disallowing parity between mother and father. For example, the baby and mother becoming close with the father pushed out, the mother wanting to be the only one needed by her baby, and the mother not being able to share the feeding responsibility.

There is a great deal of societal pressure for mothers to take the greater responsibility for raising children. The job of breast-feeding can establish that role for the mother. Not everyone welcomes that effect of breastfeeding. In the realm of family studies, in relation to evolving dual-career families, more equal sharing of roles is considered desirable.

Assistance from spouses in meeting role demands, most likely those associated with children and the household, not only may keep one spouse (the female) from being unduly burdened by home responsibilities but also may allow the development of a family pattern in which major life roles are more equitably shared.

(Elman & Gilbert, 1984, p. 324)

Outside the issue of breastfeeding, few would disagree that moving towards more equitable roles in the home may be preferable for the mother. Many applaud moves towards allowing more equitable roles for fathers in the sensitive and emotional role of parenting. Nevertheless, it is currently an area threatening the sanctity of Midwifery's pro-breastfeeding mandate.

### Midwifery's protector warrior

Dominant pro-breastfeeding literature has not explored the concept of the mothers' desire for fathers' involvement with any intention to treat the mothers' desire seriously and supportively. Sometimes the desire for the father's involvement is addressed but only in the sense of time spent with the infant or assisting with the workload in caring for an infant. The following is typical of advice to new fathers.

You may think breastfeeding means you will spend less time with your baby, but feeding is only one of the many aspects of infant care. Bathing, nappy changing, massage and simply playing with your baby are great ways to get to know this new member of the family. Help with the washing and housework while the baby is feeding is greatly appreciated too. While the baby is feeding, you can sit and just talk, enjoying the time together. When it's not feed time, you can take the baby so that mother can rest.

Australian Breastfeeding Association (2002b)

This construction of fatherhood fits the picture of a nurturing, child-rearing-mother and provider-father for the infant. The father is encouraged to get to know the baby through tasks other than feeding, and he is also encouraged to maintain the mother's role of feeding. By helping with the care-taking and housework chores he frees the mother to feed. By taking the baby when it is not feed-time he frees the mother who can rest and recover for the next feed-time. Some Midwifery wisdom on how to respond to the father's desire to feed his baby, is the strategy of reframing his self-concept as a provider, through helping him see himself as being the one who provides the proper environment for the baby to feed. To maintain any diminished sense of masculinity, he is further advised that it is his role as protector in defending the mother's right to feed the baby, for example, by not allowing anyone to criticise breastfeeding or suggest weaning. There is no place for the father to take part in feeding the infant in dominant Midwifery discourses.

Barclay and Lupton (1999) investigated how fathers in Sydney adjust to new parenthood. They found that many men wanting to be involved and to 'bond' emotionally with their child found themselves on the margins for at least six months. Breastfeeding was associated with some men's disappointment in being prevented from reaching a close, embodied relationship with their child and in not achieving mutually supportive and enriching early parenting. This was also partly because other aspects of their role as provider and worker took too much time, but in some cases it was because the mother of the baby did not want to allow them much involvement in what she saw as her role. Barclay and Lupton described three main typologies of how couples are finding different ways of negotiating their parenting roles. Those with a framework for shared rules, such as traditional roles supported by Christian beliefs, and those who liked the freedom and ambiguity of no rules, which would include not having their roles pre-defined by professionals, were the happiest. However, a more problematic situation was where the parents were frequently in conflict over their different views about how the father should behave. As Barclay and Lupton suggest, sensitivity to these socio-cultural changes in parental desires in newly formed families in western society, could help professionals to play a more positive part in this process of change.

### **Theorising parenting in a context of unstable parental relationships**

This section theorises beyond the mothers' interviews and beyond Midwifery literature in seeking to understand the importance to the mothers in this study of "father bonding". The theorising draws strongly on Sarah Blaffer Hrdy (2000)'s socio-biologic work on evolutionary theories of motherhood. None of the mothers in the present study directly discussed the stability or otherwise of their relationship with their baby's father and it was not an interview topic. What did come up were comments by some mothers about how supportive the baby's father was of her choice and how her choice had benefited the baby's father. That is - several mothers in the study stated that the father always supports her choices and typically a mother would describe her decision to bottle-feed as one that allowed the father optimal involvement and closeness with the baby.

Stepping outside dominant Midwifery discourse, it is not impossible to empathise with mothers for needing to take into consideration what they perceive to be the effects on the father-child relationship. Blaffer Hrdy (2000, p. 235) summarises the relevance of fathers to children as follows:

In industrialized countries, disadvantages to fatherless families include economic hardship, reduced status, and generally declining prospects. Costs to children are measurable in poorer school performance, higher rates of delinquency for boys, and early pregnancy for girls. In foraging societies, fatherless children are more likely to die.

Blaffer Hrdy (2000, p. 235)

Nevertheless, breastfeeding is not understood by Midwives to be necessarily incompatible with maintaining the father's role of involvement. Indeed, to dominant Midwifery and, arguably, to the majority of women who choose breastfeeding, it may appear that maintaining traditional roles of the "natural" (breastfeeding) mother and of the protector-warrior father is likely to be the most symbiotic and enduring arrangement. What then is at stake for a mother faced with raising an infant and considering the role of the father in optimising the infant's survival? The complexity of the mothers' options and a socio-biologic theory of father bonding may provide an explanation.

### *The multiple contributions mothers make to raising infants*

The mothers' contribution to raising infants is not solely in providing suitable food and emotional security. According to Blaffer Hrdy, the concept of the trade-offs mothers have to make between subsistence and status activities and reproduction activities is well established in socio-biology. She states:

Mothers have always had to make the most of resources at hand while coping with the sliding scale of paternal and alloparental help available. Mothers make tradeoffs compatible with their own subsistence, the needs of different children, and their own future reproductive prospects. These tradeoffs are made in a world of constantly shifting constraints and options.

(Blaffer Hrdy, 2000, p. 376)

The human mother has evolved with a capacity to calculate how she can "afford to put so much on the line every time she [gives] birth" (p. 267). This is because the investment required in attending to an infant makes it even more difficult for the woman to ensure her own survival and ability to support previously born children. With human babies that have prolonged childhoods, it makes "a mother so dependent on assistance from others, yet [she must be] so uncertain about whether the father would provide it" (p. 267). That is to say, mothers have to factor in the possibility of not having the support of the father. Blaffer Hrdy suggests that mothers also need to develop some capacity of self-reliance, for example, the capacity for paid work in contemporary, western society, and often this is made viable by mothers developing the support of non-parental others (that she terms 'allomothers'). Allomothers are women with surplus production who contribute to the weaned offspring of others. They are mostly post-reproductive and their commitment levels usually equate to levels of kinship.

Based on Blaffer Hrdy's theory, the mothers' desires for "father bonding", revealed in the present study, sound very similar to the closeness requirements for allomothers. There are

multiple demands on mothers to nurture offspring. In the present situation, where we have evolved extra-long human child-hoods, mothers are also typically required to contribute as providers. Added to that complication, there are diminishing numbers of unoccupied grandmothers and spinster sisters prepared to act as allomothers (paid childcare, a theme in Blaffer Hrdy's work, is still a cost not a contribution). It would seem then, that for the task of raising a child, few women are likely to choose to work alone. Mothers would give considerable thought to developing the optimum chances for their infants' successful rearing. The evolved act of calculating an optimal outcome would take place as part of a very complex balancing act. The mother has to calculate a balance of her investment and risk in her commitment to nurturing the infant and other children, as well as possibly needing to be a provider, and in terms of attracting additional support. Thus, even though contemporary mothers may be less certain than ever before about being able to retain paternal support, it would make a lot of sense for mothers to consider ways of trying to ensure continuation of that support. Therefore, in Blaffer Hrdy's terms, it may be that the bottle-feeding mothers consciously or unconsciously try to create a role for the baby's father where his closeness to the baby would secure his role as an "allomother".

#### *How bottle-feeding may be a strategy for father-bonding/(bondage?)*

Sarah Blaffer Hrdy used the term "options" in the feeding choices available to mothers, which in pre-bottle-feeding times were most commonly breastfeeding or the use of wet nurses. Bottle-feeding has been another option for infant feeding, widespread since the end of the nineteenth century. As a socio-biologic possibility, it is now possible for fathers to bottle-feed. Perhaps more importantly for this argument, it now may be possible for fathers to develop the equivalent of a 'mothering instinct', a need driven as strongly as that of a mother to continue caring for the infant. Midwifery and lay beliefs afford considerable importance to 'bonding' for mothers, that is, of forming emotional closeness with their infants through feeding them. There is also a growing understanding that it is the touching, stroking and mutual eye-contact that generates emotional attachment. Therefore, it is not difficult to imagine<sup>8</sup> that, to some mothers, since the link between breastfeeding and bottle feeding is no longer considered essential, it might appear that fathers through bottle-feeding could achieve the same 'bonding' as takes place in 'mother-love'.

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<sup>8</sup> The theorising about "father-bonding" goes beyond what the mothers said explicitly, and as pointed out "imagines" (or speculates) the significance to the mothers regarding Blaffer Hrdy's earlier theorising about mothers' options in regard to child care, allomothers and optimal survival of offspring.

Blaffer Hrdy states that monogamy raises survival rates for children, but asks about parents,

When one sex is forced to accept a breeding arrangement that is grossly disadvantageous, as many women in patriarchal societies must, what prevents mothers from defecting? This is where myth and ideology come in.

(Blaffer Hrdy, 2000, p. 258)

She goes on to attribute mothers' reluctance to defect from their responsibilities towards infants and child-rearing as based in symbolism, such as various myths of natural, mother love that are culturally circulated and internalised at a very early age into the self-concept of girls. However, it is notable that she also points out that, outside of monogamy, adult sexual relations are usually sorted out "to favor the sex with the most leverage, usually males" (p. 258). That "leverage" for males referred to by Blaffer Hrdy is usually to do with material or status advantages and females typically have less leverage dependent on the extent to which a society's resources are controlled by males. Even though Blaffer Hrdy does not explicitly state this, it would seem also that mothers also have *reduced leverage* by the disadvantage of being tied by their maternal attachment. To the mothers it may not seem ideological and they may believe, as fits the misunderstood concepts in the field, that mothers' leverage is reduced primarily from 'bonding/ bondage' developed through feeding the infant.

The capacity of many contemporary mothers to support themselves allows them to be more equal to their partners than in previous eras. This would generate different ways that the balance of survival and child rearing is approached. In particular, women may be both less certain and less concerned about maintaining a monogamous relationship than would have been the case in previous eras, when the majority of females survived by exchanging sex and child rearing for provisions from a male partner. Blaffer Hrdy recognises such father's provisions as their "obligations" and "encumbrances". However, if the commitment to the parents' relationship were to cease, the mother is more likely than the father to be burdened with a larger proportion of any remaining costs associated with childrearing. Despite "alimony laws" in some societies, as Blaffer Hrdy points out, usually fatherless family households have substantially below average provisioning for the offspring and the mother. Even so, the mother is typically less equitably burdened with the other "encumbrance" of child rearing because her 'bonding' has reduced her leverage to defect from the responsibility towards rearing the offspring. It is possible some mothers think that 'bonding' through breast-feeding can restrain fathers to sustain responsibilities. Thus, in calculating an optimal overall strategy in terms of the effects of infant feeding choice, a perceived long-term survival advantage of a "bonded/bondaged" father's reduced leverage to defect would be advantageous and worthy of considerable sacrifice to try securing it. To sacrifice the known advantages of breastfeeding for bottle-feeding may seem well worth the costs.

### ***Summary of theorised "father-bonding/bondage" concept***

The finding that mothers desired fathers to develop emotional closeness to their babies by bottle-feeding may reflect mothers' concerns about contemporary society's high levels of unstable adult relationships and scarce alloparental support. The mothers' desire for the father to bottle-feed the baby may be understood as an evolutionary adaptation through which mothers secure optimal survival conditions for herself and her offspring. If the father were to become bonded emotionally to the baby to the same degree as her mother-love, that would reduce his potential for having sufficient emotional leverage to defect from his parental responsibilities.

This theory of father-bonding/bondage is speculative and describes a probable concept not a biological phenomenon. Its relevance to explaining the increase in mothers' decisions for father involvement from bottle-feeding needs to be tested.

This chapter has examined some ways that infant feeding is powerfully symbolic of emotions and morality, but in distinctive ways for dominant Midwifery and for bottle-feeding mothers. It is at this ideological level, even when challenged by up-to-date research evidence, that beliefs that "breast is best" typically make the Midwifery field impervious to understanding why some women choose to bottle-feed their babies. What this chapter has shown, is that the mothers have a bottle-centric perspective and they believe that they are giving their baby the best. However, the bottle-feeding mothers express concern that their values are not respected. Rather they are undermined by Midwifery. Imogen expressed her frustration about the injustice of the present situation where it is the negative attitude of Midwives towards bottle-feeding that is wrong.

Imogen (01): [Mothers should be told] it's fine to bottle-feed too. You're not a second class citizen if you don't breastfeed. And like [Midwives say] 'oh, you want to bottle-feed, oh you can't be a...' like you're not a natural mother then. And that probably 'oh, you didn't have the maternal instincts because if you did you would want to breastfeed.' I love him (baby) more than I love anybody else in the world, so you can't tell me that that's not bonded because he didn't sit on my breast ... [What they say is] just wrong.

In the eyes of the mothers in this study, bottle-feeding is best. They consider that it provides equivalent nutrition, protects the mother's peace of mind and physical recovery, facilitates the baby's early development of solid social relationships, and optimises the family structure to include two equal and unconditionally committed parents.



## **Implications of bottle-centric perspective**

The chapter has developed a substantiated and descriptive understanding of mothers' bottle-centric perspectives, recognising their positive experiences with bottle-feeding and high levels of satisfaction of their infant feeding experiences. The analysis has illustrated how some women, by prioritising their overall organisation, avoidance of discomfort and anxiety, and optimising inter-relationship dynamics of baby, father, themselves and other children, have experienced bottle-feeding as the key to producing their preferred outcomes, and they distrust breastfeeding as working against such successes. The evidence in this chapter challenges Midwifery's current "deficit" models of bottle-feeding, and offers a way of respectfully incorporating the needs and desires of the currently marginalised clientele who do not wish to breastfeed.

This chapter valorises the mothers' bottle-centric perspective, suggesting that it may reflect mothers' rational desires for fathers' emotional involvement through bottle-feeding. This desire was conceptualised as arising from a socio-biologic strategy aimed at securing strong paternal commitment to the infant. This analysis is coherent with the thrust of this chapter which analysed influential concepts pertaining to emotions and morals as they pertain to the bottle-feeding choice.

## **CHAPTER 6 - Deliberated, Broad-based Health Decision-making by Bottle-feeding Mothers**

At the core of this study of bottle-feeding mothers lies the issue of health decision-making. Why did these mothers choose to bottle-feed? What role did health professionals play? How will the findings of the study inform Midwifery practice? The International Lactation Consultants Association (ILCA, 1996) argues that the predisposing factor of a woman's knowledge of infant feeding is significantly linked with a decision to breastfeed, and therefore, almost all women would choose to breastfeed their infants if they were fully informed (Hanson & Bergstrom, 1990; Tamagond, 1992). What constitutes full information is debatable, and, as with most dominant discourses, probably implies sufficient information to secure the agreement of the informant. However, knowledge and decision-making involve complex processes of evaluating information as well as individuals' feelings, beliefs and values.

The previous chapter demonstrated that the mothers in this study saw the advantages of bottle-feeding in terms of enhancing the family's social dynamics and interpersonal commitment. The present chapter investigates the ways in which the mothers' preference for bottle-feeding had taken into account issues of health. The mothers' reasoning in their decisions to bottle-feed will be analysed within the framework of health decision-making models. The analysis will show that those mothers initiating bottle-feeding have acted in accordance with their own knowledge and values to actively choose bottle-feeding. They took into consideration factors that go beyond medical evidence that breast is best to include such issues as optimising the development of quality family relationships. Policy directions such as the Bottle Friendly Hospital Initiative, will also be used to explore aspects of health decision-making models. Finally, this chapter will highlight a diametric-opposition of values about infant-feeding and infant care. It concludes that it is this opposition of values, rather than any lack of knowledge, that underlies the differences between Midwifery's pro-breast-feeding stance and bottle-feeding mothers' concerns, which are based on a broader set of issues.

## **Health-decision-making models**

Health decision models are widely used by health professionals seeking to understand or predict the likelihood of people to act in ways that promote their health. This is of relevance to understanding the decision-making process of mothers who have bottle-fed. The bottle-feeding mothers' descriptions of influences on their decision-making will be considered together with key factors pertinent to related health models. The factors and related models to be examined are:

Motivation – Rosenstock's Health Belief Model (HBM); The Health Environment – Green's Precede-Proceed model; Self-concept and values – (Rokeach's System of Belief model); Confidence – (Self-efficacy models eg Hochbaum's); and Life-style – (Wellness models).

### **Motivation**

The Health Belief Model (HBM), which has been adapted over time, was originally developed by Hochbaum, Leventhal, Kegeles and Rosenstock (Champion, 1984) who recognised that an individual's perceptions feature strongly in relation to their behaviour. It is not sufficient to be advised about a health action. Rather the person must be motivated to take action. Rosenstock (1974) stipulated that in order to decide to take health actions, an individual will usually take into account the following four components:

1. Perceived susceptibility to an adverse outcome;
2. Perceived seriousness of adverse outcome;
3. Perceived benefits in reducing susceptibility or enhancing quality of life; and
4. Perceived barriers evaluated for viability and cost of overcoming them (eg demands on energy, time and money).

Thus, this section will consider what information the women had about the benefits and disadvantages of the choices between breast and bottle-feeding, how much the mothers felt affected by the known advantages and risks, and how they chose to act on those perceptions.

### ***How the HBM applies to dominant Midwifery perspectives***

From a professional, dominant Midwifery perspective, breastfeeding (in a healthy mother) is undoubtedly the best source of nutrition for an infant. This view is widely promoted in line with BFHI policy through ante-natal classes and other public information services, for example, by the Australian Breastfeeding Association (ABA). Contemporary information typically suggests that breastfeeding has advantages of immunal and protective properties for a number of disorders. For

example, breastfed babies have a lower incidences of gastro-enteritis, asthma and future obesity. It is promoted as a preventative for women's conditions, for example, pre-menopausal ovarian cancers. The Health Belief Model would suggest that the benefits are protection against disease and enhanced mothering abilities. The professional perspective on the barriers to choosing to breastfeed would include low motivation due to not being aware of the advantages and risks; not understanding how to breastfeed. Later on it would include not managing well, for example, because of difficulties with latching on, not learning strategies to breastfeed as well as avoid pain, and having difficulty relaxing sufficiently to allow the let-down reflex to function.

From the dominant Midwifery perspective one would likely expect to see a focus by mothers on the negative consequences of not choosing to breastfeed. However, as the following analyses will show, the health beliefs of bottle-feeding mothers do not conform with this expectation. Rather, the mothers inverted the dominant pro-breastfeeding arguments: Instead of particularly weighing-up the risks of choosing to bottle-feed, they took a more serious view of the risks of choosing to breastfeed. Each case was idiosyncratic, but a pattern of health beliefs shared by bottle-feeding mothers can be illustrated.

### ***How the HBM applies to breastfeeding mothers' health decision-making***

The bottle-feeding mothers did go through the processes of decision-making as described by the model in weighing up perceived consequences. The model is often used in relation to health screening, to explain why some people do not act to prevent avoidable illness, for example, avoiding pap smears. However, mothers make a choice between breastfeeding and bottle-feeding, and therefore will act, one way or another.

### **Perceptions of breastfeeding as cause of adverse outcomes**

The process of decision-making will be traced in detail, using Imogen, Mother (01) as an example. Imogen, bottle-feeding her first baby, claimed that she had a pre-existing aversion to breastfeeding and she said, "physically it repulses me, the thought of doing it". However, she found herself in a "dilemma" at seven or eight months of pregnancy knowing that "breast is best":

Imogen (01): (worrying about)... did I want to try to breastfeed because breastfeeding's the best and all that sort of stuff. And that was a dilemma. I'm thinking, you know, should I try it, but every time I thought about it it just was just worrying me sick because I didn't want to do it, but I thought oh well maybe I should try.

Imogen's partner reported that he came from a breastfeeding family and had found her attitude odd but had known about it for several years before they married and experienced pregnancy. It was by then something he accepted. Imogen discussed Midwives' comments, that she would not be "a natural mother", that she would not "develop maternal instincts" and that she would not bond with the baby<sup>1</sup>. These became her criteria of the risks bottle-feeding. In terms of perceived susceptibility and perceived seriousness she dismissed them. To her, being a natural mother involved pregnancy and child-birth and feeling love for the child. There was already obvious proof that she had 'maternal instincts'. With regard to 'bonding', she saw this as a quality developed out of her caring for the infant's needs and the infant's attachment to her. As a consequence, she did not regard the risks raised as threats by Midwives as being serious risks to her. The suggestion of them was offensive and hurtful, but they were not serious considerations. Since she did not see herself as susceptible, she had no reason to perceive any benefits in avoiding those risks. However, she had heard that 'breast is best' and hence faced a dilemma in making the health-decision.

Although not strongly convinced of the benefits of breastfeeding, Imogen wondered if she ought to overcome the barrier of doing something she had never wanted to do because Midwives said it was best. This is what Imogen explained:

Imogen (01): But then one of my girlfriends said, if you're not going to be happy doing [breastfeeding] then the baby's not going to be happy, so why stress yourself out even before it's here. So I thought, oh, good point, I'm not doing it. (laugh) It was the best decision I made.

Imogen saw that possibility of stress as serious and her susceptibility high. She then acted in the perceived interests of her health and her baby's health by avoiding stressing over the dilemma. This entailed overcoming the advice of professionals that breast is best, and making the decision in accordance with issues important to her, namely avoiding stress and unhappiness caused by breastfeeding.

Imogen's case has illustrated how a mother's reasoning led her to take a health-decision about infant feeding, but not one that would have been predicted by professional discourse. In brief, what constitutes a health risk is more contentious than may be recognised in Rostenstock's Health Belief Model.

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<sup>1</sup> All of these terms, 'being natural', 'maternal instincts' and 'bonding' have been contested. For example, Blaffer Hrdy (2000) describes the politics of attachment theories, and even though her research appears to be pro-breastfeeding, she critiques the misapplication to human beings of studies on sheep which have a time-limit for successful attachment between mother and infant. However, those terms are used widely by both the lay community and Midwives and were terms raised by the mother, hence their reproduction for the analyses.

The same pattern of decision-making was apparent from interviews with the other mothers. Some mothers questioned the differences in quality of breast-milk and formula, some were unconvinced that bottle-feeding had the short-term or long-term adverse effects of which they had been advised, some felt that the serious risks of bottle-feeding were only relevant to Third World Countries, or that it was linked to post-natal depression because of sleep deprivation and over-responsibility. Others were concerned about discomfort, inconvenience, limits to their preferred levels of physical activity, exclusion of the baby's father, and too little time to spend with existing children in the family.

*Perceptions of seriousness of differences in quality and immune properties of breastmilk and formula*

Lisa had been bottle-fed herself and this convinced her that bottle-feeding was satisfactory:

Lisa (11): We were all bottle-fed and we all turned out alright.

Possible harm from bottle-feeding was not considered to be relevant and perceived susceptibility was low. This facilitated the choice to bottle-feed. Lisa also raised the issue of inferior milk-formula quality:

Lisa (11): Maybe they can't put hormones in the formula milk but they do make it as close to breast milk as they can in every other respect. So really I see no difference ...

Lisa appeared to have heard about the immunal properties of breastmilk<sup>2</sup>, but her belief about that benefit of breast-milk was something that she minimised<sup>3</sup> as not serious, to the point of there being no difference. Donna, had previously breastfed twins. She also minimised the differences between breast-milk and formula:

Donna (02): These days, the formula is made with so many extra vitamins and other supplements that it is practically the same as breast-milk.

Some mothers, for example Lisa and Terri, raised the issue of professional advice that bottle-feeding increased vulnerability to sickness and infection. Lisa and Terri each countered this point

<sup>2</sup> For the analysis, the researcher is guessing that by "Hormones", Lisa meant immunal properties of breastmilk, which is emphasised in ante-natal classes as benefiting the baby. Professional understanding of the effects on hormones resulting from either choice of breastfeeding or of bottle-feeding doesn't quite fit the point she appears to be making, that is, she feels that milk-formula is designed to be nutritious. Key books of the breastfeeding movement use metaphors of breastmilk as a medicine, and especially of milk-formula as a carrier of disease or an inappropriate drug. For example, Maureen Minchin (1985) lists re-called formula products and Gabrielle Palmer (1988, p. 272-274) includes Minchin's lists in her appendix of "formula mishaps". Lisa's observations of improved formula would be supported, in their acknowledgment that since the 1960s formula has improved. However, Minchin and Palmer point out ongoing problems, (some of the most recent on the list (1985) having to do with lack of registration). This is an example of different lay and professional perspectives.

<sup>3</sup> Although Lisa's reasoning minimises the risks, (and she believed that bottle-feeding had been a healthy option for her baby), Midwifery may also be guilty of minimising regarding formula's nutritional qualities, minimising evidence that some

by referring to the after-the-fact evidence that their own babies had not ever been sick. Such reasoning cannot directly indicate that it was a decision-making issue, however, they each related that point to the situation in "Third World Countries". Terri simply stated that infection rates in the research were probably based on Third World statistics, whereas Lisa went into more detail about Third World poor sanitation and a tendency to water down milk due to poverty. These she would have considered to be serious issues, but she perceived her susceptibility as low stating simply that it "doesn't apply to me".

#### Perceptions of benefits of bottle-feeding

The perceived benefits of bottle-feeding in relation to health include the avoidance of a range of negative outcomes including sleepless nights and cracked nipples. Donna felt it was beneficial to save herself from exhaustion,

Donna (02): It's so much easier with the night time feeds and things like that. If I was breastfeeding, especially like with the twins at the age of two, three months, that's constantly up every two to three hours and that would be just too exhausting, especially with the other children as well.

Francine argued that bottle-feeding had the benefit of helping babies recover from sickness, and that breastfeeding was a barrier to rebuilding the baby's health.

Francine (08): I really shouldn't say that about breastfed babies, but when they're sick ... my sister-in-law breastfed both of her children and it would seem to take them a lot longer to get over colds and flu and any illnesses because there was no boosting up, you know, you feel like you can actually build them up a bit more with the formula than with breastfeeding.

#### Perceptions of barriers to successful feeding (bottle-feeding)

The mothers' perceived greatest barrier to choosing a successful feeding method, which to them was bottle-feeding, was mostly the general pressure to feed in ways that, according to Terri (10), suit "the hospital staff" rather than the mother. That is, to these mothers, success in bottle-feeding depended on overcoming professional pressure to choose breastfeeding. Hence, several of the mothers emphasised the importance of being able to stand up for themselves. Terri stated that mothers' feeding decisions should be based on "whatever suits you". Notably, this argument fits the reasoning patterns of the Rosenstock model of perceiving benefits, if action is taken, but subverts the dominant professional discourse of breast is best.

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babies do not breastfeed well, and in recent decades the professional refusal to accept bottle-feeding minimises the rights of mothers to avoid what they perceive as intolerable or simply avoidable problems.

In addition to the general pressure to breastfeed and admonitions not to bottle-feed, some of the mothers felt that the lack of practical support threatened their success with bottle-feeding. Anne, in particular, who gave up trying to breastfeed, was frustrated at the difficulty of being given formula<sup>4</sup> and felt the minimal training in bottle-feeding had led to her making some mistakes which would have undermined her confidence.

*Similar health beliefs pattern demonstrated by a baby's father*

The pattern demonstrated in this section is that what breastfeeding mothers had in common was that they deeply considered their options and that their definitions of susceptibility and risk did not conform to professional knowledge. The partner of one of the interviewees invited himself into the conversation, and analysis of what he had to say shows that he too could reason in ways that inverted professional expectations of health behaviour. In this example, it can also be seen that models do not work in isolation, but that other notions such as "values", "confidence" and "lifestyle" are inseparable and come into play.

Both Imogen and her partner felt that bottle-feeding had allowed the father to develop his paternal skills and his bonding with the child in a way that would have been severely limited by breastfeeding. The father, Brett, had this to say:

Brett (Father 01): I'm so glad now that she didn't [breastfeed], I'm so glad, because now I've seen bottle-feeding, and I've seen with really close friends breastfeeding, and just the difference between the dads and the kids is enormous.

This father perceived that the benefits to him were improved confidence and organisation and he noted that breastfeeding was a barrier limiting involvement of fathers. He also obviously enjoyed and took pride in the role of mentor and role-model to other fathers. He wryly recounted how he would often invite one of his friends over to "coffee" because he felt his friend rang up needing support whenever he was alone with his children:

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<sup>4</sup> Maternity wards refusing to supply formula, especially to mothers who have opted to breastfeed but later change their minds, is not in line with the BFHI policy, but it may not be an uncommon hospital practice. Many Midwives feel that it is their duty to help mothers overcome difficulties in persevering with initial breastfeeding problems and attempt to re-frame women's requests to bottle-feeding change by encouraging them to keep trying, sometimes using quite dogmatic tactics. This is more likely to be effective, against the wishes of the mothers, where mothers are unaware of how to make their changed decision clear. They are not taught procedures to change the paperwork that states their first choice, they may be too emotional to express their changed mind clearly, or they may not understand about where they can obtain supplies. The MAIF agreement prevents marketing but not supply of formula. As such, even the first BFHI hospital in WA has a shop that sells formula (Personal communications, 2001), but unprepared mothers do not necessarily know this, as in the case of Anne.



Brett (Father 01): I honestly believe that comes from not really having any part, except for the little bit of play... I'm not saying that they [other fathers] don't love him [baby], don't get me wrong at all, but he just doesn't have that confidence that I'm able to have now. Whereas I can have my kids, their kids, and have them all organised and everything going smoothly.

Brett is constructing meaning that fits the health belief model. In his view, breastfeeding makes other fathers susceptible to some serious limitations which are: lack of real involvement with the baby, less confidence, poorer self-efficacy, and poorer organisational ability.

The analysis applying the bottle-centric perspective of the mothers to a common model of motivation in health beliefs. The Health Belief Model, has shown that the bottle-feeding mothers did go through decision-making processes. However, the process was followed in unexpected ways so that seriousness, susceptibility, benefits and barriers comprise different factors in the eyes of breastfeeding mothers as compared to Midwives. Because Midwifery does not recognise the choice to not breastfeed as worthwhile, it fails to see that anyone would be motivated to choose bottle-feeding.

### **Environmental Resources**

An influential health decision-making model is Green's Precede-Proceed Model. This section will describe the model in relation to the BFHI. The description shows how compelling the model is for health professionals since it incorporates a methodology for them to implement an environment that will support their preferred health behaviours. Following this description, the negative effects of the BFHI for bottle-feeding mothers will be reviewed.

#### ***The Precede-proceed social-environmental model in relation to supporting public policy***

Green (1986), whose interests were in public health, proposed that *Predisposing factors* of values, attitudes and knowledge, *Enabling factors* of skills and resources, and *Reinforcing factors* such as social norms, are important elements in health decisions and health outcomes. An effective health policy will focus on these factors with the intention of optimising those which influence a particular outcome. In the case of this thesis, this means influencing mothers to breastfeed their infants. Health care offered by professionals and health actions undertaken by health clients are not based on a static notion of roles; rather, the health actions that proceed are understood to be very much influenced by the care practices that precede them. This accords very closely with Bandura's

notions of self-efficacy as not being a matter of free choice, but one that reflects the context and in which responsible policy should be playing a useful role.

The Precede-Proceed Model can be further explicated in terms of how infant-feeding initiatives such as the BFHI are envisioned to work. Regarding predisposing factors of values, attitudes and knowledge, to effect a policy, strategies are implemented to influence and re-shape how health clients think and feel about specific health choices. As such, pro-breastfeeding education emphasises the benefits of breastfeeding and risks of bottle-feeding with the intention that women will be persuaded to take on board that knowledge and shape their attitudes accordingly.

Regarding enabling factors, strategies are implemented to influence the professional skills and resources supporting the policy. As such, the BFHI enables Midwives and hospitals to support breastfeeding, and the following are some examples:

- Requiring staff to have skills in managing breast problems;
- Routinely teaching women about expressing milk so they can manage their breastfeeding effectively;
- Monitoring for infant formula marketing infringements (e. g. Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF), 1999); and
- Placing constraints on professionals' informing role for bottle-feeding.

Reinforcing factors, the third set of this model, are closely intertwined with the factors discussed above. What the reinforcing factors do is to create an environment where one choice of action, in contrast to another (breastfeeding in contrast to bottle-feeding), becomes 'naturalised' with efforts made for that choice to appear to be both the obvious choice and the choice which is supported. Again, the Precede-Proceed model is designed for supportive intervention. That is, it resists what may be the social norms of certain families or communities who have previously bottle-fed, but instead aims to instil a sense of a different 'social norm' in line with the policy targets.

The whole of the BFHI policy is designed to reinforce the pro-breastfeeding and anti-bottle-feeding stance of the WHO code in relation to practices in hospitals. That is, without doubt, its intention has been to develop procedures whereby the 'normal' routine is to have the infant suckling at the mother's breast and whereby the alternative of formula feeding is seen to *not* be normal, such as requiring informing, consenting and form-filling administrative procedures.

### ***How social-environmental policy models can marginalise client choice***

From the perspective of the bottle-feeding mothers, however, they have felt marginalised by services that are not designed to meet their needs:

Terri (12): ... there is just so much emphasis on breastfeeding being the only way to feed that professionals are afraid to listen to anything about bottle-feeding and how these mothers are coping. It's almost a crime to bottle-feed in the professionals' eyes ... [If] you are just one of those mums who decides to bottle-feed, then you don't really get very much respect, they really think you are a bit dumb to even consider it.

Indeed, what the Precede-Proceed model is *not* designed for is adapting services to clients' perceived needs. Examination of this model highlights how in Midwifery tensions involve marketing issues. The WHO code, MAIF agreement and BFHI policy all limit the marketing of formula companies as well as restricting educational discussion about bottle-feeding. In contrast, Midwives are encouraged to 'promote' breastfeeding. For example, Henderson argues that:

Midwives should become politically and socially active by seeking input into media articles on breastfeeding that pose a positive view ... utilising mothers' positive life experiences.

(1999, p. 30)

However, the voice of bottle-feeding mothers is rarely heard because the emphasis on policy implementation by definition pushes these mothers into the margins. For example, Patti Rundall of Baby Milk Action in the United Kingdom (cited in Carter, 1996, p. 150) dichotomises "industry" as one group in opposition to "the role of Midwives or the rights of a woman and her baby"; such a dichotomy assumes that mothers are against bottle-feeding and therefore negates the rights of bottle-feeding mothers and forgets their existence.

The Precede-Proceed model of environmental resources in health decision-making is the most useful in describing contemporary Midwifery's promotion of policy, but it does not directly offer any way of aiming to empathise with, or meet the needs of (Edelman & Mandle, 1994), bottle-feeding clients — for which understanding some other models of health beliefs are more evidently useful.

## Values

Values are crucial to health decision-making, and are considered in Rockeach's (1979) System of Beliefs theory which proposes that behaviour, attitudes, values and self-concept are inter-related. Rockeach contended that health professionals make the mistake of confronting others about their behaviour because behaviour is outermost and therefore easiest to scrutinise. However, since behaviour is more subject to change than attitudes or values, and self-concept is less subject to change than values or attitudes, lasting behavioural change requires working outward from self-concept, through values and attitudes. This analysis will examine how these mothers became committed to their values' positioning in relation to the System of Belief theory.

### *How bottle-feeding mothers' values inter-relate with their choice*

Raths, Harmin and Simon (1974) listed seven criteria for identifying values that will be considered in turn:

1. A value must be chosen from among alternatives

Some of the mothers stated that they had always known they would bottle-feed or that they had always had an aversion to breastfeeding. Nevertheless, it is clear that all of the women in this study were aware of there being another choice — breastfeeding. However, breastfeeding policies, such as the BFHI limit consideration of alternatives. The mothers were resentful about lack of practical advice about bottle-feeding. They also objected to the way in which everyone felt entitled to give their opinion about breastfeeding being the best option. Such pressure often leads to action that is short-lived because it results from someone trying to impose their values upon someone else.

2. A value must be chosen after carefully considering the consequences of each alternative course of action

Typical of most mothers in this study, Penny showed evidence of having considered and discussed the infant feeding alternatives:

Penny (07): I made the decision to bottle-feed (baby) in conjunction with my husband. We discussed it at length. He had read all the brochures about breastfeeding being best for the baby and everything like that. And we'd discussed about [... various negatives of breastfeeding]. So we made the decision ... he said to me it's ultimately my decision, it would be me who would be the one that would have to be feeding her all the time.

As it happened, Penny had concluded that there could be unacceptable negative effects of breastfeeding, such as engorgement and expressing:

Penny (07): Another consideration of bottle-feeding was my return to work. In my profession [police officer] I would not be in a position to be able to express at work to relieve engorgement and maintain supply so I would eventually end up bottle-feeding anyway.

Her explanation of what she had taken into account about the benefits of bottle-feeding demonstrates the depth of her consideration on this topic. One broad aspect was that her bottle-feeding choice would be beneficial for peace-of-mind issues, such as knowing exactly how much the baby is drinking, the baby sleeping for longer, being able to have a more organised routine, being suited to bottle-feeding because she is active, and not having to take the baby to smoky environments when socialising. Another broad aspect of her choice was that bottle-feeding could be beneficial to the baby-father relationship. Penny ended her account of her decision with the following comment:

Penny (07): But primarily the reason why I chose to bottle-feed was the bonding between her and her father.

Clearly she had considered her course of action, though she arrived at a conclusion not recommended by health professionals.

### 3. A value must be chosen freely

The mothers in this study had a strong sense of making an independent choice. They commented frequently about breastfeeding mothers who had not been allowed to make a completely free choice because they were pressured to breastfeed. They argued that not all women were as strong as themselves, and nor should they need to fight for their rights. Claire and Natasha each recounted other women's experiences of being pushed into breastfeeding:

Claire (06): ... she [sister-in-law] breastfed at the start, I think because the midwife pushed her into it.

Natasha (05): A friend of mine yesterday, she was ringing me up, and she said oh the (unclear) pressure to do it (breastfeed) and that's why she did it and she didn't enjoy it most of the time, she was too tired, and she felt she wasn't going to be influenced by anybody...

Natasha, compared her experiences of the care she received in Ireland where she had her first child with the care in Australia where she had her present baby. , She noted her concerns about the effects of Australian Midwives' pressure on women and claimed that pressure would have been counter-productive for her:

Natasha (05): And I know there's a lot of pressure here to breastfeed, but that would nearly make me go the other way and really stand up and say I'm not doing it, and I don't want to do it and nobody's going to make me do it either.

Midwifery's limitations to free-choice meant that they lost credibility in the eyes of the bottle-feeding mothers.

4. *A value must be prized; you should be proud of your choice*

Early in the interviews with mothers it became clear that they were proud of their choice. Claire put this very simply:

Interviewer: If you can just tell me Claire what it's been like to bottle-feed (baby).

Claire (05): Well I think it's been good.

Jackie was obviously proud of her choice and her success in bottle-feeding:

Interviewer: So if you can just tell me what it's like for you bottle-feeding.

Jackie (10): Well I really enjoyed bottle-feeding. I just felt quite comfortable with the fact that I knew exactly how much (baby) was receiving. I didn't feel that I missed out on anything at all by bottle-feeding. I would hold (baby) just as close to me as if I was breastfeeding, and we spent just as much time together. And I felt, yeah, it was very successful for both of us.

5. *A value must be publicly affirmed; you must be willing to take a position*

All of the mothers spoke positively about their bottle-feeding experiences. Their comments were in themselves public affirmation of their valuing bottle-feeding. What Sandy said was typical:

Sandy (09): It shouldn't be bottle is the second class... I really feel that that's the way that when you walk into a hospital, that's how it's looked at. And the Nursing Mother's Association, that's a big push towards breastfeeding, and how dare you bottle-feed. I'd like to see it treated as an equal [choice].

Participation in the study was an act of public affirmation.

Claire (06): The new ones (Midwives) ... they make you feel bad about bottle-feeding. Like you're not doing right by the baby. That's what came across to me when I was in hospital.

In Natasha's case, she had to defend her choice against her husband's opposition and thus, even in the family arena, take a position in which she publicly affirmed bottle-feeding:

Natasha (05): My husband wasn't happy at all, he wanted me to breastfeed right from the beginning. I couldn't believe it actually, he was really pushing, you know, come on you have to breastfeed, this was before she was born. And I said I've no intention... you know, no way. I wouldn't be comfortable doing it either you know. You had to think of ... well will you mind just sitting down once she starts getting hungry, wherever you are or whoever you were with and doing it.

Each of the participating mothers in this study had had to take a public stand on bottle-feeding simply because they were defying pro-breast-feeding discourse. Ironically, being forced to take a public stand confirmed their commitment to bottle feed. The dominant discourse created the conditions for this confirmation.

6. *There must be repetition of your action, your action will be consistent and in accord with your other values*

When the mothers talked about how bottle-feeding suited them, that generally meant it fitted with aspects of their life they already valued. For example it was consistent with Penny's desire to be active:

Penny (07): I also find it suits me... I'm a very active person and I'm always doing things and I would probably find that... resentful isn't probably the right word, but sitting down breastfeeding is very time consuming and if you have to do it more regularly than bottle-feeding, you'd be sitting down... well I would find that I would sitting down and actually thinking of all the things that I need to be doing rather than relaxing, and therefore it's obviously going to affect how you're feeding anyway.

Bottle-feeding was also consistent with Natasha's desire to avoid anything unnecessarily difficult:

Natasha (05): I thought no, I don't want the extra pressure [of breastfeeding]. Give me the easy way out and I'll take it (laugh) and it's worked out.

These mothers had sensed that bottle-feeding suited them, would make them feel better, and underlying that they also intimated that because it was consistent with their other values they would cope better with mothering.

7. *A value is related to your priorities*

Many of the mothers stated how the choice of bottle-feeding suited their preference to be organised with a routine. Coping was a strong theme, whether the mothers were used to coping well or whether they were unsure of their mothering ability:

Claire (06): I just thought [breastfeeding] was too inconvenient for me and because being so young I thought I might get a bit stressed now and again when I had him.

Terri valued family involvement, affection and closeness, and explained that bottle-feeding assisted in meeting those priorities in her life:

Terri (12): My own parents are great (at being supportive) and they just love (baby), and also my husband's family are very involved with him as well, he gets so much love from them all. Sometimes it's a fight to see who gets a turn feeding him. It's lovely to see everyone involved with him.

Midwifery policy prioritises medical evidence that breast is best and supports breastfeeding, whereas bottle-feeding mothers tend to prioritise non-medical aspects of the infant-feeding decision choosing it so that they can enhance the broad concerns of their babies', their own, and their families' welfare.

This analysis of values, based on the criteria from Rath, Harmin and Simon (1974), has provided evidence that these bottle-feeding mothers were committed to their chosen method of infant-feeding as it fitted their broader values. The importance of such factors to the mothers is not well recognised professionally. This tends to produce the profession's deficit models of mothers who do not comply to medical imperatives to breastfeed (Duffy, 2001). The BFHI does not encourage women to establish their own value systems. The Health Belief Model of decision-making suggests, therefore, that the BFHI and concomitant Midwifery practice will simply achieve outward signs of conformity without commitment. This analysis of the values model has also highlighted the importance of the social model of health in the decision-making processes related to bottle-feeding. In short, health per se may not be a priority.

## **Confidence**

Confidence is recognised as a key factor in health decision-making. There is inner confidence, which is naturally felt or developed by individuals, particularly in relation to Bandura's notions of "self-efficacy" from his Social Learning Theory (SLT) which he has renamed Social Cognitive Theory (SCT) (Bandura, 1986), and Wallston and Wallston's (1982) notion of health-related "locus of control" whereby internal attributions of control over health decisions result in better health than helplessly being directed by others. There is also an outside shaping of confidence, particularly through the design of expectations, using incentives and "reinforcement", and through "social modelling". This section will outline the background to these concepts of self-efficacy, locus of control, reinforcement and social modelling as they pertain to the decision to bottle-feed and the BFHI.



## *How inner confidence applies to infant-feeding health issues*

### Self efficacy

Self-efficacy affects the choices individuals make in a given situation and is the self assessment by an individual of their likelihood of succeeding or failing in a particular task. Efficacy is how the individual performs in that task. The theory of general self-efficacy, as developed by Sherer and Adams (1983), proposes that general self-efficacy is a global construct. This construct is the combination of all life's successes and failures that are attributed to self. This sum total of experience and attribution affects individuals' self-expectations concerning a decision to perform a behaviour. General self-efficacy is the belief in one's ability to make a decision, achieve goals and overcome any obstacles in everyday living. The theory of self-efficacy developed by Bandura (1977, 1982) is situation specific and not generalisable between domains.

Bandura (1977, 1986) argued that a person's behaviour is largely a function of efficacy expectations and outcome expectations. According to Bandura, individuals are likely to engage in healthy behaviour if they believe that they can successfully perform the behaviour required to produce the desired outcome, and if the person is convinced that the outcome will benefit them. Perceived barriers and perceived benefits are reflected by the individual's self-concept, and this means, simply, how individuals see themselves. Self-concept and self-efficacy are intertwined.

Although self-efficacy is a relatively recent construct in health care (Bandura, 1977, 1982, 1989), research has accumulated to support its application to maternal-child health care settings (Cutrona & Troutman, 1986; Froman & Owen, 1989). Self-efficacy scales have been utilised to measure parenting skills (Donovan & Leavitt, 1989; Percival, 1990). Percival found that a sense of competence and control in the mother assisted her in the everyday care of her baby. She further concluded that, when faced with stress, those individuals with low self-efficacy were shown to give up easily, and experience high levels of anxiety or depression. Conversely, individuals with high self-efficacy beliefs were persistent and experienced less anxiety and depression with childcare in the early postpartum period (Percival, 1990). Other study findings indicate that a mother's perceived self-efficacy is an important determinant of how she copes and the choices she makes. For instance, stressors, such as lack of control of events and insensitivity by clinicians, interfered with maternal sense of capability in the initial post-partum period (Butani & Hodnett, 1980; Entwistle & Doering, 1981; Scott-Heyes, 1982). Furthermore, self-efficacy also gives a greater understanding to more specific health related behaviours, such as smoking (Baer, Holt & Lichtenstein, 1986), weight loss (Chambliss & Murray, 1979) and health education (Lawrence &

McLeroy, 1986). Therefore, self-efficacy is a useful concept to apply in understanding the performance potential of individuals (Barnard, 1989).

#### *Bottle-feeding mothers views of self-efficacy*

The importance of self-efficacy and satisfaction with the infant-feeding choice was recognised by the bottle-feeding mothers in discussing "confidence". For example, Lisa observed that the breastfed babies in the maternity ward where she had her baby continually screamed which caused the mothers to become anxious. The resultant feelings of not coping led to the breastfeeding mothers being unable to let down the milk. Terri discussed confidence from the perspective of needing overall well-being and choosing what a mother knows she will be happiest with:

Terri (12): I think you have to be happy doing what you are doing, and confident, otherwise you all end up in a mess.

What Terri implied was that anyone either breastfeeding or bottle-feeding without happiness and confidence will run serious risks and be susceptible to "messy" outcomes.

#### *Locus of Control*

A further feature of confidence is locus of control. Its prominence in the health-related literature is owed primarily to Barbara and Kenneth Wallston and their colleagues (Wallston, Wallston 1978; Wallston, Maides, & Wallston 1976). They developed a health beliefs locus of control scale, which has two dimensions, internal and external. Internal locus of control is associated with feelings of individual control over personal destiny and quality of health and the decisions made about lifestyle. External locus of control is the belief that health is dependent on powerful others, that is, the doctor or other medical personnel, or on some combination of chance, luck and fate.

Researchers have reported that subjects who have an internal locus of control exhibited a higher standard of health than those with an external locus of control (Wallston & Wallston, 1978; Lau, 1982). Abella and Heslin (1984) studied the relationship between health, locus of control and values. They concluded that "desiring or valuing health is not in itself a sufficient condition to produce a healthy lifestyle. It is also necessary for the individual to believe that he (*sic*) has control over his own health outcomes" (p. 288).

This notion of the importance of choosing for oneself was also prevalent amongst many of the bottle-feeding mothers. Many of the interviewees described themselves as being strong enough to overcome pressure from Midwives in order to do what they knew was best for them, but they also

expressed concern about the unfairness of being put under pressure and wanted to protect other women from being placed under the same pressure. One example was Sandy,

Sandy (09): I was quite switched on in my own mind ... And ... I had the confidence to say, this is what I want to do, nobody attempted to sway me. (laugh) And I think that [pressure by Midwives]'s the problem.

Several of the mothers also described their decision to bottle-feed as influencing the confidence of the baby's father. It allowed the father to have an equal role in parenting and be confident of his capabilities to fully care for the child without reliance on the mother.

Terri (12): (Baby's father) is very confident in looking after him (baby) now, I can go out and leave him (baby) with his dad and he can take as good care of him as I can.

The literature as well as the perspectives of the bottle-feeding mothers suggest that inner confidence is important in health decisions and health behaviours. It is notable that poor self-efficacy and external locus of control translates into poor confidence that in turn can explain into inadequate performance of health related behaviours as well as associated mental strain and general inability to cope. Conversely, high self-efficacy and internal locus of control were described by many of the interviewees as qualities from within that had helped to make bottle-feeding successful for themselves and the babies' fathers. There was, however, concern expressed about professional attempts to stifle the confidence of women choosing to bottle-feed. This is the dilemma for Midwives. How is it possible to empower women with the best medical knowledge without disempowering them in ways that affect confidence levels?

### ***How outer support of confidence applies to infant-feeding health issues***

Hochbaum's Health Belief Model based on Bandura's social learning theory, recognises that behaviour is not dependent solely on such inner-forces as needs and drives, but is affected by environmental and social conditions. Similarly, self-efficacy, which is an inner-drive that is important to making health decisions, can be supported socially from the outward efforts of health professionals through encouragement, social modelling and reinforcement.

Encouragement to breastfeed occurs in the BFHI, which emphasises its advantages and contrasts these with the risks of bottle-feeding. The concept of outcome expectation (a person's estimate that a given behaviour will lead to a particular outcome) is very similar to the HBM's concept of perceived benefits and barriers. Incentives can be simple and in relation to decision-making can

encompass professional advice such as "breast is best", and that slogan is therefore a strategy of encouragement.

Social modelling is incorporated into the BFHI by its overt support only for breastfeeding. The professional literature cautions against undermining mothers' confidence that breastfeeding is the right choice, for example by disallowing any visible official sanction of bottle-feeding such as a nurse in uniform feeding a baby (HHS blueprint for action on breastfeeding).

Reinforcement, which can play an important informative and motivational role in health, is incorporated into the BFHI such as in its attempts to make only breastfeeding appear normal by prohibiting pictures of bottle-feeding and disallowing formula samples and demonstrations. The provision of services to assist in the management of lactation problems reinforces the policy's promotion of breastfeeding. Within the hospital system, reinforcement occurs through accreditation, and in addition the accreditation manuals include recommended procedures for celebrating a hospital's achievement and continuation of BFHI accredited status. Behaviour is regulated to an extent by outcome expectations, that is anticipation of its consequences (reinforcements) but only as those consequences are interpreted and understood by the individual. So a consequence that is not valued is an ineffective reinforcer and will not positively influence an individual's choice.

In maternity hospitals in Perth, external methods of building confidence are applied to support breastfeeding. The down-side of the policies is that they do little to build the confidence of bottle-feeding mothers, and can seriously undermine it. The literature points out that a lack of confidence has negative health consequences. Guidelines to not demonstrate formula preparation in groups is intended to make such practices seem unusual. The result for women wanting to bottle-feed is a sense of isolation, and a lack of preparation which lowers their sense of self-efficacy.

#### *Social modelling effects on bottle-feeding mothers*

Social modelling is where observational learning takes place. Through modelling (imitating) the behaviour of the observer changes. Opportunities to observe others performing the required behaviour enhance expectations of mastery. For modelling to affect a person's self-efficacy, however, the model must be similar to the observer in their characteristics and effort. The BFHI seeks to minimise modelling of bottle-feeding. However, the mothers in this study felt that bottle-

feeding should be better supported through the use of better information and modelling practices. This is what Erica had to say on the subject:

Erica 03: [Hospitals should organise for bottle-feeding to be demonstrated better to make it less daunting.] I think a bit more support for new mums is so important for their self-esteem and confidence, which in turn reflects on the baby.

It is worth elaborating the point that the value of reinforcements and social models is in the eye of the beholder. From the perspective of bottle-feeding mothers, Midwives are less useful models than pharmacy shop assistants. It has been shown that mothers seek reinforcement of their own beliefs (Hauck, 2000), and the mothers in this study were no exception.

Anne (04): Everyone [at playgroup] breastfeeds except for me. ... some of them are doing 50/50 now, you know, topping up, and they all ask me questions now because their babies are now on formula ... And that's the thing as well, nobody tells you anything about the formula. You go to the chemist and the chemist down at (shopping centre) they've been wonderful, like they tell me when I ask questions exactly what I need to know about the formulas. The clinic nurses don't.

An interesting finding concerning confidence and modelling was that at the time babies were weaned, bottle-feeding mothers considered that they felt more confident about their knowledge of babies' nutritional intakes. Former breastfeeding mothers, who were unclear about formula preparation turned to bottle-feeding mothers for advice.

Penny (07): I get asked a lot of questions about how much she's drinking and that sort of question by the mums that are (breast)feeding, and they sort of... they're obviously looking at getting organised for weaning and that sort of thing, they've just got no concept of how much their child is actually drinking at the moment, so when they're actually weaning them, a couple of girls said oh I only made up a bottle of 40 mls. I mean she was drinking 40 mls when she was born. Whereas now she has a full bottle 200 - 220 mls. The girls have sort of got no idea about how much milk to give when they're weaning and that sort of thing.

What this section on confidence has shown is that the mothers spoke about the importance of inner confidence in coping well as a mother. They were concerned that health care services did little to support the confidence of bottle-feeding mothers and may even jeopardise it. The intention and some of the guidelines of the BFHI when analysed in terms of the outer support they offer for the different types of infant feeding can be seen to have this unfortunate down-side for bottle-feeding mothers. Some of the limitations on educating mothers about formula also meant that breastfeeding mothers knew very little at weaning time and they turned to the bottle-feeding mothers for advice.

## **Life-style**

The life-style elements of health are interpreted differently by different theorists usually in wellness models. This analysis of the mothers' lifestyle choices will consider various wellness models that focus on: self-actualisation; enjoyment and satisfaction; degree of choice in particular environments; self-responsibility; and relational connectedness.

### ***Wellness as self-actualisation of a preferred life-style***

Pender sees wellness as a state in which the person's potential for self-actualisation is emphasised, and argues that this also implies a focus on social, political and justice issues forming part of the decision-making process (Pender, 1987). In Midwifery, efforts to remove barriers to the self-actualisation of a woman comfortably breastfeeding her baby would be examples of this. The WHO Code, BFHI breastfeeding targets, and professional support for such guidelines all centre on making a united, global effort to assist in the urgent need to reverse the trend to bottle-feeding that was very damaging in under-developed countries. In Australia, there have also recently been calls for workplaces to be organised to allow breastfeeding or for funding to support mothers to stay at home whilst breastfeeding. The BFHI policy supports a social goal of improving community health standards. However, this can be contradictory to notions of choice in self-actualisation that are outside of this dominant, pro-breastfeeding discourse. Pro-breastfeeding policies make it more difficult for a woman to confidently reach her potential of designing a life-style that permits her to adhere to her own values if it is her choice to bottle-feed.

### ***Wellness as enjoyment of life***

Ardell (1979) describes wellness as a positive approach to well-being and something that is done because the approach is satisfying and enjoyable, not because the individual wants to avoid disease or live a very long life. That is, a wellness approach acknowledges that people make their own choices about health behaviour to suit their lifestyle preferences. The bottle-feeding mothers' clearly use a wellness approach in their decision-making. For example, Jackie was sympathetic to women in contexts that allowed no choice except to breastfeed, but she felt that their misfortune should not constrain her from taking advantage of her more fortunate situation:

Jackie (10): At the moment it's just... you know, it's really forced down their [Australian mothers'] throats to breastfeed. And I know that's the natural thing, but that's not what everybody wants. ... Around the time I was having (baby) this Kosovo thing... I can remember looking at the TV and thinking, well if I was in Kosovo I would breastfeed my baby because I would have no choice. But, [here] you have a choice...

### *Wellness as self-responsibility*

Further, wellness has been described as: positive, focused on health not illness, and Berne and Shantzis (1986) concluded that the key to wellness was self-responsibility. Self-responsibility has been critiqued by Hunt (1994; pp. 93-94) as:

...A concept which lacks reference to the interconnected nature of women's lives; the principle of personal control which is inherent in the notion of self-responsibility reflects the ordered world of work more than it does women's daily experience.

It has been suggested that women's lives may be dominated by the social networks in which they are embedded (Gilligan, 1982). If this is so then individual concepts such as self-responsibility may become complicated by the demands of others and the context which shapes women's lives (Hunt, 1994).

Findings of the present study suggest that women take into account both the desire for an ordered life and the advantages that order offers to enhance their social networks and relationships. That would describe their sense of self-responsibility in needing to find "what suits" their lifestyle. Lisa compared herself to another mother in hospital with her, who had a screaming breastfed baby. There were observable benefits demonstrated by the differences in:

Lisa (11): ... how organised and relaxed I was. And when my husband came in we could enjoy the baby.

### *Wellness as connectedness*

Labonte's (1993) finding that 'peoples experiences of health were more about their experiences of capacity and connectedness than about their experiences of disease or disability' (p.15) has relevance to the prioritising of father-baby-bonding that was important to many of these mothers, and also to the babies' and the mothers' connectedness with other children, grandparents and neighbours.

Donna had previously had twins and had become aware through experience that bottle-feeding was a better option for her. For example, she considered that breastfeeding carried risks to her ability to

cope, including exhaustion, the baby being less content, an inability to know if the baby was hungry or just grizzly and not having sufficient support from others to cope with the feeding demands. By choosing to bottle-feed, she was avoiding those risks. Donna especially valued the lifestyle benefits of connectedness offered by bottle-feeding, including the ability to be more relaxed and confident, and the increased participation and involvement by others in caring for the baby:

Donna (02): ... (Partner could participate more) and everyone else as well. Like grandparents and even the children, they wanted to help by bottle-feeding, and that was giving them time to get to know him (baby) as well.

The present study found that most of the interviewed women claimed to have jointly taken into account that bottle-feeding would enhance the father's paternal bonding and minimise his feeling of exclusion in caring for the baby. The special relationship afforded by supplying nutrition and having the ability to perform 100 percent of the variety of care needs was considered to be a privilege:

Penny: We'd discussed the fact that [breastfeeding] it's quite a selfish method of feeding, the fact that he wouldn't be too involved in the feeding as such.

Many of the mothers in this study valued the connectedness between father and baby that they felt was achieved by bottle-feeding.

### ***Desire for wellness professional support of client options based on client values***

Having considered wellness models, it would appear that in addition to their strong focus on happiness, connectedness and relational harmony, which are values underlying these mothers' health decision, there is an often mistaken aspect of the model that does not apply to these mothers which is the view that for wellness professional advice is irrelevant. This assumption comes from the notion that being self-responsible and capable of making the right decision for oneself should be able to happen independently. Whilst informed decision-making does assume the clients' abilities to decide, informed decision-making does not preclude professional advice. In a practical sense, this can become difficult and even paradoxical because policies on professional advice is for advice to be promotional of a particular choice, and promotion is not generally aimed at encouraging clients to take personal responsibility in making choices. What this examination of wellness models has shown is that the mothers' values underlying their life-style priorities are in keeping with their lesser emphasis upon health gains from breastfeeding and their disbelief about the risks of bottle-feeding. This is directly in opposition to the values of dominant Midwifery, which takes the largely



biologically measured stance that 'breast is best'. These differences in values will be considered next.

### Diametrically opposed values of professional Midwifery and bottle-feeding mothers

A problem underlying the different perspectives of bottle-feeding mothers and professional Midwives is that even where they have shared knowledge of benefits and risks they assign different values to each factor. For simplicity of explanation in comparing the values of these two groups, this analysis will assign high and low valuing for a number of recognised factors that influenced bottle-feeding mothers' health decision-making.

**Table 2**

Diametric opposition of Midwives' and bottle-feeding mothers' values concerning the benefits or risks of factors in choice of infant-feeding method

Known factors + benefit - risk/seriousness	Midwives' Pro-breastfeeding Values		Bottle-feeding Mothers' Values	
	High	Low	High	Low
+ immune properties of breastmilk	X			X
+ "natural" attachments via lactation	X			X
- Risk of poor bottle hygiene	X			X
+ Techniques for breast care and lactation management	X			X
+ Breast postponing home routine	X			X
+ Self-efficacy for breastfeeding	X			X
+ Self-efficacy for bottle-feeding		X	X	
- Not knowing breastmilk intake		X	X	
- Cracked nipples & breast engorgement		X	X	
- Broken sleep from breastfeeding		X	X	
+ Father bonding from feeding		X	X	
+ Easy access to formula		X	X	

This comparison illustrates how the two groups' assigned value rankings are diametrically opposed. For example, the benefit of natural attachments via lactation is highly valued in Midwifery but is considered to be of little benefit or to be a non-existent factor by bottle-feeding mothers. Conversely, the benefit of father-baby bonding is highly valued by the bottle-feeding mothers but is considered to be of little benefit or a non-existent factor by dominant Midwifery. Another example is cracked nipples and breast engorgement. That factor is assigned a low value by Midwifery because breast and milk management can be taught to mothers. However, it is assigned a high level of seriousness by the bottle-feeding mothers who prefer to avoid pain, discomfort, inconvenience, disruption to their routine, and curtailment of physical activity. In short they would see breast management as unnecessarily focusing on coping with a problem.

None of the models explored in this chapter absolutely rules out an intention for health professionals to be more considerate about clients' lifestyle preferences and individual values and choices. Only the wellness health decision-making models generally prioritise this aspect. The majority of the wellness models have been developed with an implication of people coping with wellness outside the arena of professional advice, which is not what bottle-feeding mothers appear to desire.

This chapter has demonstrated how mothers actively choose bottle-feeding. The analyses have illustrated the process by which health decisions are made, and has pointed out oppositional and competing values dividing Midwifery's medically informed, pro-breastfeeding perspective and that of the bottle-feeding mothers who take into consideration a broader range of issues. The chapter has explored dimensions of health decision-making including motivation, environmental factors, confidence, values, and lifestyle issues. This has highlighted the many differences between the perspectives of bottle-feeding mothers and Midwifery. The discussion has considered the pressures on Midwives to meet Baby Friendly Hospital Initiative targets that arise from discursive insistence that choices must be contingent on the medical evidence that breast is best, and that medical evidence alone will lead to breastfeeding being the better choice. This is what lies at the heart of the present conflict between Midwives and bottle-feeding mothers. However, in this chapter, the analyses demonstrate that while mothers follow normal, health decision-making processes, as described in the theoretical models, they reach conclusions incongruent with those of professionals. Nevertheless, the mothers make reasoned and logical choices to not breastfeed. The Baby Friendly Hospital Initiative (BFHI) policy has been shown to conform to a model of targeting and refining

professional ideals without fully accounting for client choice, and the processes underlying clients' informed decision-making.

Many health professionals have despaired over the issue of clients having seemingly irreconcilable differences between knowledge and practice. This chapter explains the differences by showing how these bottle-feeding mothers share some knowledge with Midwives but assign diametrically opposite value-weightings to specific dimensions of knowledge. Furthermore, compared to professionals, mothers consider a much broader set of factors to be relevant to their infant-feeding choice.

Women in this client group appear to see themselves as professional mothers and consumers of infant-feeding advice. They consider themselves to have the right to be assisted to make their own fully-informed choice. This chapter argues that contemporary bottle-feeding mothers' health decision making for infant-feeding is best encapsulated by the wellness model which focuses on self-responsibility and enjoying life and relationships more than on avoiding or curing illness and disease. However, it differs from that model by desiring professional support in otherwise self-directed choices, and those choices are based on broad, complex factors by which they seek to optimise and keep their short and long-term welfare and family relationships. None of the commonly available health-decision models adequately pinpoints what this study identifies as these mothers' largely unmet expectation from Midwives — that health professionals should primarily be a flexible and competent support facilitating their personal priorities. In the words of one mother, the bottle-feeding decision had resulted from a serious process of reasoning:

Penny (07): (As to why I was going to bottle-feed) ... it was a conscious decision, and that decision had reasons behind it, it wasn't something that I just plucked out of the air and decided to do.

### **Implications for health decision-making**

Bottle-feeding mothers follow processes of making a genuine commitment to a choice. They expect to be supported by professionals in making that choice and achieving their goals. Professionals need to develop greater understanding about the point where their persuasive role changes to a pressuring and marginalising role in the eyes of the client.

The diametrically opposed values of bottle-feeding mothers and Midwives have been identified and Midwifery may be able to develop more empathetic relationships by being more sensitive to the depth of commitment some mothers make to bottle-feeding.

There is very little research that supportively addresses mothers' long-term, social concerns, such as fathers possibly 'bonding' better if they can be equally involved in feeding. Instead, there is currently a focus on how to make fathers and/or both parents take up subjective positions preferring breastfeeding. Furthermore, there appears to have been no developments in improving support to improve success for this group of clients.

## **CHAPTER 7 - One-sided Advice from Professionals versus Bottle-feeding Mothers' Desires for Full Information, Practical Advice and Support**

The majority of bottle-feeding mothers expressed concern about inadequate standards of bottle-feeding information, practical advice, or support from Midwives and related health professionals. Indeed, the undertones of the women's narratives suggest that some mothers and their babies were rendered vulnerable by the limited professional advice about milk-substitute formulae. A description and investigation of those concerns provide the major foci of this chapter's analyses. At the heart of this chapter's discussion lies the interpretation of what constitutes responsible informing practices. Medically, it is considered responsible and "appropriate"<sup>1</sup> to "explain the benefits of breastfeeding and the costs and hazards associated with bottle-feeding" (WHO/UNICEF, 1981) — in other words, to point out that 'breast is best'. The chapter will argue that policy constraints on Midwifery, including the resultant widespread use by hospitals of referrals for formula information to pharmacies or chemist shops, are paradoxically creating a culture of bottle-feeding dependent upon lay advice and support. Final sections of this chapter develop the analysis and discussion offering practical suggestions that address a number of points about educational standards that bottle-feeding mothers considered unacceptable. These are collated with what the mothers regarded as useful information.

### **Investigation of bottle-feeding mothers' concerns about information**

A major concern expressed by the mothers was the inadequacy of information about bottle-feeding. Typical of the mothers' views was Anne's admonition of Midwifery services:

Anne (O4):        (The hospital's) antenatal classes (are) not interested in teaching about bottle-feeding — they need to promote that a bit more for first-time people.

It is evident that Anne was unaware that contemporary, maternity hospitals policy is precisely opposed to promoting bottle-feeding. Midwifery professionals have been socialised into promoting breastfeeding with the result that their professional culture has naturalised the suppression of bottle-feeding information. As a consequence, their pro-breastfeeding practice remains uncontested and professionals are unaware of any negative outcomes of their practice

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<sup>1</sup> The term "appropriate" is used in the NHMRC's (1996) Infant Feeding Guidelines for Health Workers.

for bottle-feeding mothers. This is difficult for mothers to understand. In their view standards of fairness and professionalism had been violated by withholding bottle-feeding information. They were perplexed, frustrated and strongly critical about this aspect of their experience of establishing appropriate infant-feeding.

## **Mothers' Criticisms of Professional Information Standards**

All of the mothers valued and desired useful, practical information about bottle-feeding. There were patterns in the mothers' criticisms, which will be discussed in this section under the following categories: (1) bias and distortion in the information provided to them, (2) the mothers' right to choice, and (3) Midwives' failure to provide bottle-feeding information and to direct the mothers' to better sources.

### ***Category 1- Bias and Distortion in information provided***

#### **One-sided pro-breastfeeding advice and omissions from bottle-feeding advice**

Jackie was concerned that no bottle-feeding information was provided and that women were pressured through inappropriate methods of presenting information:

Jackie (10):     The antenatal classes ... never even mentioned bottle-feeding. I think it should be included and I think that ... we have choices, ... I wanted to have some input [by participating in the present study] into if we can help any women know that it's okay to bottle-feed. Stop trying to force it down women's throats and give them no out. Because a lot of women don't want to breastfeed.

Penny criticised antenatal education practices for telling women that breastfeeding is the be-all and end-all, and for not telling them anything about the advantages of bottle-feeding:

Penny (07):     a lot of new mums are told that breastfeeding is it, and that's the be-all and end-all. ... And they're not actually given any facts about bottle-feeding and the fact that the formula does stay with them for longer and they do sleep better. There's just different pros and cons with everything...

Furthermore, Penny argued that there is prominent advertising about why breastfeeding is wonderful, but nothing supporting bottle-feeding:

Penny (07):     So I do feel sorry for mums that end up feeding, that can't breastfeed. But I wish that a lot of people would understand the reasons why. They're obviously listening to all the attention or the advertising or the information that's coming around about breastfeeding, how wonderful it is. They're not actually seeing any information coming out about why bottle-feeding is good.

Imogen and her partner were so disgusted about the bias toward breastfeeding and against bottle-feeding that they walked out of the antenatal classes:

Imogen (01): The only thing they mentioned about bottle-feeding is negative. It's going to cost you a lot of money, the sterilisation, because you've got to be so careful with newborns, and this sterilisation. So there wasn't anything positive about it, there were just a couple of negative things mentioned and then that was it. Back to breastfeeding. And that's when we went (laugh).

These excerpts from Jackie, Penny and Imogen illustrate an expectation, widely-voiced in the interviews, that women should be allowed to make an informed decision. Just what an informed decision entails, however, is problematic. Health policy developments rightly maintain some scepticism about free-choice, since attitudes are shaped (Bandura, 1997) and because changing thinking is an important part of the process of policy development. Nevertheless, the current practices surrounding the way infant-feeding education policies have developed, for example through the BFHI, lean more towards the suppression of information, and suppression does not fulfil the professional responsibility to allow an informed choice in health decision-making.

#### Professional information lacking credibility

The bottle-feeding mothers did not believe all of the pro-breastfeeding, anti-bottle-feeding information. Jackie, for example, had assessed for herself the differences between breastfeeding and bottle-feeding and was not convinced that bottle-feeding was harmful:

Jackie (10): I think if I'd really felt... if I'd really believed that my children were going to be in any way deprived by being bottle-fed, then I wouldn't have done it. I just guess I'd never really been convinced.

Being unconvincing is likely to be interpreted by Midwifery as a need to be more convincing. Yet the message of this study is that feeding mothers want the right to make an informed choice. This means they need to be provided with full information about all methods of feeding.

Some mothers considered that there was a tendency to simply glorify breastfeeding without accounting realistically for its problems:

Terri (12): They say all this stuff about bonding, holding your baby close and all of that, but really I hold (baby) close too when I bottle-feed, so I think it is a load of rubbish all this talk about bonding, I think it is a lot easier to bond with your baby if you are content and the baby is content and you are both not all stressed out over the feeding and how much he is taking, and all the breast problems and cracked nipples and everything ... How could you bond with your baby if you felt like that?

The relevant policies for infant-feeding health care recommend giving pro-breastfeeding advice. Promoting any one aspect is persuasive at the expense of accuracy, and particularly exaggerates the significance of particular outcomes. Evidence-based practices would not support exaggeration — for example, claims of statistical significance may still affect only a minority of cases. Overstating one side of the story leads to scepticism. For example, Claire believed that there was little difference between bottle-fed and breastfed babies:

Claire (06): I just thought you know so many people are against bottle-feeding, I just thought I'd answer it [advertisement for recruitment to the study] and tell my side of it. I don't think there's anything wrong with bottle-feeding. They say that they didn't come out as healthy or developed ...

Some mothers suggested that the compelling research was irrelevant to them. Lisa and Terri argued this in relation to differences between her context and that of the Third World:

Lisa (11): I think a lot of the talk is about third world countries, where there is poor sanitation and where they water down the milk as they are not able to buy it as they are so poor. My children have all been very healthy so all the talk about bottle-fed babies being less healthy doesn't apply to me.

Terri (12): They say that breast milk prevents the baby getting infections, but [baby] has never been sick since he was born, maybe it's all the statistics on the third world countries...

This observation should not be overlooked. Current policies are the result of international pressure to take a global approach to infant feeding issues, including, as reflected in WHO and NHMRC guidelines, that the greatest risk in infant feeding is from inadequate cleaning of equipment and improper reconstitution of substitute milk formula. Although a highly unpopular point to make professionally, there is considerable truth in these mothers' assumption that the overall risks to the bottle-fed babies of healthy mothers in affluent contexts are not comparable to the risk factors in poverty-stricken contexts<sup>2</sup>.

Policies are tending to promote breastfeeding to ever-higher standards. Some of it, such as advocating six months of exclusive breastfeeding, is in response to contentious research findings about breast/bottle differences over shorter periods of time. This might imply to some mothers that it is worthless to breastfeed for shorter periods. Penny illustrated that point:

<sup>2</sup> Paradoxically, much of the force behind the pro-breastfeeding movement was reactive against infection rates in Third World countries where bottle-feeding could have disastrous consequences amidst poor sanitation and poverty (Palmer, 1983). However, the unfortunate incidence of AIDS and HIV, especially in many African countries, has resulted in a re-examination of the wisdom of 'breast is best' policies for all (for example, Gill Siedel, 1999). Siedel, a South African researcher, forwards a strong case for taking into account the real (though regrettable) discrepancies in living standards and the correlated differences in infection rate risks from bottle-feeding. Professional literature such as "The Health Exchange" (for example, The International Health Exchange, April 2001) provides evidence of widespread problems such as water shortages (p. 4) which are not problems affecting most Western Australians.



Penny (07): From what I've sort of read about breastfeeding, for it to actually be of any benefit, you know the antibodies and the colostrum, you have to actually do it for an extended period ... 6 months sort of thing. And a lot of mums I've sort of spoken to say I'll only feed for 6 weeks and then I'll put her onto the bottle. I thought, well, why even bother.

The Midwifery field seems typically to be interested in finding ever more effective ways of persuading mothers to breastfeed. However, the findings in this section have highlighted a problem: The field's present educational practices do not meet the mothers' standards of credibility.

### *Category 2 — The mothers' right to decide*

The mothers' viewpoints were that only each individual mother can know her own attitudes about breastfeeding and bottle-feeding. Penny explained this as follows:

Penny (07): I'm not adverse to breastfeeding, but everything has its pros and cons. And everyone is entitled to make their decision based on how they weigh up those pros and cons. Everyone's attitudes are different towards different ideas and they feel differently towards different things.

There was resentment that Midwives tried to make the feeding decision for the mothers. As Imogen explained, there was a sense that mothers should work out what is best for themselves:

Imogen (01): They're just saying, well, let's all breastfeed and that's your condition from the time you can even think about a child, is breast, breast, breast. And there is a different way, and it doesn't mean it's wrong or it's right, it's whatever suits you and whatever's best for you. And for us the bottle was the best thing.

Bottle-feeding mothers considered it foolish that a woman would be persuaded by hospital staff, and also considered it unacceptable that hospital staff could consider that they could make the decision for a mother:

Terri (12): I just think whatever suits you, just feed your baby whatever way suits you, after all you are the one looking after the baby, not the hospital staff.

There was a consistent opinion that the infant-feeding decision is best made by a mother who is aware of her own attitudes, can obtain professional information, can work out what will suit her and who is not influenced by others' preferences. Infant-feeding is seen as a personal decision.

The NHMRC Guidelines (1987) on patients' choice insist on the clients' right to a choice<sup>3</sup>. Most health carers would understand the intention of this policy on choice as being aimed at preventing highly invasive medical procedures against the wishes of a patient (such as radical cancer treatment). This policy has not been widely considered in relation to health choices such as infant-feeding. This lack of recognition of breastfeeding pain ignores the fact that some women find it to be physically invasive, and (amongst other reasons for not choosing breastfeeding) want to uphold their right to not be subject to that course of action.

Guidelines about choice do not insist that patients have a right to be helped to feel good about the choice that they make. Herein lies a strong ethical issue about the caring nature of nursing and Midwifery.

Jackie (10): [People giving ante-natal classes] should be saying, if you feel very strongly that breastfeeding is not what you want then ... cover the bottle-feeding, give it a bit more time. They don't actually give it any time at all ... And because it's not covered, that's not a good thing. It should be covered in all of the antenatal classes ... So that that mother, you know, that first time mum that goes in there wanting the best for her baby, but knowing that she can't breastfeed, knowing that she desperately doesn't want to breastfeed and she's going to struggle with that, can go away and enjoy the rest of her pregnancy thinking, well, bottle-feeding is accepted and she'll feel better about it.

Many of the mothers spoke of wanting attitudinal changes from Midwives, for example, suggesting that the stigma of not breastfeeding could be removed (Sandy, 09), that bottle-feeding should be promoted (for example, Anne, 04), and that mothers should be supported. Francine had this to say:

Francine (08): I just think there's so many more people who should realise that breastfeeding may not be best for their child or for their situation. They should be able to get literature or information or 50/50 breastfeeding. When you're in hospital you should get the brochures on breastfeeding, the brochures on bottle-feeding, or the classes in the hospital. And support of whichever way... not to be... you know, made to feel that you're going on the easy way, or you're giving up on something, or you're not bonding, just all the things that are thrown at you.

However, even though the mothers expect that their choice to bottle-feed should be treated with respect, the policies and guidelines infer that professionals should not demonstrate approval of bottle-feeding. That is, the BFHI policies have led to practices in some contexts which evade the best standards of teaching about bottle-feeding before the birth because demonstrations to

<sup>3</sup> The setting of breastfeeding targets has inherent potential contradictions to the client-choice policy of the National Health and Medical Research Council's (NHMRC) (1987) guidelines. Those guidelines can be summarised as: (1.) Choices in health care; (2.) The right to be informed; (3.) The right to safety; (4.) The right to be heard; and (5.) The right to redress. In the light of this study, several of those ideals are not being met in the best way possible in serving women who bottle-feed (Duffy & Hunt, 2001).

groups are not allowed and apparently cover *only* the risks of bottle-feeding education. This approach has left these mothers feeling that they were only told the negatives rather than being fully prepared. A fundamental principle underpinning health-care is: First do no harm. Where there is professional input highlighting only negative consequences, it could be conjectured that this may do harm to mothers who bottle-feed their babies.

***Category 3 — Midwifery's failure to provide bottle-feeding information, & the mothers' better sources***

The NHMRC Infant Feeding Guidelines for Health Workers states that,

The primary objective of the WHO code is to provide safe and adequate nutrition for infants by protecting and promoting breastfeeding, and by ensuring the proper use of infant formula, when it is necessary, on the basis of adequate information [etc].

(NHMRC, 1996, p. 55)

Professional Midwifery faces a dilemma regarding drawing the line between educating mothers about bottle-feeding and indoctrination to promote bottle-feeding. Dangers associated with poor preparation for infant feeding are recognised and documented in the NHMRC guidelines. Confusion over how and when Midwifery and hospital policies should be responding appears to be leaving the important aspect of bottle-feeding information, advice and support vulnerable to unacceptable outcomes.

The first point of analysis will be to explore the reasons underlying the failure of Midwifery to satisfy the mothers' needs in respect of knowledge. In particular, it will highlight the problem of how various policies that allow for bottle-feeding education have been interpreted with increasing degrees of dogma. The second analytic point, Better Sources for Bottle-feeding Support, will suggest that the code aims to restrict bottle-feeding education to being offered by health professionals. When interpreted dogmatically, the Code paradoxically contradicts its own intentions: Current practices leave open the way for such minimal standards of education by health professionals that mothers frequently feel unprepared. They are then sometimes forced to supplement their knowledge, either from trial and error, or from alternate sources such as pharmacists, who are recognised as valid and useful providers (NHMRC, 1996), as well as baby food companies and various lay advisers.

***Bottle-feeding Mothers Questioning How Much Midwives Know***

The mothers' perceived a lack of Midwifery knowledge on bottle-feeding. Anne gave a detailed account of her frustration in regard to the inadequate levels of bottle-feeding education she had received. Unaware, as many mothers are, of the policy line that translates into postponing and minimising educational discussion of bottle-feeding — more than once Anne articulated her perplexity about the lack of information from Midwifery and Child Clinic health professionals:

Anne (04): Whereas the clinic nurses they don't really... I don't know whether they just don't know the information or they just don't tell you. Because the clinic nurse said... well one of them said I don't need to go onto the over-6-months. They told me I didn't need to go onto like the next formula. They said that was just the company trying to persuade the customers and get more money out of us for the formula. Then when you go to the chemist they say to you no, you need to go onto the over-6-months because the over-6-months has got 50% more vitamins, 50% more iron and all this sort of stuff. So you think well yes I should be going onto that because

Interviewer: He's needing more iron.

Anne: Yes, as he's going onto food and he's messing about with his milk, I would like as much milk as you can get into him and then if it's going to have 50% more iron, and as he's messing about a bit it doesn't matter too much if he wastes a bit at the end of the day.

The literature suggests that iron supplements are necessary after six months of age (Cunningham, Jelliffe & Jelliffe, 1991; Hartmann, Cox & Duffy, 1997). It is likely that due to the historical opposition to formula marketing generated by the WHO-led, BFHI, pro-breastfeeding campaign, that current NHMRC guidelines are for Midwives to stipulate that all formulas on the market are equivalent and that formula upgrades are unnecessary. To mothers, however, it appears that Midwifery professionals are unable or unwilling to give the most up-to-date advice about which is the best formula to use<sup>4</sup>. The participant observation phase of this study found that it was routine for hospitals to refer mothers' inquiries about bottle-feeding to the chemist. Therefore, Anne's statement seems credible that it would have been the chemist who would have gone into more detail about the properties of formula. Whether the development of different stages of formula took place as part of clever marketing or to develop genuine improvements in formula cannot be decided by this analysis — however, the mother's confidence in the more detailed levels of information provided by the Chemist should signal the danger of losing credibility that the Midwifery profession is creating for itself by referring discussion of formula to other sources.

This same mother continued her discussion of problems she had experienced by not being fully informed. Anne lamented not knowing about there being three different formula types — up-to-3-months, 3-to-6-months and over-6-months<sup>5</sup>:

<sup>4</sup> This would suggest that Midwives have contradictions in how they understand their responsibilities to maintain up to date knowledge of infant formula. It appears from this study, from the general tone of the Infant Feeding Guidelines for Health Workers, and also from the lack of any formal, routine testing of Midwifery knowledge of infant formula (c.f. BFHI assessments), that since Midwives are so strongly discouraged from discussing formula, there may be gaps in how much they know, and certainly variations in how they understand their responsibility to inform mothers, as is discussed in the present chapter.

<sup>5</sup> Whilst a contentious point is the degree to which different formulae are necessary or are part of a marketing strategy, a former pro-breastfeeding point commonly raised in Midwifery ante-natal classes was the fact that human milk changes quality over time to meet the development of the baby (Cunningham, Jelliffe & Jelliffe, 1991), whereas at that time most formula milk-substitutes were of a single standard.

Anne (04): I only found out the other day, which someone didn't tell me and I mean he was 5 months old when I found out (laugh), that the Karicare that I've been using you're only meant to be using up to 3 months old (laugh). I was meant to be going onto another formula.

Interviewer: A different one.

Anne: Well this one's apparently a first infant formula and only meant to be used up to 3 months because it's got L.C.P.s in it and the Omega oils, the fish oils and things for the brain. But no one told me that until I went in there and the pharmacy assistant says, by the way, is your baby over 3 months old? Yes. She said, you're not supposed to be using that formula, you're supposed to have gone onto the next formula, they've got about 3 in the range.

Anne's descriptions of her negative experiences highlight some other issues where Midwifery appears to be failing to deliver timely advice. Anne described how finding out that she had been unaware of what she should have done made her feel as if she had acted badly:

Anne (04): Yes, so things like that you don't realise until people tell you, they go, oh by the way... and you're sitting there going ohhh, geeze, like I've done something really bad now. It is very frustrating and confusing for a first time mother.

It is worth considering the lengths to which breastfeeding education, in contrast to bottle-feeding education, aims to build a strong sense of self-efficacy in mothers. Self-efficacy is enhanced by good preparation and support. It is believed to be domain specific (Bandura, 1997) so that would apply to infant-feeding skills and knowledge. Good preparation assists in a mother's infant-feeding success and enjoyment of caring for her baby (Price, 1988; Tarkka, Paunonen and Laippala, 1999). However, ante-natally, in professionally-provided classes, discussion of bottle-feeding is minimised and postponed as a strategy to encourage women to choose breastfeeding. Women are well-prepared for breastfeeding being taught about the milk supply and how to protect it and they are shown in advance of the birth various techniques to cope with possible breastfeeding difficulties, such as expressing milk should a mother and her baby become separated. Because ante-natal education and policies such as the BFHI work towards an idealised promotion of breastfeeding, the situation for women who will bottle-feed is rarely discussed in the profession, however, it is important to be aware that there are negative consequences which were described by the mothers in this study. Not least of all, as Anne's comments above demonstrate, a negative consequence of inadequate preparation for bottle-feeding is that it is undermining at the emotional level, thus risking the best development of a mother's sense of self-efficacy.

The other point arising from Anne's candid discussion suggests that inadequacies in bottle-feeding education can inadvertently leave weaning mothers and their babies vulnerable. The professional guidelines, where they translate into a reluctance by Midwives to demonstrate making-up bottles and reluctance to discuss formula, impact on breastfeeding mothers who later

may feel inadequately informed about how to change to bottle-feeding or what to do at the weaning stages. In such cases, experienced bottle-feeding mothers, rather than Midwives or other hospital workers, can become the credible sources of information:

Interviewer: Do you learn much from talking to other mothers at playgroup and places like that?

Anne (04): No not really because everyone breastfeeds except for me. I'm the only one who bottle-feeds, and then when their babies are being bottle-fed, which some of them are doing 50/50 now, you know, topping up, and they all ask me questions now because their babies are now on formula, and (baby)'s been on that since basically day dot and yes, so they start asking me questions now (laugh) about the formula. Asking me how much (baby) drinks now so the wheels have turned around the opposite way now, they're actually asking me all the questions and finding out what formula I'm on.

This set of circumstances described by Anne highlights how the set of guidelines may have become overly idealised, resulting, in some cases, in what could appear to the mothers to be the neglect of appropriate health worker advisory duties. This latter issue is extremely complicated. In the mothers' perceptions they are marginalised. However, professional definitions of appropriate information constrain the advice given about bottle-feeding. Findings from the participant observation phase of the present study indicated that there was a *defacto* delegation to pharmacies in place whereby hospitals routinely referred ante-natal mothers to the chemist for advice on formula and bottle-feeding. Additionally, the interviews with mothers suggest that in antenatal settings and in hospitals there was a broader sense of a 'gag'<sup>6</sup> that restricted discussion of bottle-feeding, other than to point out the problems of bottle-feeding.

The NHMRC (1996) guidelines document states:

The WHO code also states that feeding with infant formula should be demonstrated only by health workers or other community workers, and only to the mothers or family members who need to use it. In giving this information health workers should inform parents and others of the hazards of improper use of infant formula (WHO code Article 6.5).

(NHMRC, 1996, p. 55)

The code, in attempting to restrict formula companies from marketing directly to mothers of infants under six-months-old, opens the way for Midwifery to almost have a monopoly on bottle-feeding education. Although hospitals are obliged to mark off on a mother's care plan that the basic sterilisation and preparation has been covered, many of the mothers complained about standards, for example, only being shown once even when requesting to be shown again (Claire), not remembering having been shown or not having been shown due to trying unsuccessfully to breastfeed whilst in hospital (Anne), or they remarked about having to help

<sup>6</sup> The source of the term "gag" is Macklin's (1993) "Enemies of Patients".

other bottle-feeding mothers who had not been adequately educated, for example, Lisa who was concerned about education standards generally, and who explained:

Lisa (11): There is no class about bottle-feeding, not that I needed one anyway, as I knew how to do it. But the young girl down the street had no idea. I had to go down and show her how to make up a feed. She hadn't been shown in hospital. Of course she came home on the early discharge program after 48 hours. I told her she can call on me anytime if she needs help or advice about what milk to use or how much to give.

The WHO guidelines propose that the education function for bottle-feeding be taken seriously and to high standards, but in some cases, this has come to be formally (and arguably informally) interpreted as being minimal. This latter point will be demonstrated using the following piece of documentation as an example to show how the WHO code has interpretations added to it, that often further define and restrict professional understandings of health worker responsibilities. The original WHO code was aimed at marketing companies, and now NHMRC guidelines go further, for example, by defining the educational role of professional health workers.

WHO Code	Interpretation of health workers responsibilities	APMAIF'S interpretation of the Australian agreement <sup>7</sup>
<p><i>Article 6.5</i></p> <p>Feeding with infant formula, whether manufactured or home prepared, should be demonstrated only by health workers, or other community workers if necessary; and only to the mothers or family members who need to use it; and the information given should include a clear explanation of the hazards of improper use.</p>	<p><i>No routine formula preparation classes</i></p> <p>Mothers or family members who will be feeding with infant formula need responsible instruction on cleaning, sterilisation, preparation, safe storage, and feeding techniques which decrease risks. Full explanations should be given on the potential hazards associated with not following correct procedures for any of these steps. For example, gastroenteritis; dangers of understrength and overstrength formula; nursing bottle caries; problems arising from using products other than infant formula; risks associated with the early introduction of solids. Instruction should be given only to parents or family members who need to use it, ideally on a one-to-one basis, incorporating adult learning techniques and hands-on experience.</p>	

(NHMRC, 1996, p. 75)

<sup>7</sup> In the source NHMRC (1996) document, the APMAIF extensions are mostly concerned with marketing issues, defining font sizes, regulating what idealised pictures are, and then also defining how Australia's trade practices cannot fully restrict marketing.

It is concerning to notice how the code has become interpreted in increasingly dogmatic terms. There are three aspects that I will describe:

1. In the "Interpretation of health workers [sic] responsibilities" the column of the NHMRC guidelines has become, "*No routine formula preparation classes*", and it appears that the sense has changed from disallowing personnel from formula companies from demonstrating preparation, to disallowing "routine preparation" by health workers. The BFHI assessment profiles, for example, check for the following: "Does the policy prohibit demonstration of formula preparation as part of routine antenatal *group* instruction? [emphasis added]". In part, this policy of ideally having one-on-one education makes it less accessible to mothers and makes it appear less normal, but it is also more difficult for Midwives to organise provision of that education.
2. The issue of demonstrations being given "only to the mothers or family members who need to use it [knowledge about bottle-feeding]", raises another problem that the interpretation of who needs to use it has, as shown in 1 above, dogmatically become in practice, post-natal women who have begun bottle-feeding. Hence, antenatal preparation does not take place despite research findings showing that mothers retain little of what they learn from education shortly after the birth (Bailey & Sherriff, 1992), and despite the fact that many mothers intending to breastfeed are bottle-feeding soon after discharge from hospital (Hauck 2000). This is a disturbing element of the BFHI because even the NHMRC guidelines state that people who need to use formula include mothers who do not wish to breastfeed.
3. The mandate that "the information given should *include* a clear explanation of the hazards of improper use [emphasis added]", by many of the mothers' accounts has frequently come to mean — 'should *only* explain the hazards and basic preparation, and must offer as little practical advice as possible'. This is not to argue that avoiding risk is probably the most important part of what people should know about bottle-feeding. However, the point is that although the guidelines suggest that techniques should be used to make the education successful, this bit of the guidelines seems to be taking secondary place to the BFHI restrictions.

This pattern of increasing constraints on bottle-feeding advice and information accords with the study's findings that in the eyes of the bottle-feeding client group, Midwifery is providing inadequate delivery of the information and advice they feel they need. However, in a dogmatic interpretation of the professional policies, Midwifery's restricted role, where the BFHI is followed to the letter, could be argued as being "best practice". In addition, there are pragmatic reasons arising from resource constraints that encourage such dogmatic interpretations of the



code — and unfortunately the result is tightly restricted professional assistance to this client group. When I asked a highly active professional association office bearer what the BFHI has to offer so that intending bottle-feeding mothers can be adequately trained before they give birth (personal conversation), she became flustered but was quick to admit this was a problem. She explained that the policy is to not train mothers in groups, such as normal ante-natal classes, and claimed that the *next* thing Midwives should develop is a strategy to train mothers individually but so far everyone has been too busy to get around to doing that. Given the voluntary nature of involvement in such professional organisations, this lack of time is understandable. However, it does not justify the Midwifery profession's failure within its BFHI capacities to develop this aspect of its service.

### Better Sources for Bottle-feeding Support

Midwives and hospitals are failing to meet expectations of many bottle-feeding mothers. The WHO Code's Article 6.5 proposes that only health workers or other community workers should provide education and demonstrations of feeding with infant formula, and that the mothers are entitled to advice.

Health workers are committed to promoting optimal health and development for all infants. When interpreting these guidelines health workers should accept that mothers who do not breastfeed need appropriate information about infant formula and instruction about its use and preparation. All mothers are entitled to appropriate support and advice so they can adequately feed their infants.

(NHMRC, Infant Feeding Guidelines for Health Workers, 1996, p. 13)

In disentangling this impasse, attention will be paid to the question of what support or advice is 'appropriate', since there are different answers for the Midwifery field and for bottle-feeding mothers. The Midwifery position has increasingly stringently developed practices of being pro-breastfeeding and in effect being anti-bottle-feeding. For example, the Baby Friendly Initiative assesses hospitals' provision of information about breastfeeding, and as a close reading can show, its accrediting assessments look particularly for evidence of the absence of bottle-feeding marketing which in turn results in placing strong limits on bottle-feeding education:

(1) A written breastfeeding policy:

- "Does the policy prohibit the display or distribution of materials which promote breastmilk substitutes, feeding bottles, teats and dummies?
- Does the policy prohibit demonstration of formula preparation as part of routine antenatal group instruction?

(3) Training staff to implement breastfeeding policy:

[Various techniques and information about breastfeeding], and:

- Are the antenatal services free from promotional materials for breastmilk substitutes, feeding bottles, teats and dummies?
- Do pregnant women confirm that they were not shown how to make up a bottle as part of a group demonstration?

(6) Give newborn infants no food or drink other than breast-milk, unless medically indicated.

Are any supplements given to breastfed babies given only in cases of acceptable clinical indications, fully informed parental choice or other reason beyond the control of the Trust?

Is the facility free from promotional materials for breastmilk substitutes, feeding bottles, teats and dummies?

NB: Breastfeeding mothers may choose to give their babies a supplementary feed. It is the Trust's responsibility to ensure that mothers are encouraged to breastfeed their babies exclusively and that any decision not to do this is made after being fully informed of the benefits of exclusive breastfeeding and the risks of the supplementary feed.

([www.babyfriendly.org.uk/matern.htm](http://www.babyfriendly.org.uk/matern.htm))

These BFHI assessment conditions do not strictly place a "gag" (Macklin, 1993) on Midwives and hospitals, but the guidelines appear to commonly be interpreted as a gag in many Western Australian hospitals, given some variation from setting to setting. In fact, only one hospital in Western Australia had achieved Baby Friendly accreditation and many private hospitals' administrations saw accreditation as being unattainable (Researcher's telephone enquiries made to Director of Nursing level, 2001). Nevertheless, such policy documents have a powerful impact on all hospital practices. They are regarded as documents that can benchmark high quality Midwifery and hospital practices and have relevance for the mandatory reporting of breastfeeding rates to the government. Thus, as empathetic as some individual Midwives, other health workers, or hospitals may be towards bottle-feeding mothers' desires for strong support and information, as professionals they need to conform to various institutionalised constraints. Without dismissing professional constraints on information standards, the analysis will now turn towards understanding the situation whereby bottle-feeding mothers have reported gaining the information they considered useful from a range of unofficial sources.

Terri was dissatisfied with her Child Health Nurse's negative attitudes:

Terri (12): I actually only went to the clinic once. I don't think she approved of me bottle-feeding, she gave me one of those looks when I said I was bottle-feeding, so I just didn't go back. I get the baby weighed at the chemist and the girls there are all over him, want to hold him and all; I just got no positive vibes from the child health nurse, so I thought I don't need that.

Thus, Terri found the warmth and positive reception at the Chemist preferable to the official provision of care. Note that the guidelines to provide "appropriate support and advice" typically in the Midwifery profession would not be understood as having suggested providing such advice with warmth or "positive vibes".

Francine found it inconvenient to not be offered written documents to prepare her to best cope with bottle-feeding. The solutions women found to such problems illustrate that the WHO code's preference for infant formula to be demonstrated only by health workers or other community workers is not working well in practice. The policy may have led to a 'gag' against

marketing workers providing demonstrations but it has not led to what mothers consider to be satisfactory educational standards for bottle-feeding and nor are mothers using health workers as their only source of information:

Francine (08): They don't tell you if the bottle-fed babies, you know, do they need extra water, do they need... it's only from listening to other people saying you should give your baby water, or they may get constipated. There's no actual documentation to say, you know, this is going to happen maybe sort of thing. That was hard.

Interviewer: So where did you get the information on bottle-feeding?

Francine: Just from family who've bottle-fed. My mum obviously, she bottle-fed. And just picking up bits and pieces along the way. Clinic nurses and things like that. And you know, making big mistakes and working them out sort of thing.

Anne, too, had discussed learning by making mistakes when complaining of her inadequate preparation. She was not given practical guidance in choosing teats:

Anne (04): teats ... That's a bit of a learning experience as well. No one tells you anything about that, you just have to learn by trial and error.

Additionally, Anne appeared to have taken up an inappropriate form of demand feeding with a bottle that made her baby vomit:

Anne (04): I made a mistake in the beginning because no one told me and I was stuffing him full of milk and then he was chucking up, and I didn't realise I was supposed to not do that ... I started going, what's going on, like, and they're going, oh no, you're not supposed to feed him that much milk, you're supposed to feed him this much milk, and wait 3 hours before you give him another bottle of milk. You find that information out once you've made a mistake.

Hearing bottle-feeding mothers describe that they had to learn by making mistakes, or stating that, in their opinion, useful sources of information were available to them because they were "lucky", is extremely concerning. Relying on being lucky (and therefore risking being unlucky) and requiring access to good lay sources of support, especially where group support for bottle-feeding is discouraged, is a situation far removed from women having the right to access from professionals the information and support they feel is adequate and appropriate.

Francine's desire for written advice led her to actually contact the formula company who then provided her with brochures:

Francine (08): We got some more information on the new S26 Gold that we wanted to try and found out if there were any complications, like constipation and things like that. Found out all about it ... I rang the company and asked them to send me some brochures.

Other women received more patient and more useful advice from sisters and mothers. The fact that sisters and mothers, if available, probably enjoy helping and are likely to have less time

limitations than professional Midwives do, needs to be taken into consideration. Nevertheless, some of the mothers discussed assistance from these sources with regard to strong criticisms they were making about the official provisions for them having been inadequate.

Imogen was grateful that her sister taught her rigorous and practical methods of bottle sterilisation:

Imogen (01): I do think they needed to be more... how to clean the bottles properly, when to change the solution, things like that which you just sort of take for granted, but when you've never done it before it's all totally new. But I was lucky again, my sister had bottle-fed her four children, so she came down and showed me how to use the microwave steriliser and how to clean the bottles properly, and just little things that I didn't know.

Claire commented on her disappointment with the hospital, stating that she really learnt about bottle-feeding from her mother:

Elizabeth (Interviewer): ... did they show you much about making up feeds and sterilising equipment in the hospital?

Claire (06): Well the midwife I had she showed me once and then she told me to go do it myself ... I was a bit disappointed with that.

Interviewer: Did you go through the whole procedure of making up the feed with you?

Claire: Yes. On the first day she did, but then I needed to be reminded. And that was it. She just said you can do it yourself now ... I stayed with (my mum) for the first two days I think, and she was doing all the Milton for me, showing me how to prepare it, when to change it, and making the bottles up and things like that because I had no idea. And then I moved out and did it all myself with my boyfriend. So my mum practically told me everything to do.

This section has shown that bottle-feeding mothers may often turn to other sources for support. While it is desirable for all mothers, whatever form of infant feeding they are using, to have social support systems, it is concerning that this study found the bottle-feeding mothers to be dissatisfied with professional services and, that for some mothers, their access to information they trusted appeared to rely on the chance of them having lay support. Furthermore, the various policies arguing for primacy of promoting breastfeeding appear to have been taken up in practice as postponing demonstrations of formula preparation. The profession should be mindful that not providing high standards of bottle-feeding information, advice and support can result in undermining bottle-feeding (and weaning) mothers' competence in caring for their babies, as indicated by the findings of this study. Having won the advantage of being the official provider of infant-feeding information, Midwifery health providers will need to deliver on the obligation they carry. This study's findings strongly indicate that that will require not just constraining manufacturing companies from what they previously undertook as their

educational functions, but should also involve improving the official Midwifery standards and delivery of bottle-feeding information.

### **Proposed information standards to meet bottle-feeding mothers' expectations**

The Midwifery field would benefit from developing its understanding of the mothers' right to make a fully informed decision. Much of the reticence to providing information appears to be based on confusion over the difference between marketing, which is controlled by a WHO agreement, and the important role of providing information for mothers' education. The standard demanded by bottle-feeding mothers is to be told the advantages and disadvantages of both breastfeeding and bottle-feeding. The information would have to allow for stating Midwifery's advice that breast is best, openly discuss well-researched issues including the contention in the field, and also allow a consumer perspective, based on research, such as stating both sides of what breastfeeding mothers have liked and disliked as well as what bottle-feeding mothers have liked and disliked.

Based on transcript data of identified flawed information, useful tips from Midwives and useful tips from other sources, the following is a summary of suggestions that may go some way towards meeting the criteria of the bottle-feeding mothers' information needs.

#### ***Credible claims***

Claims about immune properties, gastro-enteritis, allergies, intelligence, obesity, SIDS and other issues should show percentages of effects in both breastfed babies and bottle-fed babies, so that mothers can calculate the risk to their baby and the gain, if any, of choosing a specific feeding method.

#### ***Relevance***

- The information should also, as far as possible, indicate the relevance to the intended group of readers (for example, educated women living in metropolitan areas of First World — studies with similar populations, sanitation, disease and climate factors).

- Information about benefits and risks could be developed to assist this client group<sup>8</sup>. Some mothers reported being put off by the goal of feeding for at least 6 months. If outlining gains of breastfeeding, it could be useful to mothers if Midwifery research were to develop a chart showing not just the ideal 6 month outlook, but the benefits (or lack of benefits) and problems or lack of problems at specific milestones: for example, 3 days = colostrum; 6 weeks =?\*, 3/4 months =?\*, 6 months =?\*, longer = need iron supplements. This would be most useful if it were combined to show the milestone's relations to the range of risk percentages for conditions of obesity, asthma, SIDS and so on.

(NB\* No specific points will be developed for this suggestion. I did try developing such information to suit mothers' needs, but it is a substantial task requiring an innovative methodology. Most research has contentious findings so justifying using one finding rather than another is beyond the scope of the present study. Additionally, the statistical figures where given (significance/effect levels) do not always readily translate into understanding the real level of risk. However, as further research, this would be a useful development for the field.)

### ***Other information requested***

#### **Formula properties:**

- How to choose best brand
- Differences between brands of formula
- Cost

#### **Information on managing bottle-feeding:**

- Support phone number
- Age/size appropriate feed size range
- How and when to increase intake
- Proper cleaning of bottles
- Information about teats

#### **Managing conditions:**

- Thickened formula for reflux
- Lactose-free for colic

<sup>8</sup> The Linkages Project (2001) developed a pamphlet, Risks and realities: FAQs on breastfeeding & HIV/AIDS, for use by Health Professionals in poor countries with high HIV levels to assist mothers in making an informed decision about their feeding choice. It offers ways of calculating risk to a community by multiplying the risk of being infected by breastfeeding (14 per cent) by the percentage of infected mothers. This sort of calculation may be useful to health workers. What mothers in this study's context would benefit from is calculations of the risk or benefit to them according to their circumstances. The NHMRC and WHO recognise that mothers who do not wish to breastfeed require good information about bottle-feeding.

Accessories that increase convenience:

- Weaning dishes
- Microwave sterilisation of bottles

Some of the points included were raised by mothers describing information that improved their experiences of bottle-feeding. Others were tips gleaned from mothers, sisters and women down the road. A striking aspect of this list, however, is that the NHMRC guidelines (1996, pp. 55-60) include nearly all of these points. The guidelines document itself demonstrates the marginalisation of bottle-feeding information, amounting to six pages in a document where the rest of the hundred pages focuses on breastfeeding, and substantial appendices about the Marketing Codes and Australia's agreements are attached.

The mothers were strongly critical of bias in information standards especially in ante-natal classes, poor support for their own training in bottle-feeding, their experiences of making mistakes with formula and that sources other than Midwives held more credibility regarding bottle-feeding advice. These alarming findings show that the principle of "feeding with infant formula should be demonstrated only by a health worker or other community worker ... (WHO Code Article 6.5 cited in NHMRC, 1996, p. 55)" is vulnerable in a context where the profession withdraws its support rather than increases it. Whilst the NHMRC guidelines discuss that in Australia Chemists can play an important part in educating about formula, from this study it appears that hospitals and the Midwifery profession's interpretation assumes playing the least part, so that routinely Chemists are used as the referral point for information about formula feeding. By leaving Midwives' access to information about formula as an entirely personal decision, it exposes those Midwives choosing to stay ahead in the field to outrage by "Baby Friendly" professionals assuming that to protect breastfeeding all Midwives must refute bottle-feeding mothers' needs. This study has identified from bottle-feeding mothers that confusion arises, and has pinpointed areas of the policy that explain why this may be the case. However, it is outside the scope of the present study to establish the extent to which Midwives face tensions in this confusing area of bottle-feeding information in their work acting as antenatal educators, maternity carers, child health nurses or administrators informing hospital policy. Certainly, however, it appears that high standards are not applied systematically and may indeed be dangerously dependent upon the confidence of individual health providers to act wisely despite apparent contradictions.

It would appear that WHO/UNICEF anti-marketing principles are being misapplied and mistakenly generalised to the educational functions of Midwives. Furthermore, the minimal conditions for pro-breastfeeding "informed consent" to bottle-feed, of covering the benefits of breastfeeding and risks of bottle-feeding, also seem to be applied as the benchmark of standards and extent of detail for this service. As this chapter has shown, such a minimal approach is not considered to be of an adequate standard by this client group of bottle-feeding mothers. It does unfairly marginalise bottle-feeding mothers.

## **Implications for information standards**

- Professional discussion needs to occur, concerning the difference between marketing and educating, and addressing the guidelines' requirement for adult learning techniques. What is known, is that early education is better for retention of information, and that good training, early learning and group support aid self-efficacy. These adult learning principles are given primacy for breastfeeding education, but have secondary importance for bottle-feeding education.
- Unbiased information needs to be developed and should take into account the issues relevant to mothers (ie Western Australia is First World, and has mostly urban households with good sanitation).
- The Midwifery profession needs to develop better dissemination of information and training during the antenatal period for intending bottle-feeding mothers. Where upholding BFHI standards is a concern, information and training may be offered to women individually rather than to groups. Nevertheless pro-active steps will be required to increase the credibility amongst mothers that Midwives have expertise in bottle-feeding, and the problems of delaying dissemination of bottle-feeding information to assist mothers who change early from bottle-feeding. 1 mothers weaning their infants should be addressed.



## **CHAPTER 8 - Hospital Procedures' Effects on Midwifery, Mothers and Infant-feeding**

The focus of this chapter is on issues related to the bottle-feeding mothers' perceptions that service to them as a group was unsatisfactory in hospital settings. Individual experiences in this regard were by no means uniformly unsatisfactory, and the analyses will highlight some main problem areas, as well as aspects of service that they found satisfying. Bottle-feeding mothers are a minority of Australia's maternity hospital clients, however, their status as a client group is that they have specific needs that are different from the breast-feeding client group which must be met (NHMRC, 1996). Hospital systems should meet the needs of multiple stakeholders. It is in the procedures and practices of the system that enactment takes place of the "dynamic interplay" (Bandura, 1997, p. 485) in balancing the needs of all stakeholders. Therefore, in order to describe such interplay, the study's investigation into the Midwifery profession's own understanding of its role in infant feeding will also be presented and discussed. Since some of the mothers' interview responses, directly or indirectly, inferred that public hospitals were less supportive to bottle-feeding mothers than private hospitals, the study's observations of differences that might account for some private hospitals' better reputation amongst bottle-feeding mothers will be discussed. This chapter has particular relevance to the research question addressing the professional dilemma of deciding the best procedures to support mothers who choose to bottle-feed.

### **Bottle-feeding mothers' perspective of hospital procedures**

The interviews with bottle-feeding mothers elicited criticism and praise which will each be described in turn.

### **Mothers' criticisms of hospitals**

The bottle-feeding mothers' criticisms included unwelcome pressure on them at various stages, unsatisfactory education on making up feeds and sterilising bottles, poor provisions for bottle-feeding, and particular problems experienced by those women who elect to breastfeed but change their plans whilst in hospital. Some of the bottle-feeding mothers who were happier with their own hospital experiences saw themselves as especially capable of, or lucky in, having survived the system and they raised concerns about how other less strong or less experienced mothers would cope.

### ***Unwelcome pressure at various stages***

The bottle-feeding mothers' experiences in hospitals at particular stages, such as pre-admission interviews, during the birth and immediately following the birth, were times when interactions with Midwives made them feel under pressure. Jackie, for example, showed how the interactions at admission where she had felt negatively judged resurfaced for her at the time of delivery.

Jackie (10): I was 10 cm's and I had to push for the baby's head was high, and I didn't trust that she [the midwife] would be able to get me through because... I guess because she was so positive about breastfeeding. And she grabbed my hand and she said, we'll get through this. And I looked at her and I didn't trust her, because she'd questioned me about my feeding.

This kind of mistrust and misunderstanding between client and midwife is very concerning, not least of all because, as is shown in the transcript, a woman can close off communication with the midwife who would have had no idea of the mental torment suffered at this very vulnerable time.

The strong sense of Midwives working against the bottle-feeding mothers also intruded into what should have been the special first moments of a mother getting to know her child. For example, Claire described her experiences immediately following birth whilst still in the labour ward:

Claire (06): [In the labour ward] I said I'll have a bottle-feed. She took a while to get it... she wasn't very happy. My mum was there to sort of say she wants to bottle-feed, let her do what she wants. So they got me a bottle.

This mother found pressure intrusive and unacceptable.

### ***Unsatisfactory education***

Several of the mothers felt that even though they had been shown the basics of bottle-feeding in hospital, their education was not very thorough, and this applied to public and private hospitals. Claire's entire hospital experience was coloured by a sense of not being professionally supported.

Claire (06): ... the midwife I had she showed me once [how to make up a feed] and then she told me to go do it myself ... I was a bit disappointed with that. On the first day she [showed me how to make up a feed], but then I needed to be reminded. And that was it. She just said you can do it yourself now.

While Imogen was praising her hospital for not pressuring her and for being helpful with night feeds, she also raised reservations she held about the standard of her education.

Imogen (01): But there was no, make sure the bottles are really clean, in as much as, you know, you've really got to scrub the bottles rather than just give them a wash around, which is what I was doing thinking they were clean. No, when to change your solution. Even though it says on the thing when to change it, but that's all new, I didn't know about that.

Natasha praised the standard of support she had experienced in her hospital, explaining that the hospital provided all the bottle-feeding equipment and made up the feeds during her stay. But she too felt that she had not been adequately prepared.

Natasha (05): It was all there ... That was the problem. They didn't actually show you how to feed her or anything.

Education standards are hard to pinpoint, and uncertainty over learning something new or low levels of confidence by the learner may be unfair measures of the competence with which the education is delivered. Nevertheless, it was a point raised by several of the mothers and therefore warrants further discussion. All maternity hospitals would have care plans that include the basics of making up feeds, sterilisation of equipment and advice such as how solids should not be introduced too early. An explanation for such expressions of disappointment by mothers is that the overall standards of preparatory education have been reduced as other changes have taken place in maternity care. As pro-breastfeeding policies have been implemented, antenatal preparation for bottle-feeding has disappeared from classes with the result that the first briefing (or first demonstration, or first hands-on experience) many new mothers receive may be during postnatal education. This does appear to amount to a worsened situation for bottle-feeding mothers compared to previous times. If their education is offered just at the point when they are least able to retain learning (Bailey & Sherriff, 1992), it can lead to additional problems.

Lisa made a further observation that highlights another problem about bottle-feeding education with regard to current pro-breastfeeding policies.

Lisa (11): Mothers who change over to bottle-feeding after a few weeks really don't know anything, they don't know how to make up a feed, they just have to read it on the tin, or ask someone who is bottle-feeding.

To only demonstrate bottle-feeding procedures to mothers and family members are already doing it, means that the majority of mothers return home without having been shown the proper procedures of weaning their infant. The intention, of course, is to not make bottle-feeding appear normal. The NHMRC (1996, p. 58) guidelines emphasise the importance of ensuring that parents are sufficiently educated in bottle-feeding, given the findings that as many as 30 per cent of Sydney mothers make mistakes reconstituting formula. The guidelines state, "when in doubt, parents should check with an early childhood nurse, pharmacist or doctor" (p. 58). Prior to the recent policy changes, all mothers were given bottle-feeding education before leaving hospital, however, as Lisa's observation points out, its absence from breastfeeding mothers' care plans does not always result in the somewhat idealised WHO Code policy guidelines for professional demonstrations. That "feeding with infant formula should be demonstrated only by health workers or other community workers, and only to the mothers or family members who need to use it", makes the system vulnerable to error and poor service. In some settings, those "who need to use [formula demonstrations]" are defined as those antenatal instances where bottle-feeding has already begun. However, delayed and insufficient demonstrations caused dissatisfaction. Mothers needing demonstrations once home may have little interest by that stage in pursuing professional advice.

#### *Poor amenities for bottle-feeding mothers and their babies*

The mothers noted that the level of care and attention in hospitals was less for those bottle-feeding. Terri's comments implied that there were no hospital facilities aimed at helping this group of clients.

Terri (12): I think [mothers who bottle-feed] are ignored, don't get any help or information and are generally left to themselves.

Francine felt that the layout and routines of her maternity ward had caused her some inconvenience.

Francine (08): ...Because I had the caesarean I was laid up for 2 days, but after that I was expected to go and leave the room, you know, if the baby's crying because he's hungry, you have to get dressed, leave the room, go to the nursing station, get your own bottle, heat it up, and come back again.

Interviewer: Would the staff not have done that for you?

Francine: No.

Francine's description shows several ways that it made her hospital experience unpleasant. It forced her to leave a crying baby, and that is not ideal for establishing closeness. Bottles had to be made up individually, which is inefficient. It also reduced the opportunities she may have had to stay within the privacy of her own rooming area and therefore maximise rest and

recovery. Such inconvenience would have been reduced if, as in other hospitals, bottles had been brought to her. As equipment was not available in her own area, the requirements bore little relevance to how Francine was likely to organise bottles at home.

Claire felt that the Midwives had refused to assist her with breast pain.

Claire (06): I wanted tablets to dry up the milk but they wouldn't give them to me.

Although there are three medical ways to suppress milk (diuretics, Bromocriptine which is a Parkinson's Disease drug being trialed for this purpose, and oral contraceptives with no oestrogen), these are generally considered unsafe and are not recommended. Furthermore, they would have to be prescribed by a doctor. It is likely that Claire was expected to conform to the contemporary approach of avoiding nipple stimulation. It is beyond the scope of this thesis to investigate, or comment on, the relative risks of medical interventions in comparison to breast engorgement, or the extent to which the current advice may be intended to leave breastfeeding as an option. Nevertheless, this negative incident for Claire shows that she was not adequately assisted in preparing for bottle-feeding in that by expecting tablets she was obviously unaware of current practices.

This incident highlights the dangers of a pro-breastfeeding system that results in bottle-feeding mothers not understanding what will be expected of them. If a mother was adequately advised prior to giving birth, she would be in a better position to organise a prescription in advance. Antenatal advice by Midwives focuses only on breastfeeding, and information provided by hospitals prior to admission consists of pamphlets only about breastfeeding.

Anne, who attempted breastfeeding without success, was also inadequately prepared to cope with the situation. It was a problem for her that she felt inadequately supported in both methods of feeding.

Anne (04): when you're trying to find someone to give him a bottle when you know that you don't have enough milk to give to him, that was really hard. There was just no support, no support at all. It would take 15 minutes for someone to come down once you've pressed your buzzer to help you attach him. And once they get there to help you they'd get your breast and your nipple and shove the baby's face into your breast. There was just no compassion, no time spent with you, it was just like go go go, this is how you do it, learn how to do it.

Erica, the other mother in the study who changed very early from attempted breastfeeding, also felt that she had not been adequately supported to bottle-feed:

Erica (03): I think especially in a public system, hospital system, the Midwives and that don't have enough time to spend with you. If you do want to try breastfeeding the Midwives don't have enough time to spend with you, showing you exactly how to do it, how to get the baby attached and everything. I mean they give you a quick run down and that's all they've got time for.

Anne complained that instead of being supported in her decision to change to bottle-feeding she was forced to try expressing to start the milk flow.

Anne (04): ...you'll be sitting there expressing and there's absolutely nothing in the bottom of the bottle and I'm thinking... (laugh) my baby's hungry like you know, surely you're going to help me feed him.

She was shocked that her hospital made it so difficult to obtain formula.

Anne (04): ...if I'd have been like with it a bit more and thought it out a bit more I could've asked my husband to go to the shops and get me some stuff, but, when you're told, oh no, you've got to go back to your room and stick him on the breast again...

This mother felt doubly victimised. Firstly, she did not receive as good lactation support as she felt she would in some hospitals; and secondly, bottle-feeding provisions were kept from her.

### *Changed plans whilst in hospital or later*

The accounts of Erica and Anne, the two mothers in this study who had intended to breastfeed but for various reasons changed their minds show interesting parallels. Each of them seemed dissatisfied with poor levels of assistance while they were struggling to breastfeed.

Erica (03) (gave up breastfeeding not enough milk): [The staff] just sort of grab the baby's head and plonk it there and you know, if the baby's got it whether you feel comfortable or not.

Each of the mothers noted that the hospitals required mothers to bring in their own equipment, but there was not much preparation for these mothers.

Erica (03): I never actually went into hospital saying I'm going to be bottle-feeding. So no there was not really any information given to me. ... I think [mothers choosing bottle-feeding] were sort of shown where everything was and everything and basically you had to take your own gear in with you, your own bottles, your own formula and everything, and I don't know if they actually showed them how to do it. They were just shown where all the sterilising gear was and sort of this is what you can use.

For Anne, who had not expected to need her own supply of formula, changing to bottle-feeding was frustrated by the lack of assistance and obstructions to the change.

Anne (04): I just did not have the information and everything beforehand. Like they didn't say to you 'you know your milk might not come through for a couple of days', or 'you might need to bring in a bit of formula, if you go and buy yourself one of those little trial packs for \$3 at the chemist, you know, bring that in, and bring yourself a couple of bottles and a couple of teats and we'll supply the sterilising equipment'. You know, 'we'll supply all that, but just bring it in just in case you need it'. No. I wasn't told any of that.

The point made about not supplying formula to unprepared mothers needs highlighting. Mothers who intend breastfeeding and then do not, for whatever reason, feel tricked by the policy in some hospitals not to supply formula or teats. Not been advised to prepare for the event of failing at breastfeeding was distressing, therefore the hospital added to the feeding difficulties rather than efficiently and positively helping to implement the mother's subsequent decision to bottle-feed. It was discussed as an issue that could only catch out first-time mothers.

Some other fully bottle-feeding mothers were also critical of how the system appeared to have adverse consequences for babies whose mothers started and then gave up breastfeeding. Even if actions did not affect them or their babies directly, part of the hospital experience included noticing how other mothers and babies were badly treated and marginalised by the system. Lisa had been concerned about the level of suffering amongst other mothers on her ward.

Lisa (11): [Re: other mother in ward not being given formula] it's against their rules ... they are not allowed to offer mothers a bottle in hospital, and mothers are not allowed to ask for one either. ... The doctor needs to order it. ... unless you are all set [with bottles] it can be a long time before the baby gets a feed.

Erica spoke in defence of first time mothers against the pressure put on them to breastfeed when they do not want to.

Erica (03): I think a lot of mothers, especially new mothers, have pressure put on them in hospital... breastfeeding's first, breastfeeding's the best, breastfeeding's the only thing to do. And if it's physically not possible, or emotionally if they can't handle it, it's very difficult to get over if they've got Midwives and sisters putting pressure on them to do it when they just don't feel comfortable or whatever.

Some mothers talked about signing consent forms in the post-natal period for their baby to be given formula. Anne seemed intrigued by this requirement and was even sympathetic to hospitals wanting to cover themselves about liability issues.

Anne (04): And I noticed that they did give him formula once in the middle of the night and I had to actually sign to say that I approved that they'd given him formula in the middle of the night or something like that. So it's a real liability issue as well I guess.

The examples given above outline the mothers' dissatisfaction with levels of health care that they experienced or observed. In any service provision including health care and Midwifery, there can be a problem of unrealistic expectations by clients. That could not be readily clarified from this kind of data alone. However, several of these issues raised appear to be effects of conforming to hospital policies that promote and support breastfeeding without having sensitivity towards the particular needs and desires of bottle-feeding mothers.

### **Mothers' praise of hospital**

Praise by some of the mothers about their hospital experiences typically concerned services or staff attitudes that fitted well with the mothers' bottle-centric perspective of the advantages to them in bottle-feeding. Aspects that were praised included efficient administrative procedures, supportive staff attitudes, and night-time support for the mothers' quality of sleep.

#### ***Non-judgemental, efficient administrative procedures***

Although the reputation of Midwives pressuring mothers to breastfeed appeared to be far reaching and a cause of dread amongst mothers electing to bottle-feed, several mothers described a feeling of relief to have not been pressured and some mothers even felt supported. Hospital admissions procedures were quite widely discussed by the bottle-feeding mothers in this respect.

Donna did not perceive her admission procedures to be pressured. Although she had been given pamphlets about breastfeeding by the hospital, she felt that her decision to bottle-feed was accepted.

Donna (02):      When I went to the pre-admission at the hospital they gave us pamphlets and asked, would you prefer to breastfeed or bottle-feed, and I said, definitely bottle-feeding. And so, it didn't seem that there was anything else to say then. From them, from their point of view, oh you're bottle-feeding, that's fine.

Donna also explained that she had previously had bad experiences with breastfeeding. There was a perception by her and others that first-time mothers came under more pressure from Midwives to not choose bottle-feeding.

Another mother, Penny, strongly perceived that the administrative task of pre-admission, instead of being used opportunistically to pressure her into choosing breastfeeding, had been carried out efficiently by the hospital to ensure effectively supporting her choice of bottle-feeding.



Penny (07): [The Midwives] actually have a pre-admission interview a couple of weeks before you're due and they ask you questions about how you intend to feed and those sorts of things. They obviously ask you questions about medical conditions and stuff, but I thought it was good how they asked how you intended to feed. And they obviously take note of what's written in the notes because after she was delivered they actually checked with me that I was still definitely bottle-feeding. I actually never had the chance to give her her first feed, she was in the humidicrib after delivery. They fed her and there was no problems at all.

However, as Penny pointed out, the current reputation of Midwives is of being a force to be reckoned with when they pressure new mothers to choose bottle-feeding.

Penny (07) (continued): And I was actually... I was dreading going to hospital and having to cope with the Midwives giving me the third degree about why I wasn't breastfeeding (laugh). ... I was actually quite surprised by the attitude of the Midwives in the hospital, I never had any comments made to me or ask whys or wherefores.

For the Midwives to have been non-judgemental in administrative interactions was surprising to some of the bottle-feeding mothers as well as being an aspect they praised in terms of having benefited from efficiency in their hospital experience.

### *Supportive comments by staff*

This same mother seemed pleased with affirmation about her bottle-feeding decision by some Midwives.

Penny (07): And in actual fact some of the Midwives came up and were saying they were pleased that someone had the gumption to stand up and do what they actually [want] to do. And a couple of them turned around and said that bottle-feeding was far better off for the family as a unit rather than breastfeeding, it saves a lot of the resentment that husbands feel when suddenly it's mum and the child and the husband's on the outer.

To pro-breastfeeding Midwives such anti-breastfeeding comments might appear extraordinarily unprofessional, if not opinionated, even though the phenomenon is documented in the literature. Yet, anti-bottle-feeding discussion, about how breastfeeding diverts from the traumas of poorer health, worse parenting, lower intelligence and so on, is routine and considered acceptable.

### *Night time support*

Two mothers, one from a public and one from a private hospital, both praised the Midwives for caring for their babies over night.

Imogen (01): I didn't have him at all, which was another advantage, you know, I'm in hospital for six days and never fed this baby once at night. BEAUTIFUL. Sleeping tablets (laugh). ... And like one midwife at

night time, I said, you know, about the fifth night or something, I said, maybe you should wake me up, maybe I should feed this kid at night. And she said, Why? You're going to have him when you get home, we'll take him, he's bottle-fed, don't worry about it, you get a sleep.

Imogen was very grateful for the extra sleep, and also appeared impressed that the midwife had put her at ease that the baby could be cared for because he was bottle-fed, and therefore she should use that advantage of bottle-feeding. Penny similarly, was pleased about the convenience of having her baby cared for at night while she slept:

Penny (07): I also found that the Midwives were quite happy to take (baby) of a night. I'd do a last feed at midnight say, and it was good that I could actually wheel her into the nursery and then get a good night's sleep. And I knew that come 6 o' clock they would wheel her back in again, when she woke up for the morning feed.

Note that the inferred health care goals of recovering after the birth underlying these accounts, of feeling strong enough to cope once at home and having rested to assist recovery, were supported by the Midwives and those goals are compatible with getting good sleep. This was in fact an advantage of bottle-feeding, that, as Penny notes, did not apply to breastfeeding mothers.

Penny: (continuing) Whereas the breastfed babies' mums would do that, but then the Midwives would have to wheel the baby in, wake up the mums so they could feed them. So they weren't achieving anything, they weren't actually getting a decent rest.

The above examples illustrate how there was praise by some of the bottle-feeding mothers, and this occurred for both public and private hospitals. What these analyses of bottle-feeding mothers' criticisms and praise have shown is that these mothers' experiences and levels of satisfaction were varied. While some mothers were pleased with aspects of hospital practices that suited their bottle-feeding decision, more mothers were critical of practices they experienced in hospital that did not suit bottle-feeding.

Based on the mothers' descriptions, it would seem as if hospital experiences vary from being very disappointing and frustrating to being praiseworthy. However, in general, the levels of satisfaction depend on a few main factors. One is whether mothers perceive that their decision to bottle-feed is respected or not, typically based on their treatment at admission, whether or not their decision is supported or challenged in the labour ward, and in the levels of helpfulness staff show towards them whilst establishing feeding. Another factor is the perceived levels of even-handedness by Midwives and hospital policy, for example, damaging perceptions of spite can arise over disagreements about breast care or difficulties in obtaining formula when mothers decide to give up breastfeeding. A further factor is bottle-feeding mothers' perceptions of how

hospital facilities match up to their needs, for example, nursery care was appreciated, and convenience of bottle-feeding equipment and adequacy of bottle-feeding education seemed to be important to the mothers.

### **Investigation of professional perspective of hospital practices**

Phase Two of this study, which explored the construction of Midwifery knowledge through participant observation and content analysis of professional information lends support to the bottle-feeding mothers' opinion about the dominance of pro-breastfeeding practices and policy. Evidence of this may be seen in the areas (1) professional forums; (2) professional contacts' attitudes; and (3) how hospitals are shaped for particular client groups, which will be discussed in terms of their shaping of Midwifery practices.

Of interest is the degree to which pro-breastfeeding policies and practices are supported professionally, at the level of the organising bodies of professional Midwifery groups and from the perspective of influentially-placed individual professionals, such as Nursing Directors. Context also makes a difference. In this study, it was found that mothers perceived a difference of standards in attitudes amongst different hospitals, with some perceiving greater pressure in the government sector of hospitals and more support for bottle-feeding mothers in the private hospitals. However, one of the two mothers in the study who was a failed breast-feeder also claimed that her friends received better lactation assistance in a private hospital than she had received in a public hospital. As such the difference across sectors was of interest in the participant observation stage of the research.

### **Professional forums shaping Midwives' practices for care**

Professional associations are a useful sources for gauging and describing dominant discourse, since it is a professional objective to develop and disseminate information. During the period of this study, Australian professional Midwifery journals continued to report on BFHI progress in different Australian states, celebrating success stories. There was no debate of the concerns of bottle-feeding mothers. My attendance at meetings coincided with my first experiences of incidentally mentioning to Midwifery colleagues that my research focus was mothers' experiences of *bottle-feeding* (i.e. I was not researching breastfeeding). It was clear that some of my peers were stunned and appalled to the extent that one long-standing colleague even commented, "Do we want to know you?" This was a sharp reminder that observance of BFHI principles was a requirement to be accepted in the group. Meetings rarely focused on infant

feeding issues, although notes were made of changes in other countries or states. The BFHI received some administrative attention such as mention of progress and needs for monitors and assessors. Meetings were generally more pre-occupied with the imperatives of advancing a professional association. Specifically, there were urgent concerns about recruitment matters, that were considered potentially to have the capacity to deprofessionalise Midwifery, and legal developments on home birth issues.

Meetings of professional associations, not surprisingly, attract some of the field's most committed members. Their goal is to improve infant and maternal health. Professional Midwives see themselves as epitomising caring. So what did these forums suggest about Midwives' views on the marginalisation of bottle-feeding? Firstly, the group is apparently united in its support, and in many cases its passion, for the BFHI's advancement of breastfeeding. They are, however, treating BFHI's principles and imminent future growth as a *fait accompli*. Heated debates over infant feeding took place many years ago, but breastfeeding is now an uncontested discourse. Raising bottlefeeding issues, as I was, raked over old, tired ground in an inappropriate context. Participation in such professional groups carries a burden of responsibility and a time-consuming commitment. Questioning attitudes to bottle-feeding would have inappropriately threatened the smooth running of meetings, which brought together a time-pressured group of over-stretched volunteers who wanted to stay focussed on their agreed directions in order to meet their many and varied responsibilities.

In summary, the local professional association meetings were set on course and could ill-afford the time and energy to question the principles behind the BFHI. This was a result of time, rather than any predisposition to not care. Ruzak (1978, cited in Hunt, 1994, p. 225) described the stages in social movements. These are (1) consciousness-raising, (2) policy determination, and (3) institutionalisation. It would seem that in Australia, and most probably globally, the breastfeeding movement is firmly in the third stage.

### **Professional contacts shaping Midwives' attitudes for care**

Members of professional association groups would typically hold the most identifiably 'professional' attitudes within the profession including a commitment to developing and upholding policy. Professional associations, like policy documents, represent 'idealised' views with a coherence rarely achieved in real hospital contexts. The association meetings appeared to mirror the dominant "impenetrable" breast is best discourse (Seidel, 2000), but some of the same people from the group held key professional positions in hospitals, and on an individual

basis were more amenable to giving slightly different perspectives on the implications as they understood them of the pro-breastfeeding policies.

I approached some of these professionals directly to investigate the differences between public hospitals and private hospitals. Questions asked included, "What percentage of mothers leave this hospital breastfeeding their babies?", "Is this hospital BFHI or not?" and "Is this hospital striving towards the BFHI accreditation?"

At the time of the study, government breastfeeding target rates were 90% at hospital discharge. An immediate difference in investigating this was that public hospitals all responded to the question, most giving over-estimated figures such as 93% that they then corrected downwards into the 80 per cents<sup>1</sup>, although one public hospital claimed they were not allowed to give out figures. In comparison, private hospitals avoided giving out figures, although one hazarded a guess at "about 90%". Two of the private hospitals contacted stated that they were not striving to become BFHI accredited – in one case the reasons given were that mothers needed the nursery and used dummies, and in the other case, the explanation was that the Midwives would have liked to, but the doctors would not let them close down the nursery.

At the time, for the whole of Western Australia, only one government hospital was BFHI-accredited and a further three government hospitals were considered to be close towards achieving accreditation status. These are very low rates, and one key player attributed the slow progress of the policies to Western Australian hospitals being parochial and predicted that many would follow suit once the additional accreditations showed the viability of BFHI for this state.

### **Hospitals shaping Midwives' caring: Questions of sector**

I made some telephone enquiries and worked on a variety of maternity wards as a participant observer in order to understand issues arising from the interview data: Are government hospitals more pro-breastfeeding than private hospitals? Can any differences be accounted for in terms of different resourcing levels? Whilst on duty, I looked for overall patterns and differences relevant to bottle-feeding procedures.

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<sup>1</sup> These downwardly adjusted figures accord more closely with Donath and Amir's (2000) analysis of rates prior to 2000 being below the government targets of 90%. What is also interesting is that amongst maternity staff on maternity wards who were not in administrative positions, many in non-BFHI hospitals also over-estimated breastfeeding policy: Several Midwives, in casual comments, appeared to strongly believe that the non-BFHI hospitals they worked in were already BFHI-accredited.

### *Observations of three types of maternity ward*

The observations will be presented as composites of three different types of maternity ward: — (1) a pro-breastfeeding private hospital, (2) a near-BFHI public hospital (ie aiming for accreditation), and (3) a pro-bottle-feeding private hospital. Max Weber's work suggests that "ideal types" are a starting point for research and provide a framework for specific instances. Initially I had expected to find mainly binary public and private sectoral differences. However, it appears that most government hospitals will more uniformly and overtly support the BFHI principles, whereas more clear distinctions are observable in the private sector. My observations compared how staff made sense of their environment and their Midwifery culture, how resourcing levels of the equipment and staff support affected services, and how each hospital offered nursery services.

At the pro-breastfeeding private hospital, ante-natal mothers enquiring about what to bring if they are bottle-feeding are told that nothing is needed as everything is provided. However, if they have special bottles they would like to use they should bring those in. At the near-BFHI public hospital, mothers are told that if they have attended the bottle-feeding class they should have a sheet listing things to bring in: Mothers *must* bring in their own formula, and the hospital does not advise the use of dummies but they can be brought in. The hospital also provides bottles but mothers can bring their own to use. When requesting advice on what kind of formula to bring in, the response is that they cannot advise because that would be seen as supporting particular companies, but Chemists may be able to make a recommendation (i.e. NHMRC (1996) guidelines are followed to the letter). At the pro-bottle feeding hospital mothers are advised that everything will be provided.

Therefore, whilst all hospitals allow for bottle-feeding and the use of dummies, there are differences in the attitudes and practical support for bottle-feeding. Midwives aiming for the highest professional standards would rank those hospitals in reverse order to the bottle-feeding mothers' ranking.

To the bottle-feeding mothers, the near-BFHI hospital is superficially polite, using their request for information as an opportunity to subtly tell mothers they are doing the wrong thing. It is unhelpful in that it cannot or will not even advise on the choice of formula. It is uncaring in that it does not even provide the basic necessity of a simple menu item for its smallest, most vulnerable patients. Bottle-feeding mothers, interviewed for this study, complained that the hospitals helped them but in actual fact they do not want to. The BFHI policy is, after all, designed to persuade mothers to choose breastfeeding, but has little more to say about

supporting those mothers who will pursue the choice to bottle-feed. On the other extreme, the pro-bottle-feeding private hospital is considered by bottle-feeding mothers to be sympathetic to their needs.

The pattern of differences continues in the hospitals' practices regarding levels of support for exclusive and non-exclusive breastfeeding. Once mothers have begun bottle-feeding their choice is quite firmly established. However, with breastfeeding practices it is more complicated in that some mothers will want to express milk or have feeds supplemented by formula "top-ups", for various reasons. It is these less definite situations, where the options are more contentious in the Midwifery field, that the hospital policies led to differences in approach. The pro-breastfeeding private hospital would be pro-active in telling a mother with bleeding nipples to "rest her breasts" and would tube-feed the baby so that its sucking patterns did not develop to reject the breast in favour of artificial teats, whereas the near-BFHI public hospital would encourage the mother's perseverance in order to not threaten the milk supply unless the mother herself adamantly refused to tolerate the discomfort. I observed how one mother, known to be a heroin-user who had taken Speed before delivery, was treated very respectfully with a midwife patiently assisting her to position the baby correctly, helping the baby to latch on, and giving the mother lots of praise for trying and encouraging her. The baby (that was nicknamed amongst staff as the 'Speed baby') had to be administered phenobarbitone and be monitored. It is notable that the present WHO position on this would recognise drug problems as contentious, and many American hospitals would be unlikely to recommend breastfeeding by a drug-user. In the near-BFHI hospital, there were several drug-addicted mothers. When I made a collegial query about whether bottle-feeding would be recommended, the response was that this hospital never recommends anything other than breastfeeding. In stark contrast, the pro-bottle-feeding hospital would routinely offer breastfeeding mothers the opportunity to have their babies taken to the nursery while they slept at night and the babies given "top-up" feeds of formula to prolong their sleep. Thus there were observable differences between both the attitudinal levels of enthusiasm for the use of breast or bottle, and the practical levels of facilitating easy accessibility or barriers to the use of formula and artificial teats.

The most noticeable factor which has been used in this chapter's definitions of types of hospitals, and which appeared to have the greatest differentiating influence between maternity wards, was the balance between rooming-in and nursery care of babies. A typical busy night shift will be described for each of the three types of hospitals observed, comparing work-load, the main functions of the nursery, and the effects on feeding outcomes.

<b>Comparison of night shift on three types of maternity ward</b>			
	<b>Pro-breast Private</b>	<b>Near BFHI Public</b>	<b>Pro-bottle Private</b>
<b>Staff</b>	1 on delivery, 3 on wards + partial rotated duties in nursery	Delivery ward in separate section from ward, 4 on wards	1 on delivery, 1+ 1EN on nursery, & 2 answering ward bells
<b>Patients</b>	20 mothers*: 3 ante- natal & 17 with babies, + 6 babies without resident mothers, transferred from neo- natal unit of children's hospital	28 mothers: 5 ante- natal & 23 with babies (NB Maternity ward separate from hospital's sick baby unit. But, jaundiced babies rooming in under lights, newborn twins rooming-in, babies of various drug addicted mothers including "speed" baby rooming in.)	30 mothers: 4 ante- natal, 9 with babies rooming-in, 18 babies in nursery.
<b>Nursery functions</b>	Care of 6 recovering former neo-natal care babies, fed with expressed milk or formula.  2 breastfed babies baby-sat but not to be nursery fed.  One breastfed baby tube-fed while mother advised to rest bleeding nipples.	0 resident babies. 1 baby warmed for 30 minutes.	10 nursery-care babies being just born, very small or sick. 8 nursery-babysat babies: 2 breastfed with note to take to mothers at 7.30 am; 2 breastfed being given formula top-ups; 2 bottle-fed; 2 newborn babies to be breastfed but given formula overnight.

In the pro-bottle-feeding private hospital, the staff ratio was slightly better than the other hospitals and the night shift had a sense of quiet order. The nursery was used mainly for babies who had returned from specialised neo-natal care to the mother's private hospital after the mothers had returned home. Thereafter, it was used to support breastfeeding mothers allowing them to have a rest where necessary in order that the mothers would cope later with breastfeeding demands.



In the near-BFHI public hospital it was very rare for mothers and babies to be separated, even to the extent of sick, jaundiced babies being treated in rooms with the mothers, where the bright lighting around the mothers could concern some health professionals, and, as described above, even where mothers were drug users. The nursery was a relic of hospital architecture used mostly as a communal store room, and most of the Midwifery work was done in the wards especially assisting mothers to achieve breastfeeding. Staff morale was high, reflecting a strong sense of achievement in following the professional wisdom in difficult circumstances. This account will also describe two examples of Midwives' enthusiasm to put in extra effort that supported breastfeeding. One was the "Speed" baby being fed the mother's expressed colostrum by syringe (which is more time-consuming than feeding with a bottle and artificial teat but helps babies to not reject the breast later); the midwife enthused loudly about how good this was for the baby thereby encouraging the mother, who seemed to visibly grow in confidence and was successfully coping suckling the baby herself within a few hours. Another example was a different midwife setting off to collect a mother and twins from the delivery suite. She joked that the only way she could cope on such a busy night was if the mother bottle-fed, but this was said in such a way as to convey professional pride in recognising that breastfeeding took time and care to establish and she knew it was her role to encourage that if at all possible. That mother was indeed also supported that night to successfully suckle her twin babies. Mothers who did use formula had to sign for informed consent, as recommended by NHMRC (1996) for all hospitals. However, this type of hospital's form had more time-consuming procedures to produce and enact for every bottle of formula. Additionally, the form used included a lengthy statement about the hospital's pro-breastfeeding policy. Not all mothers read the form, but from the perspective gained from the interviewed mothers, this was a marginalising ritual that advised mothers that they were not doing the right thing by their babies and asked that their agreement be signed thereby confirming that they did this knowingly. Such a focus on a policy, which is not designed to suit their needs, would have contributed towards their resentment of Midwives.

In the pro-bottle-feeding private hospital, it was much more likely that mothers and babies would be separated both in terms of treating babies with health or development issues, and especially as a babysitting service to mothers. In the interviews, two of the mothers who spoke glowingly of aspects of their hospital experience referred specifically to this service that allowed them a break to sleep. Midwifery management saw their role as being client-oriented, and staff conveyed to mothers that it was their job to make sure they left hospital well-rested. Compared to the near-BFHI public hospital, which had comparable staffing and patient ratios, the workload was chaotic and stressful. Compared to the other public and private hospitals' orientation towards rooming-in there were an extra eight babies being fed, changed, and

comforted by staff rather than mothers. This latter point may well be an expected outcome of a private hospital's client focus, except it had the effect of forcing some corners to be cut by staff, in this case at the expense of breastfeeding mothers' needs.

Two examples of the disadvantages to breastfeeding mothers and babies will be described. On a fairly busy night the midwife in charge of the nursery set about in the evening to prepare for a mother and newborn baby to be returned from delivery. She ordered that the mother be administered a sleeping tablet and the baby be brought to the nursery where it would be fed formula. In response to my query about the mother needing to breastfeed, she was emphatic that the particular obstetrician involved would "go mad" if the mother did not sleep. There was a stamp at the ready in the nursery for gaining mothers' consenting signatures. Although it was about 10.30 pm and the mother could viably have been helped to breastfeed and thereafter be administered the sleeping tablet, it was clear that the nursery could not be left understaffed for any longer than absolutely necessary and so bringing in the newborn baby was the most time-effective solution. It is disturbing that the mother was compliant in agreeing to procedures but in the morning was confused and distressed that her baby had not been brought to her to feed at night. She was also quite docile in accepting an explanation that in this hospital they always make sure the mothers get sleep. The hospital did have lactation consultants on day shifts who may have been able to help mothers in situations like this, but the procedures were far from what is known to be ideal for establishing lactation.

The second example was that by very early morning the nursery midwife had to prioritise her tasks. Without discussion she wrote instructions on some paper napkins, "Don't wake mother before 7.30", and placed them on the cots of two exclusively breastfed babies who were being looked after in the nursery. One of the babies was unable to be pacified for the period of approximately four hours until then and had to be taken to the mother at about 6.45am. While this might seem an unremarkable event, it illustrates that the stress levels for staff were high, and any short-cut that kept staff in the nursery rather than releasing them to the wards needed to be taken out of desperation to cope with all the babies in the nursery. The time of 7.30am may not have been arbitrary since it coincided with the shift change-over and thus re-allocated the task to the day staff. The significance of this is that it demonstrated that priority had to be given to ensuring that bottle-feeds, including top-ups to breastfed babies, were completed since those bottle-feeding tasks had undeniably been assigned to the nursery. Whereas, tasks on wards for those breastfeeding mothers who expected their babies to be brought in as soon as they were ready to feed again were the only ones that could be delayed without as much direct accountability. My observations would also suggest that such actions were seen as a necessity based on the intensity of work in feeding so many infants in the nursery. It is doubtful that it

was based on actions reflecting a pro-bottle-feeding professional judgement by individual Midwives. As an example of how individual staff might be pro-breastfeeding in that hospital, at the beginning of the night shift, one staff member who should have handed-over stayed behind for an hour to settle a baby with expressed milk using a cup and spoon. The problems of an excess workload in comparison to staff: feeding ratios in hospitals with strong rooming-in policies, indicate one aspect of how hospitals orientate more towards one group than towards another. The problem, caused by a hospital policy that favoured nursery services to rooming-in but did not employ sufficient staff to cope with the nursery demands as well as have staff adequately assisting breastfeeding mothers, oriented itself (at night time) more towards supporting bottle-feeding mothers in ways they would find satisfying, but which may have marginalised the other group.

Participant observation suggests that the greatest differences in hospitals, that might explain the different perspectives of the mothers, lies in the different orientations of the hospitals to interpreting the policy, more than sectoral differences (ie public vs private) or differences in resourcing levels. Many public hospitals, especially those aiming for BFHI accreditation are oriented towards a pro-breastfeeding policy — with exacting standards of rooming in, few dummies/pacifiers, and nurseries used only occasionally for low-demand communal resources such as weighing machines and warming machines, and storage of nappies. There are also private hospitals that are pro-breastfeeding, although not to such exacting standards. Subtle differences such as freer use of dummies, formula being available for “top up” feeds with less fuss and more at the mothers’ discretion are common in private hospitals, and rooming in is encouraged in pro-breastfeeding private hospitals, although if mothers request it babies can be brought out to the nursery. In the pro-breastfeeding hospitals rooming-in is encouraged even for bottle-fed babies. In contrast, some private hospital nurseries are hubs of activity at night, with most babies being bottle-fed or supplementary fed while the mothers sleep, or they are venues for babies to be changed and watched and from where, to varying extents, nursery staff follow mothers’ requests for babies to be brought to them at feeding times. It is hospitals fitting the latter description which two of the interviewed bottle-feeding mothers praised for allowing them to sleep, and which are defined here as being pro-bottle-feeding due to the lack of adherence to Midwifery policy guidelines, and unfortunately also the compromising of establishing breastfeeding for willing mothers in some cases.

A surprising finding was that although most hospitals are aware that breastfeeding targets are considered to be signs of successful management, several private hospitals in Western Australia do not appear to consider that accreditation will benefit them if it means compromising their client-focus. In fact, in some hospitals the use of nurseries is insisted upon by doctors who may

well see that as the marketing-edge and standards of service that private hospitals have over public hospitals. There is a trend to relax BFHI standards in terms of allowing some limited use of pacifiers and supplementary feeds rather than exclusive breastfeeding, but this will still not encompass the specific nursery issue that private hospitals are unable to give up. The accrediting claimed by Midwifery through the BFHI is therefore somewhat diminished, and highlights an issue for Midwifery that the balance between policy requirements and Midwifery's potential influence need to be appropriate to community standards or risk becoming ineffective. There is government backing of \$4 million to implement staff training and promotion of breastfeeding, but more time is needed to see how far that might influence private hospital policy orientations in Western Australia.

The findings about professional and hospital procedures need consideration in relation to the full picture of infant feeding practices. Current policy, based on UNICEF/WHO (1989) Ten Steps to Successful Breastfeeding and BFHI guidelines, encourages hospitals to promote breastfeeding at every possible stage of contact and includes procedures to encourage breastfeeding within half-an-hour of the birth. It appears that in the near-BFHI pro-breastfeeding hospitals, or at least with some Midwives, this professional recommendation is attempted even with mothers who state their preference to bottle-feed or have put their choice to bottle-feed in writing. Not surprisingly, such attempts to ignore their election to bottle-feed were perceived by the mothers as undue pressure. The reputation of Midwives for acting in this way was more widespread than the practice, but it did occur. It indicates a failure to recognise the provision in the policies for informed consent that allows mothers to choose and be supported in bottle-feeding.

Most professions draw boundaries for what are acceptable practices and they refer clients wanting or more suited to other services to practitioners in different fields. For example, chiropractors offer bone manipulation whereas mainstream general practitioners offer anti-inflammatory drugs to clients suffering back problems, and psychologists offer counselling whereas psychiatrists offer drugs to clients with mood disorders. However, the Midwifery profession is not in a position to distance itself from bottle-feeding. Under health care structures in Australia, Midwifery has two client groups for which it is responsible for establishing infant nutrition. There are its breastfeeding clients who follow the preferred method of infant feeding, and then another 17-23% of clients in Australia who bottle-feed.

The present situation in hospitals appears to be that one group's needs are being met at the expense of the others' needs. The dominant discourse has trialed and developed optimal breastfeeding strategies in the Baby-Friendly Hospital Initiative, however, that policy is

presently almost oblivious to the specific needs of bottle-feeding mothers. That is not to say that the practices in all hospitals marginalise their needs. Bottle-feeding mothers appear to be most impressed where maternity ward policies allow night time nursery care for babies. However, those hospitals which run tightly staffed night-time nurseries do appear in some ways to be compromising the conditions for those mothers who wish to breastfeed their babies and who are also encouraged to use the nursery.

The dominant discourse would argue that since breast is best, any advantage of hospital care should go to breastfeeding mothers. However, that suggestion is highly flawed because, as this present chapter has shown, pro-breastfeeding policies in some hospitals have marginalised bottle-feeding mothers, leaving them feeling dissatisfied in ways that reflect badly on the Midwifery profession. When considering problems such as the plight of mothers who bottle-feed and have not been prepared for what to expect or how best to cope, their plight contrasts markedly with the current antenatal preparation for breastfeeding which has exemplary standards. Recent developments for women intending to breastfeed mean that, routinely, they are advised in advance about such things as avoiding nipple soreness and other breast pain, and they are guided by specialist lactation consultants. By comparison, the Midwifery profession has made no recent advances in the care practices supporting successful outcomes for clients who have chosen to bottle-feed their infants.

### *Suggested future directions for hospitals' bottle-feeding services*

It would seem that major improvements in services for bottle-feeding clients could be made even within the main thrust of BFHI types of policies. The BFHI requires a written policy for breastfeeding, but what does not appear to be widely appreciated is that this does not exclude hospitals from also having policies for bottle-feeding. The BFHI explicitly does not and cannot prevent the bottle-feeding choice although it requires informed consent.

What is a bottle-feeding policy likely to look like? Based on the findings of this chapter, and with the intention of staying close to BFHI and NHMRC requirements, I will offer several tentative suggestions that of course would require further investigation and discussion in the field. The suggestions are mostly intended to serve as a clarification of opportunities to provide a very high standard of services to this bottle-feeding client group. Many of the opportunities already exist but may be applied haphazardly with the result that many bottle-feeding mothers feel inadequately supported.

***Suggested directions for bottle-feeding policies to complement BFHI breastfeeding policies***

1. Mothers' rights to be supported in their informed choice to bottle-feed should be respected, and this should not imply that the hospital in general is not pro-breastfeeding.
2. Informed consent includes having been advised that breastfeeding is recommended and having been informed of the risks associated with bottle-feeding and benefits of breastfeeding. It is a two-way process that also allows health providers to ensure that they uphold each mother's decision.
3. Information provided by professionals should be factual, and should include levels of contention and levels of relevance to specific client groups. Therefore, full information will not be limited to the informed consent requirements but can include anything in the field that is backed by rigorous research and has not been discredited.
4. Hospital administrative staff and Midwives need to understand when and how to deal with bottle-feeding clients in ways that are even-handed and that avoid pressuring or marginalising the clients.
5. Useful, up-to-date and thorough preparatory education needs to be developed for bottle-feeding, including discussion of breast care for non-breastfeeding women.
6. Supporting educational pamphlets on bottle-feeding with practical advice and well-developed illustrations should be available to ante-natal clients and in maternity hospitals. However, support materials should observe the NHMRC rules of not promoting specific formula brands and not using misleading wording or idealised images of bottle-feeding.
7. Antenatal demonstrations to individuals of making up milk substitute formulas and sterilising bottle-feeding equipment must be pro-actively offered with minimal inconvenience to prospective bottle-feeding mothers.
8. Care plans should have upgraded standards of bottle-feeding education, minimising administrative inconveniences of informed consent, allowing for repeated demonstrations or supervised practicals until mothers feel confident, especially for mothers in hospitals that provide made-up formula, and paying particular attention to the practical and educational needs of mothers changing from breastfeeding.

9. Provisions suited to supporting bottle-feeding can be offered. Sleep support through nursery care can be made available to this group of clients. Improved provisions should be designed and developed, for example, mobile trolleys for individual preparation of formula, bottle-heating and equipment sterilisation could allow bottle-feeding mothers and babies the same levels of convenience, efficiency and privacy as afforded by rooming-in when breastfeeding. Midwives may choose to develop high levels of knowledge to support bottle-feeding and their skills should be recognised and not penalised by hospitals or the Midwifery profession.
10. Where services suited to supporting bottle-feeding are implemented, full resourcing needs to be allocated to ensure that resources for breastfeeding support are not jeopardised, and *vice-versa*.

The need for good infant feeding support, not only for breastfeeding but also for bottle-feeding, is not new, of course. It was even stated in the original WHO Code. For example, Article 4.1 states that governments should be responsible to plan, provide, design and disseminate information, and it listed areas of responsibility including "where needed, the proper use of infant formula, whether manufactured industrially or home prepared" (WHO, cited in NHMRC, 1996, p. 66). It is the failure to develop this part of the policy into system-wide improved practices consistent with contemporary expectations of service that accounts for most of the differences and difficulties in mothers' experiences. For many of the mothers, support is simply common sense. For example, Erica added in writing the following clarification to her transcript:

Erica (03): Perhaps an idea for maternity hospitals [is they] should have a Breastfeeding Team who would go around and take the time to teach mums how to breastfeed in a comfortable relaxed manner, not rushed. This would take work off the nursing staff and make new mums especially more relaxed. They could also have information and do practical run-throughs of sterilizing bottles and making up formula for mums who choose to bottle-feed. Even though they can read the instructions on the formula tin it can be daunting for someone who hasn't done it before. I think a bit more support for new mums is so important for their self-esteem and confidence, which in turn reflects on the baby.

There appears to be uncertainty and contestation over the extent to which Midwives must pursue their duty to promote breastfeeding before accepting and enacting their seemingly contradictory duty in supporting mothers who make the informed choice to bottle-feed terms. Ongoing confusion prevails, with hospitals and Midwives responding to vague clauses such as "where needed" to establish their approach to servicing this group. Such uncertainty in some cases may make the service provider stake-holders cautiously place limits that are too extreme. The vast focus in policy and development being on breastfeeding, has played a major part in

establishing conditions preventing or "gagging" open discussion of the need for improved services to the bottle-feeding client group. As such, what appears to underlie most of the problems is a lost understanding about the importance of supporting the client group of informed and consenting mothers who wish to bottle-feed. The original contribution of this study regarding bottle-feeding support is its extrapolation of common areas of confusion and suggestions as to how solutions may be approached. The study highlights that the bottle-feeding client group can indeed benefit from its services and offers suggestions for how Midwifery may begin moving forward. It proposes developing Midwifery services for infant-feeding that respond to the diverse needs of both broad groups of infant feeding clients. However, such a proposition will be extremely challenging to meet since that will involve overcoming what are now institutionalised marginalising practices for bottle-feeding.

### **Implications for hospital procedures**

- Hospitals, in conjunction with relevant individual Midwives, regional bodies and government organisations as necessary, should develop methods of providing exemplary services to both client groups, breastfeeding mothers and bottle-feeding mothers.
- It will require more sophisticated strategies at the hospital level than appears to presently be the case. Recognition that both types of infant feeding can be supported well, but the facts that the mothers in different client groups will have different needs, such as information, and arguably nursery rest provisions, and that those needs require proper resourcing, must also be considered.
- However, several improvements to redress situations where bottle-feeding is marginalised, may be easily achieved with a better understanding of the scope of current policies. For example, the need for a written breastfeeding code does not preclude the need for a complementary bottle-feeding code intended to provide a high standard of service to this client group.



## **CHAPTER 9 - Summary of findings, Implications for practice, and Proposed Caring-Options-Responsive model for Midwifery Services**

This summary chapter reviews the findings of the thesis, draws together the implications for practice, makes suggestions for further research, makes recommendations to improve client satisfaction, and outlines a proposed Options-Responsive-Care model for Midwifery services in overseeing the establishment of infant feeding.

### **Review of findings**

The study has listened to the voice of bottle-feeding mothers and has found them to be intelligent and caring mothers who have made a considered and coherent decision to bottle-feed. It has also found that bottle-feeding mothers feel marginalised by Midwives, and investigations of this suggest that it has become enshrined in Midwifery policy to cater to breastfeeding mothers. In practice, this results in professionals not giving as much care in terms of relevant information and support resources to bottle-feeding mothers. As well, the current "Breast is Best" (BFHI) movement is shown to be deriving its momentum from and contributing to unfair negative attitudes associating bottle-feeding with uncaring mothering, an association that has been discredited by the present study. Such a situation has far reaching implications for practice being contradictory to what should be setting Midwives apart – which is their caring role as health care providers. While this study recognises that encouraging breastfeeding is desirable, it argues that too little recognition is given to the mothers' right to choose and be respectfully supported in bottle-feeding. The thesis makes practical suggestions for how the Midwifery profession and hospital practices might better serve bottle-feeding clients.

### **Research Achievements**

The aims of this study, were to add to the knowledge of infant-feeding by:

1. Developing a descriptive understanding of the experiences of bottle-feeding, specifically incorporating the perspectives of mothers.
2. Exploring how Midwifery professional knowledge might be enhanced by the study's findings.

3. Examining the relevance of current theories of health and decision-making about infant-feeding.

### Research Questions re-visited with summary "responses"

The broad research question was:

**Broad Question:** What are the experiences of bottle-feeding mothers?

**Broad Answer:** Bottle-feeding mothers are marginalised by pro-breastfeeding Midwifery policy.

- They make a deliberated, broad-based decision on feeding prior to the birth.
- They are content with their decision and convinced it helps them cope well.
- They are dissatisfied with current lack of appropriate services for their needs.

The research sub-questions reflecting two competing professional goals for Midwifery with regard to bottle-feeding practices were:

**Sub-Question A:** How might understanding these mothers' experiences lead to improved methods of encouraging future mothers to make the feeding choice of breastfeeding for their infants?

**Answer A:** Nothing directly targeting improving breastfeeding rates, but an improved approach:-

- Improve neglected aspects of bottle-feeding information and services.
- Discuss both options for feeding, keeping information factual and professional.
- Encourage more committed choices by helping mothers identify their values.
- Understand and redress negative effects of marginalisation.

**Sub-Question B:** How might understanding these mothers' experiences suggest solutions to the professional Midwifery dilemmas of when, and in what ways, a mother's choice to bottle-feed should be accepted and supported?

**Answer B:** Mothers make decision before birth.

- BFHI allows for informed choice, so be respectful.
- Offer unbiased information on both feeding options.
- Pro-actively offer individual antenatal bottle-feeding preparation training to mothers who have decided to bottle-feed.
- Develop useful information for bottle-feeding clients.

The research sub-question reflecting the broader theoretical underpinnings of health decision-making was

**Sub-Question C:** *To what extent do current theories about health decision-making account for the decision to bottle-feed?*

**Answer C:** Current theories do not adequately address the reality of women's infant-feeding decisions.

- The dominant decision-making theory is health promotion entailing Environmental Resources (i.e. education and support for pro-breastfeeding policy). The bottle-feeding decision is regarded as a failure of policy.
- Environmental Resources (as BFHI) is incompatible with recognising, as Wellness models do, the importance to mothers and depth of concern for protecting their lifestyle, values and desires in relation to their infant feeding choice.
- Wellness models emphasise mothers' desires to make their own choice, but are incompatible with the mothers' wish to also be fully professionally resourced, such as being professionally informed of both their feeding options and supported in either choice.
- This thesis will propose a "Caring-Options-Responsive" model of Midwifery services, with increased capacity to respond to bottle-feeding mothers' preferred style of health decision-making and client-professional relationships.

## **Findings in relation to specific research themes, and implications for practice**

The study's finding of bottle-feeding mothers' experiences of marginalisation led to the investigation of further themes, as detailed below:

### ***Pressure by Midwives***

This was found to be mostly due to pro-breastfeeding policies. An implication was identified, that the role of Midwifery needs to be clarified with respect to its responsibility for establishing *all* infant feeding. In light of the finding of the marginalisation of bottle-feeding, issues of clients' rights to a choice and how to provide for the bottle-feeding choice should be reviewed.

### ***Mothers' bottle-centric beliefs and post-decision attitudes about their choice***

The finding that the mothers' liked bottle-feeding and did not see themselves as failed breastfeeders or suffer guilt is contradictory to the dominant literature and "Breast is best" and "Baby friendly" discourses. The following are some implications arising:

- The systematic analyses of this study add to the research base an accurate and updated description of bottle-feeding mothers' beliefs, fears and hopes.
- Detailed deconstructions of bias have demonstrated how some knowledge that is highly regarded in the Midwifery profession is marginalising, for example, how the supposed moral need for Midwives to save bottle-feeding mothers from guilt is false, and how the association of bottle-feeding and bad mothering is unfounded but still relentlessly perpetuated.
- The identification of bottle-feeding mothers' desires for the emotional involvement of the father with the baby and related hypotheses about a new "father-bonding/bondage" concept have highlighted the importance of understanding the symbolic meanings of bottle-feeding if empathetic professional-client relationships are to be developed.

### ***Bottle-feeding mothers' decision-making processes***

The study discovered that the mothers deliberated on their choice, often choosing social reasons especially the phenomenon (to them) of "father-bonding", which in some cases is the deciding factor in their opting to bottle-feed. The value-weightings given by the mothers and by professionals to specific issues are diametrically opposed.

Several implications arise from these findings:

- These mothers expect to be fully assisted by professionals in making their own choice and achieving their goals.
- The bottle-feeding mothers showed evidence of following processes to make a genuine commitment to a choice. This is an aspect that could be further investigated in terms of the dilemma of deciding professionally the point where our persuasive role is changed to a pressuring and marginalising role in the eyes of the client.
- In identifying diametrically opposed values of these mothers and Midwives about relevant factors in the infant-feeding choice, Midwifery may benefit by being more sensitive to the depth of commitment some mothers make to bottle-feeding.
- There is very little research addressing mothers' long-term, social concerns, such as fathers possibly developing closer emotional ties or "bonding better, sic" if they can be equally involved in feeding, but instead existing research has a focus on how to force fathers and/or both parents take up subjective positions of preferring breastfeeding.
- There is little research testing or developing tests of or useful responses to bottle-feeding mothers' values, for example their perceived enhanced maternal sleep when the father

bottle-feeds in relation to the mothers' feeling of coping better. Nearly all the recent care developments relate to enhancing breastfeeding care, and ways breastfeeding mothers can be assisted to cope or to persist with breastfeeding.

### ***Standards of ante-natal and post-natal information***

The analyses have showed that mothers' dissatisfaction with "biased" information, a perceived lack of relevance to their needs was a cause for concern because of the way the BFHI is interpreted and practiced in many settings. Policies are serving as a "gag" on professional information about milk substitute formulas, and that educational role for bottle-feeding information is referred to pharmacists/chemists.

Implications identified include,

- The need for professional discussion of and development of information, practical support and advice without disregarding policy constraints.
- The need for unbiased information to be developed and presented with regard to the issues relevant to mothers' actual situation (ie Australian metropolitan context is First World, mostly urban households with good sanitation).

### ***Variations in services at different hospitals***

The investigation identified three main types of hospitals in Perth, Western Australia, that showed the public hospitals to typically be oriented towards breastfeeding, and private hospitals to vary; whereby the greatest identifiable difference in orientation centred on how each maternity hospital provided any rooming-in and night nursery facilities. Each hospital system worked in the favour of some clients and not others. The implications are:

- Midwifery should develop more sophisticated strategies at the hospital level or system level to deal with diversity in its client groups.
- Improved understanding of the scope of enacting policy may also be beneficial to Midwifery. For example, written bottle-feeding policies are not a formal requirement but could be helpful for ensuring more fairness in delivering bottle-feeding services alongside and complementing the BFHI policies for assisting breastfeeding clients.

## Suggestions for further research

- Investigations of awareness about marginalising effects for bottle-feeding clients of current pro-breastfeeding policies amongst Midwives, child health nurses and hospital administrators. Qualitative studies could identify indicators of attitudes and problems for Midwifery practice. Quantitative evaluations of levels of understanding and levels of concern across the profession could inform future professional development directions.
- A theory speculating a socio-biological concept of bottle-feeding's possibilities for "father-bonding/bondage" was forwarded regarding the increasing desire by bottle-feeding mothers to involve fathers in feeding infants. This theory of what the concept entails has explanatory potential for the symbolic meanings and implied worth of infant feeding options, and hence the associated strength of feelings and commitment to this choice (despite having no more validity than other feeding-bonding theories). This study's hypothetical socio-biological argument detailing the meaningfulness to bottle-feeding mothers needs to be tested and refined using in-depth interviews with mothers, or mothers and fathers, whose desires about infant feeding include father-bonding. Its relevance is that understanding infant feeding discourses may lead to improved empathy with bottle-feeding clients. It may be beneficial for future cross-disciplinary studies such as Barclay and Lupton's (1999) on changing family structures and 'new fatherhood'.
- The present study identified the new and puzzling phenomenon for Midwifery of the mothers' desires specifically for fathers' *emotional* "bonding with the baby" by bottle-feeding. This could be investigated to develop other hypotheses of its relevance, or to understand its capacity to threaten rapport with professionals who may dispute its importance.
- Investigate pro-breastfeeding ante-natal education differences between breastfeeding mothers and bottle-feeding mothers in the style (qualitative question) and in the extent to which (quantitative question) they had deliberated over the advantages and disadvantages according to their perspective of feeding both options and in reviewing their personal values before committing to one choice. The hypothesis would likely be that in BFHI contexts a higher rate of breastfeeding choices are made without full deliberation, and hence with less, and possibly inadequate, levels of commitment.
- Testing "self-efficacy/ confidence building effects of ante-natal training for bottle-feeding". Comparisons of bottle-feeding mothers from control groups using current BFHI ante-natal classes, with mothers from experimental groups where mothers are pro-actively provided ante-natal demonstrations of formula preparation and other practical advice. Hypothesis is

that training will improve self-efficacy levels, possibly leading to increased confidence and its associated benefits.

- Extrapolation of infant-feeding research findings that have relevance to Australian child-bearing women's contexts. For example, showing level of risk in Metropolitan areas to their child of gastro-enteritis, obesity and SIDS. Risk shown in easy to understand percentages and indicating probability without breastfeeding and with breastfeeding for milestones of 1 month, 3 months, 6 months and 2 years. Factors of mothers' health and so on to be incorporated. This would be an enormous task involving philosophical and statistical decisions about how to interpret the data, with the goal of providing clear, accurate risk assessment materials for use by mothers.
- A large-scale survey of hospitals to compare how they balance care provisions for bottle-feeding and for breastfeeding clients, and to find out the range of facilities and services offered to, or withheld from, bottle-feeding clients.
- Investigation of policy and administrative issues regarding the issues at stake such as changes in funding or in associated costs should BFHI breastfeeding policies be supplemented by complementary policies for high quality bottle-feeding support. In addition, addressing possibilities of finding new ways to meet desires of different stakeholders, such as the use of dummies, allowance for nursery rest periods to support rooming in, improved bottle-feeding facilities and other contentious issues.
- Case studies or action research projects investigating the viability of using bottle-feeding policies to compliment breastfeeding policies.

## **Recommendations to improve client satisfaction**

Responsibility for bottle-feeding clients, in ways that may well improve Midwifery's relationship with all clients, will be outlined for the following: Sensitivity to differences; information development and provision; and better support within the BFHI.

### ***Sensitivity to differences:***

- Bottle-feeding mothers' desire to be fully informed.
- Recognition of bottle-centric perspective.
- Recognition of strength of values, feelings and desires underlying preference for bottle-feeding, for example, desire for father-bonding.

### ***Information development and provision:***

- Full ante-natal feeding preparation education.
- Weaning education including usual intake levels for all mothers.
- Developing and disseminating consumer information, for example on types and purposes of different formulas.

### ***Support within the BFHI:***

- Training for practitioners regarding difference between professionalism and pressure.
- Individual ante-natal formula preparation training.
- All information about either breastfeeding or bottle-feeding to be factual not marginalising.
- Development of complimentary hospital policies for bottle-feeding.

## **Proposed Caring-Options-Responsive model of Midwifery services**

Drawing together the findings, implications and recommendations regarding the bottle-feeding mothers' needs and desires and the role and constraints of professionalism for contemporary Midwifery, a new model of care for the profession is proposed, and its approach will be outlined.

### **A New Approach: A Caring-Options-Responsive Model**

**'Caring'** is the overall humanistic stance of respect and of encouraging clients to be responsible for their own health decisions in order to enjoy health, relationships and family dynamics according to their complex personal circumstances, values and priorities.

**'Options'** is an approach to allow clients to seek and obtain full information about their options. Information should be presented in ways that are meaningful and relevant to the client, for example in terms of environmental, social and personal circumstances including available health care facilities, standards of sanitation, previous individual and family health history, and lifestyle aspirations. Health professionals can and should still state that what is their recommended option, and can ask clients to respect their need to suggest which is best, but in the normal course of care provision the profession will not withhold or distort information about the other viable options.



**'Responsive'** is the recommended orientation towards client needs and desires. Health providers should also be responsive to the choice that each client makes, adequately providing training, information and practical support to meet the needs and concerns of client groups for any viable option.

The study's findings about bottle-feeding mothers' experiences, including problems caused by pervasive marginalisation of this client group by Midwifery professionals, have all contributed knowledge applicable to the proposed approach that could potentially become a new theoretical model of Midwifery care.

Such a model seems appropriate for professionally supporting health issues arising in relation to a dilemma or complex choices necessary for making life-adjustments to accommodate changes such as life-cycle events. This is how the mothers in this study appeared to perceive the issues of infant-feeding. It is suited to contemporary, westernised, democratically minded clients who, ideally - like the bottle-feeding mothers in this study - feel capable of being self-responsible for a health issue, have sufficient logical thinking capacity to mentally assess information, and who are motivated to decide the best approach for themselves according to the criteria they choose based on their own values. Its relevance to client groups without all those ideal qualities, however, may need adaptation. Such a model would be suited to social contexts where levels of affluence allow choices, where democratic values encourage negotiation and personal responsibility, and where health providers are willing to support clients rights to benefit from those aspects of their social context.

The proposed Caring-Options-Responsive model whilst based on the existing humanist, caring models of Nursing, highlights professional goals for the infant feeding field, which, in the eyes of many mothers, requires a 'health' decision rather than an 'illness' decision. Compared to the disease prevention model underlying the BFHI, it would allow more flexibility and negotiation to provide bottle-feeding services alongside Midwifery's breastfeeding services. Proposing a model with potential to increase flexibility and negotiation, however, will undoubtedly signal alarm by some quarters of the Midwifery profession fearing erosion of hard-won BFHI achievements. However, health systems need relevance to their primary purpose of serving the public, and without sufficient system-responsiveness will deteriorate anyway as disaffected clients and those clients' sympathetic supporters come to regard the facilities, including staff, as alienating, self-serving bureaucracies (Bandura, 1997). The present bottle-feeding mothers' sense of marginalisation appears to be already moving that client sector towards having such an unfortunate perspective of the Midwifery profession and some hospitals' maternity services. Given the extent to which bottle-feeding mothers' choices reflect their aspirations to support

their own strongly-held values, there is likely to remain this client sector rejecting Midwifery services perceived to be obstructing rather than assisting them in shaping their own destinies. As such, balancing the tensions between pressure and alienation with the tensions between personal liberty and social control should be a vital consideration in defining future directions whereby Midwifery may enhance and broaden its relevance to contemporary clients.

## CHAPTER 10 - Conclusion

### Reflective overview of the study's research into bottle-feeding mothers' experiences

This study of bottle-feeding mothers' experiences and the implications of those experiences for midwifery has progressed from modernist beginnings to a postmodernist journey to explore and explain the experiences of bottle-feeding mothers in the context of current midwifery policy and practice. From what had been conceived and anticipated as a complicated but singularly describable 'object' of the aforementioned "mothers' experience", this study discovered unexpected levels of intricacy and complexity in the multi-faceted phenomenon of infant-feeding. Consequently, the thesis has examined those experiences in terms of discourses and sets of inter-related relationships involving midwifery health care policies and practices, lay practices, and the subjectivities of bottle-feeding mothers and "Baby-Friendly" midwives.

The study has analysed the respective constructions of reality by the two groups, bottle-feeding mothers and pro-breastfeeding midwives, and has drawn attention to mutual 'deficit' models each group holds of the other. The study claims that current policies marginalise bottle-feeding mothers, and identifies the power relations between midwives and mothers in an analysis that refutes power as being a one-way process - at least in contemporary, Western health care systems. As Foucault proposed:

This is just a hypothesis, but I would say it's all against all. There aren't immediately given subjects of the struggle, one the proletariat, the other the bourgeoisie. Who fights against whom? We all fight against each other. (Foucault 1980: 208)

(cited in Porter, 1998, p. 224)

The research project evolved as the findings emerged that for mothers and midwives perceptions and experiences of infant-feeding were not of any 'fixed, singular reality'. Rather, they were discourses comprising "practices that systematically form the objects of which they speak. (Foucault, 1974: 48-9)" (cited in Porter, p. 210). Postmodernist, hermeneutic assumptions of multiple realities were thus adopted to analyse the multiple discourses of infant feeding, in the context of the dominant midwifery discourse of "Breast is best". There are several important findings for midwifery practice. One is that the mothers' experiences of bottle-feeding were positive and even joyful in relation to the impact on their life-style, families and values, and this has not been widely discovered or published in existing, contemporary research. Another important finding is, in bottle-feeding mothers' perspectives, midwives either did not know or did not care about how best to bottle-feed.

This project, in line with the thinking of Porter (1980), has incorporated a mixture of modernist and postmodernist assumptions and techniques in an attempt to conceptually untangle the resentments of both bottle-feeding mothers and midwives towards each other. It stops short of merely analysing power, and still holds to the assumptions of social theory that, "it is possible rationally to explain social reality and, in doing so, point to weaknesses in the form that society takes. Thus, it implicitly points the way to progress" (Porter, p. 225). This present study has identified a number of insights by mothers and it has sought to turn mutually destructive discourses and practices into constructive improvements in midwifery's client relations and services. This will require an openness by the midwifery profession towards seeking ways of respectfully engaging with all new mothers to establish infant-feeding in ways that accord with the mothers' needs and expectations. Further, it will need a commitment by midwifery professionals to developing more sophisticated strategies for adequately meeting the diversity of its responsibilities.

### **Significance of study's key findings**

The fact that the mothers in this study intelligently considered their decision to bottle-feed has seriously challenged the deficit model of bottle-feeding mothers. The analyses provide valuable insights into the reasoning behind these women's choices. These highlight the need to question the constraints of dominant professional discourses which may be limiting midwives in their capacity to meet the standards of advice and support expected and desired by mothers who choose to bottle-feed. Indeed, James Carter contended that:

midwives need to ensure that the siren voices from both activist groups and industry are treated in an objective and dispassionate manner. There is strong evidence for the contention that they should be given greater support and guidance on how to do so.

If midwives are not provided with more objective and professional guidance, there will always remain the risk that, even unwittingly, they may compromise their professional responsibilities to those placed in their care.

(Carter, 1996, p. 153)

The study has explored the bottle-feeding mothers' complaints about contemporary midwifery, and has sought to develop a deeper understanding of the Australian context of midwifery and of the complexity of issues, constraints and possibilities for the field. Specific dilemmas surrounding present professional practice have been explicated by examining key policy documents and their interpretation by professional health providers. The thesis has advanced positive suggestions about the kinds of information that could be useful to midwifery's clients. Strong ideological constraints and resource constraints, consistent with an overly rigid interpretation of policy directives related to WHO and BFHI guidelines have led to practices in some midwifery care settings that suppress information on bottle-feeding. Based on the

interviewed mothers' point-of-view on the problems of not being sufficiently prepared together with what they said they had found out that was useful for bottle-feeding, recommendations of standards of information and practical advice were outlined. The study's findings and relevant recommendations have pointed towards the profession addressing its current failings of counter-productive dogma by moving towards an approach that to be descriptive shall be termed the 'Caring-Options-Responsive' model of midwifery services.

In this proposed 'Caring-Options-Responsive' model, clients could seek and obtain full information about their options, and the information would be presented in ways that are meaningful and relevant to the client. This study indicates that in meeting the needs of new mothers, based on findings of their decision-making processes, 'relevance' should include realistic assessment of the client's environmental, social and personal circumstances by evaluating the impact of available health care facilities, standards of sanitation, previous individual and family health history in relation to the client's lifestyle aspirations. Midwifery could and should openly state the preferred approach for clients, which currently is breastfeeding, and it should ask clients to respect their need to suggest which is best. However, in the normal course of care provision, midwifery should not withhold or distort information about other options, which in this case is bottle-feeding. midwives would also respond to the choice that each client makes, adequately providing training, information and advice to meet the needs and concerns of both breastfeeding and bottle-feeding mothers. The overall 'care' stance would be one of respect, and of encouraging clients to be responsible for their own health decisions in order to enjoy their health, relationships and family dynamics according to their own best way of identifying and then meeting their personal priorities.

## **Final reflections**

On reflection, this study has ultimately developed hermeneutic goals, whereby I have taken on the role of 'interpreter' for two groups, primarily the bottle-feeding mothers and also the generally pro-breastfeeding midwifery profession. The investigation of the experiences of bottle-feeding mothers has combined modernist interview questions asked of mothers with a postmodern critique of the midwifery field, and has drawn on a variety of qualitative techniques, especially phenomenology and participant observation, to elicit the often-competing perspectives of the bottle-feeding mothers and midwives. Kurt Mueller-Vollmer's light-hearted and apt description of the reputed origins of hermeneutic thinking is a suitable metaphor for how daunting and humbling the research experience feels, as I offer the findings of this thesis as a contribution to the field of midwifery:

The etymology of the term hermeneutics carries an obvious relation to Hermes, the messenger god of the Greeks, and suggests a multiplicity of meanings. In order to deliver the messages of the gods, Hermes had to be conversant in their idiom as well as in that of the mortals for whom the message was destined. He had to understand and interpret for himself what the gods wanted to convey before he could proceed to translate, articulate, and explicate their intention to mortals.

(Mueller-Vollmer, 1986, p. 1)

Whilst identifying clearly with the role of a messenger but certainly not as a god, I hope this thesis will be taken up by midwifery as a worthwhile message about the benefits of avoiding dogma in providing services to clients, whether or not those clients ultimately choose to act on our professional preference or to take up alternative viable and legal options. Suggested directions for services to bottle-feeding clients outlined in the thesis are intended to point towards such a possibility.

The thesis has aimed to do justice to the participating bottle-feeding mothers by using their descriptions, criticisms and suggestions, and has also aimed to do justice to the dedication of many highly committed professionals in the field of midwifery. As well as description, the thesis has provided a constructive message that is paraphrased below. My hope is that listening to the mothers in the study can usefully inform the midwifery profession on how to enhance its relationship with all women who are their clients:

### **Last word on behalf of bottle-feeding mothers**

Bottle-feeding mothers enjoy what to them are relational, personal and health-related benefits of their infant-feeding choice. Mothers desire professional midwifery support services of information, advice and practical assistance that will allow each mother to make her own informed decision to optimally balance her values in nurturing and caring for her baby.

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## **Appendix A: (Informed consent form for mothers participating in study)**

### **Consent Form**

By signing this document, I am giving my consent to participate in a research study investigating bottle feeding experience. The study will be submitted to Edith Cowan University as a requirement for a Doctor of Philosophy thesis.

I understand that I was selected to participate in this study because I am bottle feeding my baby, living in the Perth Metropolitan area, and over 18 years.

I understand that an audio-taped interview (taking approximately one hour) will be conducted in my home at a time convenient to me. I will be asked to describe feelings, thoughts and experiences that relate to bottle feeding my baby. I also understand that the researcher will contact me in 1-2 months for a follow up telephone interview.

I have been informed that participation in this study is entirely voluntary. I can refuse to answer any specific questions and I can withdraw from the study at any time.

I understand that no personally identifying information will be associated with the descriptions I give. Pseudonyms and a coding system will be used instead of names and only the researcher will have access to the original transcripts.

If I have any questions relating to this study, I can contact Elizabeth Duffy by telephone on 9383 7257.

Participant's signature.....Date.....

Researcher's signature.....Date.....

Thank you, for your participation in this research.



## **APPENDIX B - (Mother-to-child transmission through breastfeeding of HIV/AIDS, STDs, Hepatitis C and drugs)**

Concurrent with the time-frame of conducting the present study on bottle-feeding issues, AIDS/HIV has come to the fore globally in the field of breastfeeding. It is outside the scope of this study to offer a detailed examination of current issues regarding the risks breastfeeding poses for mother-to-child transmission of problems: AIDS/HIV and a number of other infectious diseases, e.g. STD's and Hepatitis C, and drugs. Nevertheless, it would be remiss to not briefly address the implications of the HIV/AIDS with respect to mother-to-child transmission through breastfeeding, and to offer a brief summary of its effects on health policies. The brief account offered here also highlights what happens when professionalism becomes inflexible.

The Australian NHMRC (1996) guidelines do list "instances when infant formula is necessary" and "when a mother is HIV positive" is one of those instances. As an advanced country, the policy has not been disputed. However, globally, it is contentious. In 1998 WHO/ UNICEF/ UNAIDS issued a consensus statement recommending that HIV positive women be encouraged to 'make an informed decision' around infant feeding choices. Gill Seidel (1999, p. 21) noted that the statement represented "a significant shift " away from the previously dominant, seemingly "impenetrable discourse of breast is best", which, she argued, had led to the problem of strong resistance by health professionals to the recommended change of policy guidelines for HIV positive mothers. Seidel accused the breastfeeding activist lobby of resisting out of fear that the HIV epidemic will undermine the institutional, capital, professional and training investments in place to support breastfeeding. It is remarkable that similar accusations were made against milk formula marketing in such regions (for example, Palmer, 1988) which originally motivated the WHO and UNICEF marketing code. Health care and its accepted approaches does vary according to dynamic, changing contexts and social attitudes.

HIV/AIDS is now widely spread in some parts of the world, and mother-to-child transmission by breastfeeding is a large-scale health risk especially in countries such as South Africa, where much of the population is poor. Gill Seidel (1999) estimated that breastfeeding was thought to account for some 25% of HIV + babies in South Africa. Seidel cited 1997 figure of 29% of pregnant women attending antenatal clinics in one South African province testing HIV positive, it affects approximately 7.5% of South African births. HIV will be transmitted to approximately half of those infants. Affected mothers face the troubling option of feeding their infants whereby they may possibly transmit HIV, or alternatively they risk transmitting disease such as gastro-enteritis via unsterilised bottle-feeding implements and malnourishment from insufficient

capacity to afford formula. There are also other cultural, political and resourcing factors that add to the problems of resistance to the most recent advice for HIV in Africa such as influential political views that mistrust HIV and its treatment as being a racial issue, the so-called "virgin cure" that continues the spread of the disease, and unaffordability of treatment due to the combined effects of poverty and drug profit levels.

The implications and figures of risk are contentious. On the one extreme, it is argued that in poor contexts "artificial feeding can triple the risk of infant death" compared to breastfeeding by an HIV+ mother (Linkages Project, 2001). Siedel was skeptical that advising anything other than bottle-feeding in an HIV case was anything more than self-interest by the pro-breastfeeding industry. Additionally, the health risk in terms of disease is not the only consideration. Some radical literature even suggests that, rather than prolong the life of a child certain to suffer in the future as an HIV orphan in Africa, it may be more humane to encourage mothers and children to experience the dignity of breastfeeding whilst acknowledging the reality of the high probability of death one way or another to the child.

In summary, the situation for Third and Fourth world countries with AIDS and HIV epidemics illustrate that it is hard to respond to diversity amongst clients. The impact of the specific problem of AIDS is comparatively small in many countries such as Australia, but some babies face this risk. It was not an issue that appeared to have affected any of the mothers in this study, and it was never raised in the interviews. The present study was developed with particular relevance to Australian mothers and babies who, as is most typical for the context, on the global scale happened to enjoy good health and a high standard of living. Therefore, there is no intentional relevance of this study to the issues of AIDS. Notably, however, AIDS is the fracture-point that is challenging dominant discourse. What mothers want has been taken less seriously.