BEING A ‘GOOD MOTHER’: EXAMINING THE DISCOURSE OF FIRST-TIME BREASTFEEDING MOTHERS

Jennifer Leigh Bloch

210511052

Supervisor: Kershia Sunjeevan

Co-Supervisor: Professor Mary van der Riet

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DECLARATION

I, Jennifer Leigh Bloch, the author, hereby declare that unless specifically indicated to the contrary, this thesis is the result of my own work, that all sources that I have used have been properly referenced and that I have not previously submitted this research at any other university for degree purposes.

Student: Jennifer Bloch

Student number: 210511052

Date: 15 July 2023

Signed:

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Abstract

This study employs a qualitative research design, using a social constructionist approach to examine how first-time South African mothers position breastfeeding as an imperative of good mothering. Six first-time mothers participated in the study using purposive sampling from a private baby clinic site in KwaZulu-Natal. They were interviewed online due to the COVID-19 Pandemic. The interviews were transcribed in detail and analysed using discourse analysis. The research findings examined how mothers demonstrated good mothering through their commitment to breastfeeding. The mothers constructed breastfeeding as a project and positioned their bodies as sites that they needed to manage, to work to attain these good mothering standards. The findings showed that the mothers positioned experts as fundamental for breastfeeding success to receive advice, guidance, and reassurance, especially when they experienced difficulties.

In the sample, three of the mothers introduced formula, which was positioned as the alternative to breastfeeding. This was accompanied by mothers constructing their failure to fulfil an exclusive breastfeeding ideal and they experienced feelings of guilt, shame, and inadequacy. These three mothers re-negotiated the standard of breastfeeding as an imperative of good mothering by drawing on a counter-discourse that positioned their babies as happy and healthy when using formula. The research concludes that the mothers in the study defined their motherhood identity through their socially constructed successes and failures in breastfeeding. Breastfeeding ideals considerably influenced them, and they constantly measured themselves against these medical and social standards. The impact is that these sociocultural norms position breastfeeding as an essential act of good mothering and contribute to a state of intensive mothering that renders mothers vulnerable to shame and guilt. The findings recommend challenging sociocultural infant feeding constructs and the discourses shaping modern-day motherhood.

Table of Contents

Chapter 1

Introduction

Breastfeeding is the act of feeding a baby breastmilk and is ascribed significant medical and social value. Breastmilk is well known for being the optimal source of nutrition through the phrase ‘breast is best’, which society frequently draws on in infant feeding decisions (Burns et al., 2012). Mothers worldwide are encouraged to breastfeed their babies exclusively for the first six months of their lives and to continue offering breastmilk until their child is two years of age (UNICEF, 2018; WHO, 2011). Public health bodies consider breastfeeding essential to alleviate the risk of infant mortality and "keep every child alive and to build healthy, smart and productive societies" (UNICEF, 2018, p. 1). The value of breastmilk is well documented in the medical and social research that lists its benefits for an infant's immune system, a baby's physical and cognitive development, and supports bonding and positive attachment (Gertosio et al., 2016; Wall, 2001). These health messages have formed a pro-breastfeeding discourse that influence decisions about infant feeding. When drawing on these many published social and medical benefits of breastfeeding, there is an expectation that mothers should breastfeed, to prioritise their baby's needs and well-being. Consequently, breastfeeding has been socially and medically constructed as an imperative practice.

The pro-breastfeeding discourse is encapsulated in the dominant discourse of good mothering in contemporary parenting. This discourse requires a mother to prioritise her baby's needs, and for mothers who draw on this discourse, breastfeeding is positioned as "the proper and moral choice" (Knaak, 2010, p.346). The good mothering discourse implies that formula feeding is constructed as the lesser and artificial option, and mothers are questioned in their duty of care when formula is introduced. From this stance, the pro-breastfeeding and good mothering discourse constructs breastfeeding as an act tantamount to being a good mother (Marshall, Godfrey & Renfrew, 2007). Mothers must navigate the

decisions made about infant feeding amidst the complexity of these idealistic standards. The implication is that these high standards render mothers vulnerable to questioning their mothering capabilities, and mothers can experience feelings of guilt and inadequacy if they do not breastfeed (Hauck & Irurita, 2003; Knaak, 2010; Larsen et al., 2008).

Following birth, the process of breastfeeding has been constructed as an "engrossing, personal journey" that requires total commitment and persistence (Nelson, 2006, p. 15). Mothers may experience inadequate milk supply, breast infections, mastitis, sore and cracked nipples, physical fatigue, and pain from expressing, coupled with breast refusal by their infants, tongue ties and reflux, or being too sleepy to feed (Hall & Hauck, 2007). These difficulties threaten breastfeeding success for mothers who identify with the pro-breastfeeding discourse to be ‘good mothers’. Knaak (2010) argues that the good mothering discourse implicates mothers who do not uphold the ideal of exclusive breastfeeding and introduce formula (as the alternative). These mothers may be questioned in their devotion and commitment to their infant due to the construction of morality in infant feeding decisions (Knaak, 2010). The immense societal and medical pressure to fulfil these expectations can overwhelm a mother at one of the most vulnerable stages of her life as a parent. Thus, expectations and meanings within these dominant discourses of motherhood and breastfeeding contain "empowering and oppressing" features that require further critical engagement (Wall, 2001, p. 594). In the South African context, there is limited research that examines how new mothers navigate the ideals of infant feeding within this dominant discourse.

Purpose of the research

Considering the above, breastfeeding is socially constructed to be more than the activity of feeding a new baby. Blum (1993, p.291) argues that breastfeeding offers a "lens that magnifies the cracks and fractures in the construction of the contemporary mother". The current research examined how first-time South African mothers negotiated their position as good mothers by drawing on, rejecting, or redefining the meaning of breastfeeding in this

discourse. This was done by analysing how they talked about their breastfeeding expectations and experiences. The research contributes to the South African literature on how mothers construct good mothering through the act of breastfeeding.

The research objectives

The objectives of this research were:

- To examine the breastfeeding expectations of first-time mothers and how they informed their initial subject position as mothers.
- To examine how first-time mothers positioned themselves within the good mother discourse concerning their breastfeeding experience.

Structure of the dissertation

Chapter two of the dissertation reviews the literature and selected research studies on the discourse of good mothering and breastfeeding to show how breastfeeding is constructed as a critical act of good mothering. The chapter discusses the theoretical framework of the post-structuralist feminist theory. I present a critical engagement with the discourses of breastfeeding and good mothering using this theoretical position.

Chapter three presents the methodology used for the research study. I discuss the qualitative research design and the social constructionist approach used in this research. I detail the sampling, recruitment, data processing, and analysis processes. The chapter concludes with the ethical and quality considerations of using qualitative research.

Chapter four presents the findings of the dissertation that address the research questions. A detailed discursive analysis of selected extracts from the interview transcripts examines how mothers talk about breastfeeding and position themselves within the good mother discourse.

Chapter five presents the dissertation's discussion, where I draw on the research findings and how they align with the literature on breastfeeding and good mothering.

Chapter six concludes the dissertation. The conclusion presents the strengths of the research and recommendations for future research. I review the quality considerations in qualitative research and reflect on the research process.

Chapter 2

Literature review and theoretical framework

In this chapter, I review the literature on the discourse of good mothering and the social construction of breastfeeding and introduce the theoretical framework. The first part of the review presents the good mother discourse and the constructed standards of mothering. I explore literature that argues that breastfeeding is positioned as a significant activity of good mothering, both internationally and in South Africa. I review the literature examining how mothers demonstrate this expectation of good mothering by seeking expert advice and managing their breastfeeding body. The following section discusses the literature on the alternative to breastfeeding and how mothers navigate their positions as good mothers when using formula. The review ends with a discussion of the theoretical framework of the post-structuralist feminist theory. I have selected this theory to discuss how the broader political, sociocultural, and medical influences have shaped modern motherhood.

The good mother discourse

The good mother discourse encompasses a set of ideologies and standards that positions a mother as central to all things related to her child (Knaak, 2010). A good mother is expected to devote herself to her child by selflessly offering her time, energy, and resources (Schmidt et al., 2022). Hays (1996, cited in Johnston & Stewart, 2003) argues that these mothering standards are intensive, have implications for her performance, and are used to prove that she is a good mother. This is echoed by Wolf (2011), who, in her feminist writings, argues for these intensive mothering practices to be framed as a form of "total motherhood" (p.xv). The total motherhood and intensive mothering discourse encompasses exhaustive expectations that a good mother must oversee her child's health, psychological well-being, safety, and education, and remain vigilant regarding present and future risks that could harm her child's development (Wolf, 2011). In doing all of this, a good mother, will

produce a happy, intelligent child who is attaining their developmental milestones, thereby benefiting society (Wolf, 2011). In the discourse of good mothering, a mother is therefore positioned as central to fulfilling her child's needs (Schmidt et al., 2022). Consequently, there is an increasing emphasis on a mother taking responsibility for managing risks to her baby's health. The research on good mothering further notes that a particular stereotype of a good mother exists where she is a full-time, stay-at-home, predominantly White middle-class woman who is fulfilled by being domesticated (Johnston & Swanson, 2003; Waltz, 2014). Previous research has found that the good mother discourse is more prominent amongst Westernised, educated and middle-to-higher-income mothers who have been found to favour these idealised standards (Avishai, 2007; Kukla, 2008; Waltz, 2014). These Westernised ideals embodied in the good mother discourse have become embedded in social and cultural values that inform how mothers make decisions related to child-rearing. Much research argues that breastfeeding has become the symbol and standard of good mothering in the West. It has been examined in literature from the global north, such as Canada, Norway, America, England, and Australia, as well as the global south, such as South Africa (Andrews & Knaak, 2013; Avishai, 2007; Burns et al., 2012; Lee, 2007; Waltz, 2014).

Breastfeeding is an activity of significance in the good mother discourse, as the mother's body is positioned as the site to repeatedly perform her good mothering (Kukla, 2008). Feeding a baby is not confined to a single moment for a mother to prove her maternal position, as this continues until the baby is weaned off milk and solely eats solid foods (Kukla, 2008). Brookes, Harvey and Mullany (2016, p. 342) argue that "contemporary attitudes and the medical practices promoting the superiority of breastfeeding are closely aligned to deeply ingrained societal beliefs about what it means to be a successful mother". Thus, breastfeeding is an act that is repeatedly required in the early stages of a baby’s life, and it is an act of significance as Lee (2007) states that "how good a mother a woman is has come to be measured by whether she breastfeeds" (p.1088). The implication of this is that

breastfeeding is constructed as a "test one can never pass but it always at risk of failing" (Kukla, 2008, p.79). Breastfeeding is an act that encapsulates and structures the good mother discourse, as the mother's body is a tool positioned "for intensive mothering to be accomplished" (Stearns, 2013, p. 362).

Much literature examines how mothers demonstrate acts of good mothering, from pregnancy to birth, and in all areas of parenting their children. The contemporary ideology of good mothering frames the act of breastfeeding as a superior choice, as it is "systematically" positioned as such by drawing on elements of medical discourse, risk culture and ideologies of mothering (Rodgers, 2020, p.140). Faircloth (2009, p. 15) argues that these good mothering ideals are internalised by mothers who "self-identify through mothering" and, as a result, being a good mother becomes the "primary frame by which women communicate and sustain their identity" (p.15). As presented in chapter one, international public health campaigns promote breastfeeding for its medical benefits. They draw on these health benefits to motivate mothers to exclusively breastfeed for the first six months of a baby's life and to continue until they are two years of age (UNICEF, 2018; WHO, 2011). These messages are encapsulated by the phrase 'breast is best', which is well promoted in social and medical contexts on the topic of infant feeding. Through these medical and social messages, a pro-breastfeeding discourse has emerged that draws on the medical benefits of breastmilk and includes a discourse of nature, as it is a substance produced by a mother's body to feed her baby. Consequently, breastfeeding is constructed to be the 'best thing' mothers can do for their babies (Hausman, 2004). In the next section, I will examine the literature on breastfeeding discourse and how this has become embedded in good mothering practices.

Breastfeeding discourse

The natural discourse of breastfeeding constructs breastmilk as wholesome, balanced, and the most natural form of infant nutrition (Wall, 2001). As the mother's body

produces breastmilk (which is not artificial), it is deemed to be "nature's perfect food" for a baby who relies entirely on their mother to meet their nutritional needs (Wall, 2001, p. 596). The natural discourse further implies that mothers possess a "universal" and "inherent capacity" to breastfeed as a biological response of the maternal body (Wall, 2001, p. 597). The natural discourse implies breastfeeding is a "relatively easy process that any mother should be able to succeed at and find rewarding" (Wall, 2001, p. 597). The premise of this discourse is that first-time mothers expect breastfeeding to be "the natural thing to do" (Wall, 2001, p.597). In these health and parenting messages, mothers are told of the value of early attachment and mother-infant bonding on their baby's brain development and social development, and there is an expectation that mothers further consider this in the act of breastfeeding (Wall, 2001).

Breastfeeding includes the symbolic moments of bonding between mother and baby during feeding and is therefore positioned as the "idealised form of infant nurture" (Hausman, 2004, p. 278; Wall, 2001). Hence, in examining the discourse surrounding breastfeeding, mothers are presented with the benefits of breastmilk as a pure and nutritional substance supporting their health needs and the social and emotional benefits of attachment by having a baby attached to their body during feeding. The implication is that breastfeeding is positioned as the superior option that mothers should choose to prioritise their baby's physical and socio-emotional development. The premise embedded in good mothering discourse is that "mothers will gain satisfaction from doing what is best for their babies or that they will find the close and intimate connection with their baby that breastfeeding provides" (Wall, 2001, p. 601). These messages are promoted and held in parenting educational materials and perpetuated through interactions with health professionals who advocate for breastfeeding. They have become assumed and embedded as part of the pro-breastfeeding discourse. Thus, when a mother forms her initial expectations of breastfeeding in this pre-natal period, she must navigate these pro-breastfeeding messages (Knaak, 2010). The effect is that a mother's beliefs about infant

feeding are "heavily conditioned" by these medical and social discourses (Knaak, 2010, p. 349).

A good mother is committed to breastfeeding

A mother forms her expectations of breastfeeding before the baby is born. In her research, Waltz (2014) found that South African mothers started learning about breastfeeding while pregnant. They researched the topic in books and online sources, looked at pictures and sought information from medical experts, and watched video demonstrations of the correct latch and techniques (Waltz, 2014). This information was used to inform their initial commitment to breastfeeding.

In her review on the cultural constructions of motherhood, Kukla (2008), found the message communicated to mothers in antenatal classes was that breastfeeding was an investment in their baby's health, which draws on the premise of good mothering discourse. Mothers' breastfeeding expectations are consequently influenced by their external social systems, such as family, health experts and the media. These beliefs are perpetuated through parenting guidelines, positioning the mother as responsible for breastfeeding success. The overarching message mothers receive is that "if you don't breastfeed your baby, you're automatically out of the running for mother of the year" (Douglas, 2001, p. 244, cited in Kukla, 2008, p. 347). In their research on a sample of Australian mothers, Hauck and Irurita (2003) found a complex interplay between a mother's beliefs and how these dominant discourses inform their breastfeeding expectations, which she must navigate. From this position, whether to breastfeed becomes a "discursive formality" as it is a socially expected act of good mothering (Knaak, 2010, p.348).

Following the baby's birth, the postnatal period is when a mother's initial breastfeeding expectations are tried and tested (Murphy, 2000). In the early days of a baby's life, feeding on demand involves frequent feeding every few hours. Stearns (2009) found that mothers constructed breastfeeding as a laborious and time-consuming process reliant on

their available maternal body. Long-term breastfeeding requires initial commitment, learning, persistence, and hard work (Burns et al., 2010; Guyer, Millward & Berger, 2012). In her research in Canada, Knaak (2010) discursively analysed the talk of thirty-three mothers to explore how mothers construct their decision to breastfeed. Knaak (2010) found that breastfeeding has become increasingly idealised, which conditions mothers' beliefs and decisions about infant feeding, and secondly, breastfeeding represents more than its nutritional benefits. The pro-breastfeeding discourse positions breastfeeding as a "core mothering belief" that mothers internalise as part of their role and maternal identity (Knaak, 2010, p.349). In the good mothering discourse, Knaak (2010) argues that breastfeeding has become "a key marker (to self and mothers) about who they were as mothers, about how they mothered, and about what they stood for" (p.349). For the mothers in her research, Knaak (2010) found that this discourse implies that breastfeeding was a vital marker of a mother's commitment to enacting good mothering ideals by doing her best and prioritising her baby. Machirori (2021) highlights that this postnatal period is a crucial time for how a mother will present herself to the world by carefully balancing her expectations concerning these socially constructed standards with her lived experience.

Across the literature, breastfeeding challenges have been examined (Hall & Hauck, 2007). As mentioned in the previous chapter, mothers may experience inadequate milk supply, mastitis, sore and cracked nipples, physical fatigue, and pain from expressing, coupled with breast refusal by their infants, tongue ties, reflux or being too sleepy to feed (Hall & Hauck, 2007). Shakespeare et al. (2004) found that when these difficulties arose, mothers felt unprepared or anxious about their breastmilk supply and struggled with the demand of frequently feeding their babies and the feeling of pain or discomfort in their breasts. The implication is that mothers must navigate these breastfeeding experiences, which contrasts with the ideals of the natural discourse. Consequently, Knaak (2010) found that difficulties with breastfeeding were presented as opportunities to demonstrate good mothering and evidence of their perseverance, commitment, and dedication to continue

offering their baby 'the best'. To maintain breastfeeding during these difficulties and ensure long-term continuity of breastfeeding, mothers looked to the advice of an expert presented in the section to follow.

A good mother follows expert advice

A good mother is expected to take professional advice on raising her children, as they are positioned as the primary expert, not the mother herself (Knaak, 2010). In health contexts, experts such as midwives, nurses, lactation consultants, and doctors are well-positioned to advocate for breastfeeding, and mothers look to these experts to provide the necessary information and practical skills for breastfeeding (Hausman, 2004). This begins during the prenatal period and continues following birth. Mothers seek information about positioning the baby during breastfeeding and want advice and suggestions to get things right (Graffy & Taylor, 2005). Burns et al. (2012) found that when experts are held in high esteem and deemed to have the answers and knowledge for breastfeeding success, mothers follow the advice of professionals with unquestioned obedience.

In her review on the cultural constructions of mothering, Kukla (2008) discussed how the La Leche League, an organisation that offers lactation consultations with experienced breastfeeding mothers and promotes breastfeeding, influenced new mothers' framework of good mothering. The La Leche League are known for their stringent recommendations that position exclusive breastfeeding, directly from the breast, as the best option. On the other hand, the artificial nipple (in the form of a bottle) is constructed as a threat that may corrupt this feeding practice (Kukla, 2008). This limits the feeding activity to the mother and reinforces Blum's (1993) argument that breastfeeding leads to "exclusive mothering" as it is solely dependent on the mother and her body (p. 3, cited in Wall, 2001, p.594). In the section to follow, I have drawn on key research that has discursively examined the role of experts in offering advice to mothers about breastfeeding and how experts have been positioned.

The role of the midwife

In their research in Australia examining the interaction between mothers and midwives, Larsen et al. (2008) identified a mechanistic breastfeeding discourse that influences how mothers talk about and experience their lactating bodies. In these interactions, the midwife's role was to assess the breastfeeding process and to focus on the amount of milk the mothers produced to consider how this could be optimised (Larsen et al., 2008). The midwives were positioned as the technicians who could assist with operating and managing the breasts, which were constructed as the necessary ‘equipment’ (Larsen et al., 2008). This reinforces the objectification of the feeding process, as the mother's breasts need to be managed (Larsen et al., 2008). The implication is that the interactions between mothers and experts construct breastfeeding as a production process (Dykes, 2006). In this mechanistic discourse, the mother is the passive recipient, and her embodied knowledge must be dismissed (or it remains silent) as the health professional is positioned as the breastfeeding expert (Larsen et al., 2008). In this discourse, the role of the professional is to assess and guide a mother to breastfeed, and this aligns with the intensive mothering ideals where an expert is required to aid mothers with their child-rearing decisions. The implication is that breastfeeding becomes a project to achieve as part of demonstrating good mothering practices. The mother draws on this discourse to manage her body (and breasts) from this objectified position.

By drawing on expert-led advice, breastfeeding becomes an act to master, and mothers rely on experts’ knowledge and skills to succeed, and to be deemed a good mother (Avishai, 2007; Murphy, 2000; Waltz, 2014). When breastfeeding is constructed as an ‘act to master’, within the good mothering discourse, the health expert’s role becomes pivotal for mothers who want to get breastfeeding right. In the next section, I present the research by Avishai (2007), whose discourse analysis is a significant piece of literature, as she examines how the mothers in her study managed their breastfeeding bodies as a project to attain good mothering standards.

A good mother manages her breastfeeding body

Avishai (2007) discursively examined the talk of twenty-five educated, middle-class mothers in the United States of America (USA). Her research examined how mothers positioned their lactating body as a site to manage and constructed breastfeeding as a project to be achieved. Avishai (2007, p.135) found that framing breastfeeding as a project elicits the "self-discipline involved in compliance with broader middle-class mothering standards" set by sociocultural, political, and medicalised contexts and shapes parenting in first-world countries, specifically in the USA. In the era of professionalised motherhood that intersects with dominant discourses of intensive mothering, these high standards construct mothering as a 'full-time job'. Avishai (2007) found that her sample of career-driven mothers constructed breastfeeding as a goal to achieve and complied with intensive mothering standards. This group of mothers set high expectations to exclusively breastfeed their babies for the first six months and refrain from supplementing feeding with alternatives. Avishai (2007, p.136) describes these ideals as "pervasive mothering standards". The implication is that mothers invest significant preparation in breastfeeding (technology and gadgets) and scrutinise the amount of breastmilk they produce, to work towards achieving these standards. Avishai (2007) found that mothers "researched, planned, implemented, and constantly assessed" their breastfeeding process (p. 136). However, the ideals held within the natural and pro-breastfeeding discourse were challenged by their lived experiences.

From this project-style approach, mothers focused on performing and producing breastmilk and employed strategies to optimise their bodies and do whatever they could to breastfeed (Avishai, 2007). Their bodies became the baby's "food machine", as the mothers in her study spoke of their breasts not being their own but there for their babies (Avishai, 2007, p. 141). This contrasts with the intuitive and natural position of learning to trust their lactating bodies to provide nutrition for their infants, held within the natural discourse. Much breastfeeding literature presents breastfeeding as a romantic and bonding experience between mother and baby (Wall, 2001). However, the mothers found it laborious and

challenging (Avishai, 2007), and what is not visible, is the labour of the mothers' efforts to feed their infants. The findings of Avishai (2007, 2011) have been confirmed in research by Stearns (2009) and Waltz (2014), which will be presented below.

Breastfeeding as 'body work.'

In her research, Stearns (2009) discursively analysed the talk of sixty-six breastfeeding American mothers and found that breastfeeding was "body work" (p.64). Her research highlights how mothers focused on producing "quality milk" (Stearns, 2009, p.66). To achieve this outcome, the mothers monitored their fluid intake, took their vitamins, and ate healthy food to ensure optimal output. The mothers further restricted their diet when they perceived their baby was sensitive to certain foods they received through breastmilk. This 'work' on the maternal body was routine for these mothers. Stearns (2009) described it as "learned bodywork [that] requires the development of skills and techniques" (p.73), and as mothers experienced challenges, they would apply their skills to the task at hand. The breast pump was used to extract and store milk as a technological device to support the production so that they did not have to substitute with formula. Stearns (2009) found that nonworking and working mothers pumped additional breastmilk to keep an emergency supply in their freezer for when they were out and unavailable for feeds. The discourse of breastfeeding as natural did not account for the significant work the mothers needed to do to maintain exclusive breastfeeding (Stearns, 2009). Again, the investment mothers make to ensure their body performs is in tension with the construction of breastfeeding as natural (Blum, 1993). Positioned as a full-time job, breastfeeding is constructed as 'body work' or a 'project'.

Stearns' (2009) research aligns with Wall's (2001) findings as she examined how the pro-breastfeeding discourse has displaced mothers in breastfeeding, to become a subject separated from their bodies. The implication is that a mother's body is positioned as the ecosystem of the optimum source of nutrition for the infant (Wall, 2001). Within the intensive mothering discourse, she is responsible for self-management of her diet, intake of fluids, and abstaining from risk-taking behaviours (Wall, 2001). This construction is further examined by

South African anthropologist Waltz (2014), who builds on the previous research of Avishai (2007, 2011).

Breastfeeding as a full-time job

In her research, Waltz (2014) examined how eight middle-class first-time mothers in South Africa talked about breastfeeding. Waltz (2014) found that her sample of career-driven mothers framed the act of breastfeeding as a job, and they drew on their previous identities as professional, career women who were succeeding in the workplace. Waltz (2014) found that mothers drew on work-related discourse to apply themselves to excel and achieve in breastfeeding. Waltz (2014) found that the mothers identified with their 'intellectualised side' as professional women to guide the process of breastfeeding and consequently placed high expectations on themselves to be "totally devoted mother[s]" (p.44) while simultaneously aiming to "strive for independence in their careers as autonomous women" (Waltz, 2014, p. 44). Waltz (2014) emphasised that for this group of mothers, their dedication and commitment to breastfeeding was "the ultimate marker of the good mother" (p.44). Waltz (2014) concluded that good mothering is equated with intensive mothering when mothers use the project approach to manage their breastfeeding bodies. Waltz (2014) found that this discourse presents high expectations that lead to mothers feeling guilty and ashamed when they are not attained. I discuss this in the section to follow.

Maternal guilt and shame

The premise upon which the discourse of good mothering is founded is that a mother must keep her child from harm (Lee, 2007). One of the earliest perceived risks of harm concerns an infant's nutrition, which is why infant feeding practices are at the centre of the good mother discourse (Striley & Field-Springer, 2014). These sociocultural norms are embedded within the good mother discourse and reflective of pervasive parenting standards (Avishai, 2007). Many mothers draw on these socially constructed expectations of breastfeeding, and mothering discourses, to navigate their role as a mother and the task of

feeding their infants (van Esterik, 1994). These standards are used to measure and judge decisions made by mothers around breastfeeding and are internalised as they judge themselves (Knaak, 2010). Knaak (2010) argues that mothers are conditioned regarding infant feeding decisions. Knaak (2010) found in her sample of Canadian mothers that their intention to breastfeed was more than the aim to ensure the health of their baby, it was connected to the broader context of risk, specifically the negative associations with formula (as being deemed the lesser option) that they wished to avoid. Thus, despite breastfeeding difficulties, mothers feel immense pressure to continue breastfeeding to uphold the standard of providing their infant with 'the best' (Andrews & Knaak, 2013). The implication is that mothers are monitored and held to account (by society, themselves and in medical contexts) when they do not breastfeed. In her research, Knaak (2010) found that breastfeeding mothers judged those who did not breastfeed, questioning the goodness of those mothers who used formula, thereby maintaining the intensity of these standards within the good mothering discourse. Thus, the pro-breastfeeding discourse has contributed to a discourse of risk surrounding using formula. This is further reinforced and maintained through public health campaigns constructing breastfeeding as the best offering. Consequently, mothers manage this risk by dedicating themselves physically and emotionally to breastfeeding success to avoid the risk of moral danger, as formula use is considered not to prioritise their infant's well-being (Murphy, 2000; Knaak, 2010).

Mothers who cannot meet the high expectations of good mothering are vulnerable to feelings of guilt and shame (Taylor & Wallace, 2012). The ideals embedded in the pro-breastfeeding and good mothering discourse can lead to mothers questioning themselves (and not the dominant discourse) when these standards cannot be met (Hauck & Irurita, 2003; Larsen et al., 2008). It is noteworthy that Guyer et al. (2012) found that their sample of British mothers presented their feelings of guilt, irrespective of their breastfeeding duration. This guilt was greatest when they believed they had placed their needs above their baby's, indicating the intensity of this discourse and how mothers used these standards to judge

themselves. Mothers who introduce formula must navigate a "moral minefield of good mothering ideals and assumptions" in negotiating their position as good mothers (Guyer et al., 2012, p. 725; Murphy, 2000; Schmied & Lupton, 2001). In the following section, I introduce the literature on the discourse of formula use, which is positioned as the alternative to breastmilk.

Introducing formula as the 'alternative'

In the early twentieth century, when formula was introduced as a safe alternative to breastmilk, it became an everyday product used by mothers in the global north (Brookes et al., 2016). Although medical professionals endorse the use of formula, breastfeeding has been promoted through global initiatives, with WHO setting targets to increase the number of babies fed breastmilk exclusively by 50% (WHO/UNICEF, 2003). Marshall et al. (2007) found that in their observation of 158 new breastfeeding mothers in England, they spoke of their resistance to introducing formula. However, for the mothers who struggled to breastfeed, formula became the next best option to meet their baby's nutritional needs. Lee (2007) found in her sample of British mothers that the mothers who introduced formula continued to measure themselves against the moral benchmark of breastmilk being best. This affected how they formed a positive maternal identity whilst using formula, as the 'breast being best' message was internalised as a core mothering belief (Lee, 2007). Thus, mothers find themselves drawn to the pragmatic offering of formula while experiencing tension accompanying this decision. This is based on the constructed risks associated with its use as they enter a moral minefield of risk consciousness, uncertainty, and complexity (Lee, 2007).

Larsen et al. (2008) examined published studies completed in the global north on how mothers constructed their decision to end breastfeeding. The authors found that the decision to terminate breastfeeding was a crucial decision that mothers spent substantial time justifying. The mothers spoke of the intensity and difficulties of breastfeeding, which they did not feel prepared for. Larsen et al. (2008) found that the mothers sought

reassurance from health professionals to continue to try to make breastfeeding work and advice on which formula to use. For some of the mothers who stopped breastfeeding, they found their experience of bonding with their babies was better. When using formula, they constructed their babies as calm and sleeping better, and were satisfied they were growing well. It was very important for the mothers to see their babies thriving on formula (Larsen et al., 2008). In doing this, the mothers deviated from the dominant discourse of breast being best and formed counter-discourse to rationalise their decision. In the following section, I present the research on the counter-discourse of breastfeeding and good mothering.

Forming a counter-discourse

In her research of how thirty-six British mothers spoke about their decision to use formula and manage risk consciousness, Murphy (2000) found that mothers who chose to use formula resisted the construction of being negligent and not committed to their babies in their talk. Instead, they offered reasons for choosing to use formula and realigned their position as good mothers by doing this. The mothers spoke of the “disjunction between their own experiences of motherhood and expert prescriptions about optimal maternal behaviour” (Murphy, 2000, p. 319). The mothers did not challenge nor resist the discourse that they are regarded as responsible for the well-being of their babies or that their babies' interests must be prioritised over personal needs (Murphy, 2000). This meant endorsing the ideology of good motherhood; however, they resisted the interpretation that their choices or behaviour were anything less than what the discourse contained (Murphy, 2000).

Murphy (2000) found that when introducing formula, mothers spoke of their responsibility for their baby's well-being and provided several reasons to justify their decision. The mothers spoke of formula being used because of poor latching and their baby resisting the breast (Murphy, 2000). They highlighted that their baby was still happy and healthy receiving formula (Murphy, 2000). In doing this, they could resist the risk of being deemed to be negligent or scrutinised for a lack of commitment.

Similar findings were shared by Símonardóttir and Gíslason (2018), who examined the talk of seventy-seven mothers in Iceland who chose to use formula instead of breastfeeding. The authors specifically focused on how the mothers formed counter-discourses that argued for their good mothering when introducing formula to their babies. This was not a lightly informed decision, as the mothers experienced severe difficulties such as mastitis, pain, infections and sore nipples and low milk supply when breastfeeding. They invested significant emotional and physical energy to establish breastfeeding, but it was insufficient to continue exclusively breastfeeding. Alexander (2010, p. 957, cited in Símonardóttir & Gíslason, 2018, p. 6) argues that in these situations, mothers experienced a "crisis in [their] sense of self" when they were unable to establish breastfeeding. Consequently, the mothers constructed a competing discourse to contest the dominant pro-breastfeeding discourse.

In the research of Murphy (2000) and Símonardóttir and Gíslason (2018), there are similar findings of the counter-discourse that mothers draw on: the baby is healthy; it was beyond their control; breastfeeding is painful and uncomfortable, and breastfeeding does not mean bonding. Each of these is discussed in the section to follow.

The baby is healthy

In her findings, Murphy (2000) examined how the mothers who introduced formula presented the account that the baby was healthy, therefore, unharmed by formula. Formula use was defended by their baby's weight gain and the view of the health visitor. The mothers drew on the experiences of others whose babies had been formula-fed and healthy (Murphy, 2000). These personal observations were used to discredit the information mothers had read about the risks that accompanied formula use. By drawing on this counter-discourse, mothers reassert themselves as good mothers for making this decision. Using formula was redefined as an act of responsibility by putting the baby's welfare above others' opinions. Símonardóttir and Gíslason (2018) found a similar construction, as these mothers had

internalised the message that 'breast is best', so a healthy formula-fed baby offered "some redemption" for using formula (Símonardóttir & Gíslason, 2018, p. 7).

It was beyond their control

Murphy (2000) identified a second construction of breastfeeding being "beyond the mothers' control" (p.309), drawing on contextual difficulties that negatively impacted on breastfeeding. Formula use was constructed as an inevitable outcome due to stressful circumstances (such as a traumatic birth experience) that were not within their control. The mothers stressed that this was an involuntary decision and emphasised their distress at not being able to fulfil their commitment to breastfeeding. By reframing the use of formula to prioritise their baby's nutritional needs, the mothers' morality was upheld "not in spite of, but actually because of their decision to formula feed" (Murphy, 2000, p. 311).

Breastfeeding is painful and uncomfortable

The mothers in Murphy's (2000) study introduced the experience of physical pain during breastfeeding, to justify formula use. Within the discourse of good mothering, the needs of the mother are positioned secondary to those of the baby, and hence discontinuing breastfeeding due to painful, cracked nipples and engorged breasts rendered these mothers vulnerable to being seen as selfish and placing their own needs first (Murphy, 2000). Murphy (2000) found that this group of mothers spent considerable time discussing their extreme pain and physical discomfort in breastfeeding. The mothers spoke of the physical suffering that accompanied breastfeeding, and how it negatively impacted on their well-being. Thus, formula was positioned as the solution for them to feel physically better by alleviating their pain and discomfort so that they could continue to prioritise their baby's needs (Murphy, 2000).

Breastfeeding does not mean bonding

In their research, Símonardóttir and Gíslason (2018) found that some mothers rejected the construction of breastfeeding as essential for bonding with the baby. These

mothers constructed breastfeeding as an "emotional rollercoaster", unhelpful for bonding due to difficulties in managing their mood and emotional well-being (Símonardóttir & Gíslason, 2018, p.8). The mothers spoke of their postnatal depression contributing to their negative experience of breastfeeding. The mothers were presented with the choice of continuing to breastfeed and being depressed, or ending breastfeeding to improve their mental health. The mothers challenged the construction of breastfeeding as necessary for bonding between mother and child and instead spoke of breastfeeding being unpleasant and stressful (Símonardóttir & Gíslason, 2018). The authors found there is a stigma accompanying this discourse which is based on the premise that mothers should enjoy breastfeeding to promote bonding. The mothers expressed the feeling of guilt about ending breastfeeding without a legitimate (medical) reason and spoke of the value in being able to talk about their experiences without feeling ashamed (Símonardóttir & Gíslason, 2018).

In their research, Símonardóttir and Gíslason (2018) found that mothers spoke of the benefits of supplementing feeding using formula and emphasised their relief when drawing on the counter-discourse that highlighted the positive aspects of formula use. The mothers spoke of better enjoying their role as a mother by alleviating the struggle of persisting with breastfeeding. The research discussed in this chapter has emphasised that introducing formula is a decision that mothers deliberate before making. In doing this, the mothers continue to align with the standards of the good mother discourse. Thus, mothers negotiate their decision to use formula to prioritise their babies' needs as there is a close interplay between their agency and the perpetuation of the dominant discourses at play. Reframing formula in a positive was is influenced by the mother's sociocultural context, drawing on counter-discourses available to them. None of the mothers in Murphy's (2000) and Símonardóttir and Gíslason’s (2018) research actively challenged breastfeeding as a necessary act of good mothering. This means mothers must re-position themselves, and adapt, to fit the perceived ideals within good mothering and the pro-breastfeeding discourse (Machiori, 2021).

In the next section, I introduce post-structuralist feminism to engage with the engendered complexities of the current sociocultural parenting standards that continue to uphold the good mothering discourse.

Theoretical framework

The post-structuralist feminist theory forms part of the larger feminist approaches that focus on how women experience oppression and exploitation in society, the workplace, and the family. It aims to bring change through conscious action by men and women (Van Esterik, 1994). Feminist theory seeks to be transformative as it critically engages with the institutions in place that propagate engendered stances in a patriarchal society (Creswell, 2013). This is done by examining how language and discourse influence women's lives, as it acknowledges the complexity and contradictions in social constructions of human behaviour (Gavey, 1989). Post-structuralist feminism examines how women are positioned as gendered subjects and seek to make overt the power relations that construct and maintain gendered discourse that is accepted as normal in society (Creswell, 2013; Davies & Gannon, 2005). This is done by examining the "discursive and regulatory practices" that construct the "grand narratives" people identify with and believe they own (Davies & Gannon, 2005, p. 312). When critically engaging with discourse, post-structuralist feminist theory questions how women have essentialised certain ways of being, such as the good mother discourse, and how these idealised standards are taken up as one's own (Davies & Gannon, 2005). Davies and Gannon (2005) critically argue that "the point of feminist post-structuralism is not to expose the hidden truth of sex or gender in all its simplicity, but to trouble that which is taken as stable or unquestionable truth" (p.314). This is relevant to critically examining how breastfeeding is positioned as an imperative for good mothering and how feminist research can contribute to disbanding these idealised standards.

Feminist research has focused on empowering women within their role as mothers, as opposed to prescribing standards that deny the value of their experience (Blum, 1993). There is much feminist engagement in the activity of breastfeeding, as it is an activity that

intersects "nature, science, women's sexuality, and children's needs" (Wall, 2001, p.593). The complexities of interdependence and interaction in the breastfeeding experience should be acknowledged in published research (Schmied & Barclay, 1999). Blum (1993) argues that there are currently two diverging stances in feminist literature on breastfeeding: the construction and the deconstruction of breastfeeding. The societal construction of the meaning of breastfeeding, within the idealised expectations of good mothering, is maintained and created through sociocultural and political influences. Thus, the personal is considered political in the context of feminist theory and breastfeeding (van Esterik, 1994). Therefore, post-structuralist feminism critically discusses how current social constructions disempower women as mothers. This might involve critiquing the discourse's focus on 'achieving' breastfeeding (van Esterick, 1994). In her feminist writings on breastfeeding, Van Esterik (1994, p. 72) states that breastfeeding reflects “the uniqueness of human beings and the uniqueness of every mother-infant pair”. She argues that insisting on uniformity of practice in breastfeeding will fail the mother and that “politically correct breastfeeding” should be avoided (van Esterick, 1994, p. 73). Van Esterick (1994) argues that prescribing standards for breastfeeding assumes that it can be controlled and managed, which is not what mothers experience. Therefore, a post-structural feminist critique of the dominant medical and natural discourses of breastfeeding is essential because these discourses minimise the individuality of the mother's experience of breastfeeding and hold her accountable to pre-set expectations that she 'ought' to follow.

In post-structuralist feminism, Davies and Gannon (2005), argue that a woman as a gendered subject is not fixed, as she can shift her position according to what her current context means to her and how she positions herself in relation to others. Therefore, a mother's agency is embedded in multiple and contradictory discourses. Hence the current discourses of breastfeeding and motherhood should not be considered the norm nor a valid measure of motherhood success due to their socially constructed nature (van Esterik, 1994). The post-structural feminist theory advocates against binary categories of breastfeeding

within mothering practices. It empowers researchers to help articulate the complexity of how women navigate their role as mothers and the task of feeding their infants.

The current research examined how first-time middle class South African mothers positioned themselves as good mothers through the act of breastfeeding. The research aimed to contribute to the literature on good mothering and breastfeeding discourse in South Africa. The objectives of this research were to firstly examine the breastfeeding expectations of first-time mothers and how they were used to inform their initial subject position; and secondly, examine how the first-time mothers positioned themselves within the good mother discourse concerning their breastfeeding experience. In this research, I aimed to answer the following research questions: How do first-time mothers talk about their expectations and experience of breastfeeding? Furthermore, how do mothers construct what it is to be a ‘good mother’ through breastfeeding? In the next chapter, I present the research methodology of the study.

Chapter 3

Methodology

In this chapter, the methodology used for the research study is presented. I discuss the qualitative research design and the social constructionist approach used in this research. I detail the sampling, recruitment, data processing, and analysis processes. The chapter concludes with the ethical and quality considerations of using qualitative research.

Research design

The study used a qualitative approach to examine first-time mothers' breastfeeding experiences. Qualitative research enables the in-depth research of phenomena, behaviours, and events from the individual's perspective (Babbie & Mouton, 2005). As such, a qualitative research design is well suited to exploring the complexity of human behaviour (Snape & Spencer, 2003). Babbie and Mouton (2005) further highlight that using a qualitative research design enables the researcher to capture in-depth, open, and thick descriptions of phenomena. As the researcher, it allowed me to "delve into questions of meaning" in the data collection process (Starks & Brown Trinidad, 2014, p.1372). Spencer (2007) advocates for using qualitative research to examine the inherent complexities of breastfeeding and for it to be better understood within the current sociocultural context.

Within qualitative research, two main paradigms inform the epistemological stance, namely the interpretive and constructionist approach. The interpretive approach uses ordinary language to understand individuals' social world better. However, it does not consider the role of the social context on the subject (Terre Blanche, Kelly & Durrheim, 2012). Social constructionism differs from interpretivism as it examines how “social realities are produced, assembled and maintained” (Holstein & Gubrium, 2008, p. 374, cited in Silverman, 2013, p. 107) and contributes an explicitly critical element to research in social sciences (Terre Blanche et al., 2012). Social constructionism focuses on how feelings,

thoughts and experiences are products of systems that exist at a social level (Terre Blanche et al., 2012). These frameworks are upheld through the words we use, as "language helps to *construct* [the] reality" of individuals (Terre Blanche et al., 2012, p. 278, emphasis in the original) and are maintained through organised sets of beliefs that form discourses (Terre Blanche et al., 2012). A social constructionist approach was the most appropriate approach to examine how mothers talk about their breastfeeding experiences and to draw on ideologies of motherhood. The approach was selected because the research objectives and theoretical framework aimed to examine how the mothers constructed their experiences.

Research questions

In this research, there were two questions I wanted to answer: Firstly, how do first-time mothers talk about their expectations and experience of breastfeeding? Furthermore, how do mothers construct good mothering through the activity of breastfeeding? These questions informed the sampling, recruitment, data collection and analysis process. Each of these methodological stages will be discussed in further detail below.

Sampling

In qualitative research, purposive sampling (also called criterion sampling) allows the researcher to decide on sampling criteria ahead of time to specify the research participants needed to answer the research question (Creswell, 2012). Ritchie, Lewis, and Elam (2003) explain that purposive sampling has two principal aims: firstly, to select participants who have the necessary features and characteristics relating to the subject being investigated, and secondly, to ensure that diversity is included within the key criteria for further exploration. This was the most appropriate sampling technique, as specific sampling criteria informed how I sampled and recruited the research participants.

Sampling criteria

The first criterion was to sample first-time mothers living in South Africa. I selected first-time mothers because they were new to the experience of breastfeeding and

motherhood, to provide first-hand accounts of breastfeeding. I aimed to sample mothers who had accessed privately paid-for pre-natal and ante-natal care and who were breastfeeding (or had attempted breastfeeding) following the birth of their babies. This criterion was informed by previous research where mothers from a Westernised, educated, and middle-to-higher-income have been found to favour the pro-breastfeeding and good mothering discourse (Avishai, 2007; Kukla, 2008; Waltz, 2014). Further criteria included mothers over 18 years of age, as they are adults and can consent to participate in the research. I selected the criterion that the participants were fluent in English, which meant that I did not require an interpreter. This meant I could conduct the interviews in English, as this is my first language. I decided to exclude mothers who had babies with health complications as this may have prevented the mother from breastfeeding and contribute to additional stress, which was not the focus of the research. Purposive sampling was also beneficial because it meant sampling could be done within the limited time constraints to complete this research study.

Sample size

In qualitative research design, a smaller sample size is used to focus on in-depth, detailed accounts of participants (Creswell, 2012). A small sample size was also chosen for pragmatic reasons, specifically the time constraints of the mini dissertation. The final sample size for the research was six mothers. The sample size was finalised due to reaching data saturation after I had sampled and completed the interviews. Hence, I did not recruit any more participants after the sixth mother.

Recruitment

Permission to complete the research was granted by the University of KwaZulu-Natal's Biomedical Research Ethics Committee (BREC) (BREC/00001183/2020) (see Appendix 1) before I commenced recruiting participants. I identified a recruitment site where I could complete purposive sampling of mothers who had recently given birth and, for

pragmatic reasons, who were in my local area. I contacted a midwife who manages a private baby clinic in KwaZulu-Natal, offering paid midwifery services to mothers. I selected this site for recruitment due to the sampling criteria, as mothers were already accessing midwifery services from this site. At this clinic, most of the mothers who attended, and used the services of the clinic were from a middle-class socioeconomic background. The access to this setting enabled a sample to be recruited within time constraints for this dissertation to be completed.

In my telephone call to the midwife (who shall remain anonymous to ensure the confidentiality of the participants), I explained the aim of my research study. I asked if she would be interested in having her clinic used as a site to recruit mothers for my research study. The midwife agreed to discuss the study further, and I arranged to meet her in person at her clinic site.

I explained how I would conduct the research study at the in-person meeting. I offered the midwife an opportunity to ask me questions about the research process. I clarified the sample criteria of first-time breastfeeding English-speaking mothers, over the age of 18 years who did not experience complications with the birth of their baby. Following this, she was satisfied with the details of the research study, and she signed a gatekeeper's permission letter (see Appendix 2). At this meeting, I also asked the midwife to sign a confidentiality agreement as an ethical requirement of the research to ensure that the identity of the mothers sampled from the research site would remain confidential (see Appendix 3). The midwife agreed to this and demonstrated an understanding of the importance of confidentiality in research. I completed an invitation letter for the prospective participants that detailed the aim of the research and how it would be conducted practically (see Appendix 4). The letter included necessary information about myself as the researcher and the contact details of my supervisor and the UKZN BREC. The letter included information about the benefits and risks of participating in the research and the expectation that I would abide by the ethical standards of the BREC. I also included details of support

organisations that mothers could contact as needed. This letter was placed in a sealed envelope, and I dropped off ten copies with the midwife. The midwife handed out the letters to mothers who met the sample criteria, and she did not disclose to me any details of whom she had given these invitations.

Six mothers contacted me through email correspondence and text messages from May to June 2020 and shared their interest in participating in the research study. I communicated the process of how the interviews would be conducted. I explained the ethical constraints of confidentiality and how their details would be anonymised in the research, and they each confirmed their willingness to proceed. Each mother provided me with their email address, to which I emailed a copy of the informed consent form to read prior to the meeting for the interview (see Appendix 5) and a copy of the agreement to have the interview recorded (see Appendix 6). Each mother was informed that they could contact me through email or telephone to discuss the forms and have their questions answered prior to the day of the interview. The mothers signed a copy of the informed consent form and the agreement to record the interview form and scanned the documents to me via email. This was done before the interview took place.

All six mothers who contacted the researcher and demonstrated interest in participating were interviewed as they met the sample criteria. The details of the sample of the six mothers are that they were first-time mothers who were from a White ethnic group, were fluent in English, and their ages ranged from 28 to 45 years of age. Table 1 below presents the details of the research participants, and I have allocated each mother a pseudonym to ensure their privacy.

Table 1

Research participant details

Pseudonym	Age	Career	Marital status	Baby's Age	Sex of baby	Feeding method
Sarah	28	Teacher	Married	7 months	Male	Exclusive breastfeeding
Cara	28	Teacher	Married	4 months	Female	Formula (after 3 weeks of breastfeeding)
Roxanne	35	Business owner	Married	7 months	Male	Mixed feeding
Tracey	33	Finance	Married	3.5 months	Female	Exclusively breastfeeding
Melissa	28	Sales	Married	2.5 months	Female	Exclusively breastfeeding
Keira	45	Medical professional	Single mother	4 months	Male	Mixed feeding

Sarah, Cara, Melissa, Keira, Tracey, and Roxanne participated in the research and were interviewed about their breastfeeding experiences. All six mothers had careers that positioned them in a middle-to-upper socioeconomic background in South Africa. The mothers were educated, professional women in teaching, medicine, business, finance, and sales careers. Five of the mothers in the group were married in heterosexual relationships. One mother was single and had used in-vitro fertilisation to conceive her baby. All six of the mothers had delivered their babies in a private hospital, with two mothers delivering through a vaginal delivery and four mothers through a caesarean section. All six mothers accessed the private clinic's postnatal care and midwifery support to differing degrees and were breastfeeding or had attempted breastfeeding. The ages of their babies ranged from two and a half months to seven months of age. Sarah, Melissa, and Tracey were able to maintain exclusive breastfeeding following the birth of their babies. Keira and Roxanne used formula to supplement their breastmilk supply, and Cara decided to formula-feed her baby after attempting breastfeeding and terminating breastfeeding after three weeks. In the next section, I discuss the data collection process.

Data collection

In qualitative research, the researcher is the primary data collection instrument and actively facilitates conversations with research participants (Silverman, 2013). The social constructionist approach positions the interviewer as a key role player who actively co-constructs the interview's content (Kelly, 2012). This is because the interviewer and interviewee are influenced by each other as the interview context is not neutral but rather "the arena within which particular linguistic patterns can come to the fore" (Kelly, 2012, p. 297). Hence each role player contributes to the process of meaning creation. Interviewing was an appropriate data collection method for the research study, and it has also been used in previous research on the topic of breastfeeding discourse and motherhood (Avishai, 2007; Waltz, 2014). Using interviewing, I could talk with the mothers about their breastfeeding experiences which generated content to analyse. Communication techniques, such as probing, were used to generate more information on a key point of interest and encourage the interviewee to talk more about a topic (Legard, Keegan & Ward, 2003). I developed an interview schedule from reviewed literature on breastfeeding and good mothering. My interview schedule included open-ended questions to generate the conversation (see Appendix 7).

The interview schedule

The interview schedule was divided into five sections: the first section collected the necessary demographic data about each mother to learn more about their age, relationship status, details about their baby and their birth experience; the second section explored the mothers' expectations of breastfeeding and their current infant feeding experiences; the third section asked the mothers to talk about their views on motherhood; the fourth section explored how mothers viewed breastfeeding concerning the act of mothering, and finally, the fifth section concluded the interview with reflecting questions offering the mothers' opportunity to share what they have learnt about breastfeeding, and themselves.

The interview process

When the interviews were due to commence in May 2020, there was a global health crisis, namely, the COVID-19 pandemic. In response, the South African government instated rules of social distancing to ensure the health and safety of the South African people. This meant that all in-person contact was restricted to prevent the spread of the virus. My data collection took place over three months, specifically from May to July 2020, and the COVID-19 virus remained a prominent concern during this time. As a result, I amended the original protocol for the data collection process to complete the interviews online following the university Ethics Committee's policy on social distancing requirements in research processes. Online interviewing using a video application was the next best option to conduct interviews. It enabled me, as the interviewer and the participant, to see each other during the conversation and maintain social distancing. I reviewed the literature on online interviewing to explore my options, and Archibald et al. (2019) found Zoom, an online video-conferencing programme, a reliable application for qualitative interviews because the researcher and participant can see each other during the interview and the programme allows for the recording of the interview.

I conducted the interviews via Zoom, using a paid account, where an encrypted email invitation was sent with a link for each participant to join individually. I confirmed with each participant that they had access to WIFI or the internet and ensured they were content to proceed with the interview through Zoom. All six mothers were familiar with Zoom, using it within their social networks and for work-related purposes. I advised each participant to contact me if they needed support to use the application or were experiencing technical difficulties. I completed the interviews in a private room with the door closed to ensure privacy. The mothers selected a convenient day and time to participate in the interview. Each mother had childcare arranged for their babies at the time of the interviews, and they completed the interviews from their homes.

I ensured that I checked that each mother was comfortable to proceed and reassured them that they were free to pause the interview to check on their baby. The length of the interviews ranged from one to two hours. After each interview, I ended the Zoom online video call, and the recording was saved as an mp4. file on my laptop. I assigned a pseudonym to each participant and labelled the interviews from Interview 1 to 6 in password-protected folders. I was the only person who listened to the recordings. Following the University of KwaZulu-Natal's BREC ethical standards requirements, these audio files will be deleted after being kept for five years on my laptop.

Data processing

The six interviews were transcribed using Jeffersonian transcription conventions as it enables the detail of the conversation to be captured in the transcript to show the tone, volume, pauses and hesitation, as well as sounds such as laughter, pace, intonation, and sound elongation, which provides a detailed account of the talk (Jefferson, 2004; Silverman, 2013). These conventions are provided in Appendix 8 and included in the selected extracts in Chapter Four on the findings. Using Jeffersonian conventions is valuable as it enables the researcher to include the details of the talk in data analysis to examine what the talk is achieving.

I transcribed each interview shortly after it was completed, and this enabled me to reflect on my interview questions and identify any opportunities in probing and questioning that I could be more aware of in the interview. I found the transcription process using Jeffersionian conventions time-consuming, and it took up to eight hours to transcribe one of the more extended interviews. To ensure the accuracy of how each mother's talk was captured, I spent significant time relistening to the sections of the talk to insert the correct conventions to represent the talk best and capture the nuances. An advantage of this was that I became very familiar with my data, which was beneficial for the data analysis process, which I describe in the section below.

Data analysis

Discourse analysis examines "the way versions of the word, of society, of events, and inner psychological worlds are produced" (Potter, 2004, p. 202, cited in Silverman, 2013). A discourse "is a framework of language that consists of common assumptions which, in most cases, are invisible" (Cheek, 2004, cited in Burns, 2012 p. 1739) as it is "embedded in social, cultural, and political settings, and used for certain purposes" (Lupton, 2003, p. cited in Lupton, 2011, p.642). Hence, a discourse is shaped, created, and reproduced through language organised through categories, concepts, and practices (Lupton, 2011). Discourse structures society and is reproduced through social interaction, ways of thinking and the subjectiveness of the individual (Gavey, 1989). Therefore, the meaning of a social practice, held and maintained within discourse, is relevant to its specific context and will change accordingly (Weedon, 2004). Weedon (2004) further explains that discourse is the linguistic location for expressing knowledge and power produced by sociocultural influences and institutions, and people use it to define and position themselves.

Discourse analysis recognises how language constructs reality and how it plays an important role in maintaining that reality. Analysing discourse through language makes the hidden patterns and processes overt and interpreted (Gavey,1989). When discourse is analysed, there is an opportunity to identify the influence of power and interrelated social systems that contribute to and produce the frameworks embedded within language. This means language is not value-free and that when people communicate, it is more than a transfer of words and information. Instead, it is an interaction where personas and subjectivities are shaped, and meaning is created (Weedon, 2004). Discourse offers "subject positions" for people to "take up" (Weedon, 1987, cited in Gavey, 1989, p. 464). The value of understanding subjectivity is how individuals describe their sense of who they are to the world around them. It is actively mediated by the talk about oneself and others, shaping and creating meaning and identity (Weedon, 1987, cited in Gavey, 1989).

The process of internalising forms of identity which the individual ‘takes on’ is then ‘performed’ and lived out. This performance includes the “repeated assumptions of identities in the course of daily life” (Weedon, 2004, p. 6). In exploring the concept of performance within discourse, Weedon (2004) explains that individuals situate themselves within specific discourses and repeatedly perform their identity and subjectivity until this becomes internalised (like second nature) and part of the subject’s reality. Gavey (1989) argues that people actively identify or resist certain constructions to decide how they position themselves in relation to discourse. Discourses deemed 'dominant' are considered natural, are unquestioned, and are how power relations are perpetuated in society (Gavey, 1989). The post-structuralist feminist theory acknowledges the value of discourse analysis as it examines how the "rational conscious subject is decentred, and the play of desire and the unconscious is made relevant" (Gavey, 1989, p. 313), shedding light on the discourses available in that context.

In her writing on discourse analysis, Gavey (1989) explains techniques a researcher can use to complete a discursive analysis by carefully reading through the text and including conventions to identify "discursive patterns" (p.467). These patterns can be identified through the inconsistencies and contradictions in the interview talk and coded accordingly. There is no one method for discourse analysis, as it is a broad form of analysis that is "attentive to both details in language and to the wider social picture" (Gavey, 1989, p. 467). Terre Blanche, Durrheim and Kelly (2012) offer further guidelines to complete discourse analysis, namely for the researcher to take up a position of critical reflection when reviewing the data, to ask questions about the action and be aware of its context, and to look for binary opposites, repeated words, expressions, and figures of speech in the transcripts. It is, therefore, a process of drawing out what is implicit to identify how the participants construct their experiences and position themselves with dominant discourses through language.

In this section, I have discussed discourse analysis to demonstrate that it is an effective means of analysis for this research study. It examines how socially constructed

frameworks inform people's subject positions (Weedon, 2004). It was the most appropriate form of data analysis to answer the research questions. It was selected to identify the socially constructed meaning underpinning mothers' breastfeeding experiences and beliefs of good mothering. In the following section, I discuss the ethical considerations of the research and issues of quality and qualitative research designs.

Ethical considerations

In this research, I used the ethical considerations outlined by Wassenaar and Mamotte's (2012) recommended framework to discuss these ethical elements and how I have applied them to this research study.

Collaborative partnership identifies how the community can be involved through active participation in the research, specifically how the community can express the need for the research and be involved in each stage (Wassenaar & Mamotte, 2012). There was limited collaborative partnership in this study as I decided to complete this research based on feedback from first-time mothers in my social circles who spoke of the stressors accompanying breastfeeding. From this stance, the social value of this research is that it addresses a sensitive and value-laden topic for many first-time mothers. To further increase the social value of this research, I will offer a summary sheet of the final research dissertation to all six mothers and midwife to disseminate the results to them.

The ethical element of the fair selection of participants ensures the researcher has avoided stigmatisation for the selected population of the study (Wassenaar & Mamotte, 2012). Mothers were not directly incentivised to participate in the study and were not compensated for their time or internet use. This was unnecessary as each of the mothers had WIFI in their homes due to working from home because of the global COVID-19 pandemic lockdown restrictions. Each mother, who was over 18 years and fluent in English, confirmed their voluntary agreement to participate in the research prior to completing data collection. The stigmatisation of participants was reduced through confidentiality and using

pseudonyms to maintain their privacy. Thus, the details of the participants would not be known and linked to their responses, so the chances of stigmatisation are minimised.

The favourable risk/benefit ratio was considered according to the likelihood that the research participants would experience harm by participating in the study. In discussion with my supervisor and BREC Ethics application, I identified very low risks for the mothers participating in this research. I identified that mothers might experience stress or discomfort when talking about experiences that may have been difficult, as well as current stressors relating to infant feeding and motherhood. To address these risks, I put the following measures in place: I provided contact information for a counselling service by a local charity in the area and information for a support group for mothers with young babies. This information was for their consideration, and the details were included in the study invitation letter (see Appendix 4). During the recruitment process, I checked if mothers felt comfortable before the interview and reminded them of the services recommended if they were experiencing stress. I informed each of the mothers of the measures in place to protect their privacy, including being given pseudonyms in the research. I explained that the interview would stop if they experienced stress or discomfort to avoid increasing their distress.

All six mothers discussed the benefits of discussing their breastfeeding experiences and motherhood. The mothers each shared their hope that the information from this research could be used to benefit other first-time mothers.

The mothers were shown respect during the data collection process, and the ethical element of ongoing respect is demonstrated by the mothers being informed that they could withdraw from the research at any time. As the research entailed one interview per participant, there has not been any further correspondence with the mothers, nor the need to monitor them throughout the research process, as this was not the remit for the study. The details of the clinic site and midwife have also been kept confidential as a further measure to ensure the confidentiality of the participants.

Wassenaar and Mamotte (2012) further advocate that all researchers must ensure all research participants' voluntary and informed consent, which was upheld in the recruitment and data collection process. All six mothers signed a consent form (Appendix 5) that detailed the voluntary nature of the research, what informed consent meant and the details of the research process. I explained this requirement to each mother, and the consent form was signed and emailed to me prior to commencing the interviews.

In the next section I introduce the issues of quality in qualitative research and draw on the guidance of Silverman (2013) to consider how the scientific requirements of research can be maintained when using a qualitative research design.

Scientific validity

Scientific validity in qualitative research is upheld to the degree that the social phenomenon being investigated is accurately presented (Silverman, 2013). Silverman (2013) recommends that researchers consider the reliability and validity of qualitative research in such a way that it maintains scientific requirements to ensure it is credible, dependable, and transferable. I discuss this further in the section to follow.

Credibility in qualitative research relates to the quality of the alignment between the selected theoretical framework, the research questions, the data collection process, and the analysis of the findings (Korsjens & Moser, 2018). In this research, I have detailed the sampling, recruitment and data collection process and evidenced how the research aims and the theoretical framework informed these processes. Credibility of the data in the study was enhanced by transcribing the interview recordings verbatim to achieve referential adequacy. I used Jeffersonian conventions that detailed the pace, volume, and pauses and captured sounds of laughter when transcribing their interviews which enhanced the credibility of the analysis (Appendix 8). The discourse analysis of extracts from the six mothers' interviews provides evidence of how the findings were attained, enhancing the credibility of the study. Together, this strengthens the coherence of the research and contributes to its credibility.

Credibility was further enhanced by noting Silverman's (2013) concerns for how a researcher can become immersed in the qualitative data, and anecdotalism can occur. This means the researcher may make errors by selecting few or specific extracts to support a particular outcome and argument. Silverman (2013) advocates for the researcher to be critically aware of this error by introducing the refutability principle. Silverman (2013) recommends that a researcher initially refute or argue against any generalisations made to prevent false conclusions in the analysis of the findings. In the findings, I included multiple extracts from the mothers' interview transcripts to refute the error of selection bias. I tried to disprove my initial findings by examining the data from all the interviews before forming my conclusions. Silverman (2013) further recommends using the constant comparative method, together with comprehensive data treatment, whereby all the data collected should be included in the analysis process and critically examined to identify if there are findings that disprove the conclusion. All six interviews were transcribed fully, and the extracts coded as the discourses were identified. In comparing the accounts of the six mothers, I could distinguish differences in their positions, as they did not all say the same thing and highlighted these contrasting constructions in my analysis. Silverman (2013) finally recommends acknowledging and analysing deviant cases to identify variance in the data. In analysing the variance in the data, I presented evidence of the good mother discourse in each of their talk and how the mothers adjusted their position towards breastfeeding and formula to maintain the standards of good mothering.

Dependability relates to whether the research findings occurred as the researcher claims (Van der Riet & Durrheim, 2012). Dependability in this study was enhanced by providing a detailed description of the research process, the sampling process (listing the specific criteria), recruitment process, and data collection process. The detail including the supporting appendices used in this dissertation's recruitment and data collection process allows the reader to determine the dependability of the findings of the study. Dependability has been enhanced by providing sufficient information to for a reader to assess this study,

and potentially to enable future research to examine similar or different findings if these same steps are followed.

Transferability refers to whether the research findings are transferable to similar people in similar contexts (Kelly, 2012; Korsjens & Moser, 2018). It is enhanced by providing details of the sampling criteria and the recruitment process, and the participants in this research. The details about the research process are provided; this enhances the transferability, which refers to the extent to which the findings can be transferred to like people in like contexts.

Reflexivity

Reflexivity entails critical self-reflection of my position (my unconscious bias and pre-conceptions) as the researcher and how this has influenced each step of the research process, specifically my interaction with participants during the interviews and the data analysis process. Therefore, I must name my position and reflect on how this impacted the research process. As a white woman from a middle-class socioeconomic background with experience with breastfeeding, I am aware that I have been influenced by the good mothering discourse and demonstrated sensitivity towards this. My position would have influenced how the mothers presented their breastfeeding experiences, which is well-recognised in discourse analysis. Being in a similar position as a mother could have contributed to offering each mother a safe space to share their personal experiences in detail, thereby enriching the data for analysis. There are, however, possible implications that my similarities may have influenced the mothers to respond in a certain way during the interview to present themselves as good mothers. Mothers may have sought to talk more about their good mothering when considering my similarities. I wonder how each mother would have responded if I was of a different gender, age, or race and what the data would have revealed. This is something that can be considered in future research. It would be interesting to examine the effect that a male researcher has on the data and how a researcher of a different gender would influence mothers.

During the research process, I benefitted from supervision to aid the necessary process of reflexivity. The supervision offered contributed to my awareness of instances where I was over-identifying with the data in my analysis. Instead, it reminded me to remain focused on what each mother was saying, as opposed to making inferences about their experiences. I was also tasked to reflect on the meanings held within mothers' talk critically and not draw on my own experiences to make inferences in my analysis process. This strengthened the quality of my analysis process.

Discourse analysis recognises the co-construction of the interview, with the interviewer playing a key role in how the topics are presented and discussed. I had an interview schedule prepared in advance, but I wanted this to guide the areas to be explored, as opposed to being a rigid questioning aid. In listening to the interviews and analysing the transcripts, I aimed to improve the quality of my interviews and be mindful to keep within the boundaries of my focus areas. I have noted that the quality of my interviewing style improved across the six interviews. In the first interview, I found instances where I used statements to elicit further information from Sarah (in interview 1). In hindsight, I could have used more of my open-ended questions. In my final interview with Keira, I felt more confident in the interviewing process and used more open-ended questions supported by probing statements. This reminded me of the importance of preparing for the interview and allowed me to reflect on my interview schedule.

During the research process, I have also reflected on the power and dominance of the good mother discourse and how mothers sought to demonstrate, justify, and rationalise their infant feeding decisions to me when talking about the topic of breastfeeding. The post-structuralist feminist stance is a valuable theoretical framework because it acknowledges these power dynamics in the broader sociocultural context. The implication is that mothers hold themselves accountable to these idealised standards to ensure they prioritise their baby's needs. Consequently, they are predisposed to be vulnerable to social scrutiny in contexts that maintain this dominant discourse, for doing anything deemed to be lesser. The

mothers who used formula spent significant time justifying their decision during the interview, to provide evidence that this was a decision that was well thought through. From a reflective stance, this is a position I can relate to, being a first-time mother who has encountered the powerful influence of the pro-breastfeeding and good mother discourse. I have reflected on the implication of these discourses on mothers' well-being and how they scrutinise and shame themselves for and experience feelings of inadequacy. This is an unhelpful stance for new mothers who are adjusting to the significant life change of motherhood. I wish to continue being mindful of challenging this, as mothers should instead hear positive and uplifting messages during this time.

Chapter 4

Findings

In this chapter, I present the findings of the analysis of the data. All six of the mothers in this study constructed a good mother to be one who prioritises her baby's wellbeing and health and gives her baby 'the best'. For these six first-time mothers, the construction of the good mother began during their pregnancies. Following the birth of their babies, the mothers drew on their breastfeeding expectations to inform their decisions and actions related to infant feeding. The first section of this chapter presents how the good mother discourse is evident in their talk about (1) their commitment to breastfeeding; (2) the management of their breastfeeding body; (3) and drawing on expert-led advice. The second section of the findings examines how mothers talk about introducing formula in infant feeding, the accompanying construction of 'failure' with this decision, and how mothers draw on a counter-discourse to maintain a positive maternal identity.

A good mother is committed to breastfeeding

When I asked the mothers to talk about their breastfeeding expectations, all six of them positioned themselves as being prepared for breastfeeding, ensuring that they were 'ready for the task at hand'. The mothers spoke of 'knowing' about the value (and imperative) of breastfeeding. In their talk, this 'knowing' informed their position of commitment to breastfeeding. Extract 1 is from the interview with Melissa, who works in sales and is a mother of a 2-and-a-half-month baby girl. I asked Melissa to talk about her breastfeeding expectations. The line numbering on the left-hand side indicates where the extract is placed within the interview transcript. The conventions in the extract are from the Jefferson transcripts conventions (see Appendix 8).

Extract 1

Int: Yes I am very interested, like you say, your:: um: your expectations before she was born, around breastfeeding.

Melissa: Okay so um: (.) I – I'd always known I was going to breastfeed my child, or I was going to do the best I could to breastfeed my child, <let's put it that way> as I know it's not always the ↑easiest thing. So I'd always – that was just the standard that I was going to put ↑every effort in to breastfeed my child.

In the extract above, Melissa responded to the enquiry about her breastfeeding expectations. In her words, "I'd always known I was going to breastfeed" (line 152), Melissa positions herself as unwavering in her decision to breastfeed, which was made during pregnancy. The word "always" (repeated in lines 152, 154) constructs breastfeeding as inevitable and without exception. Melissa positions breastfeeding as a key activity of mothering, something she has anticipated doing for a long period of time. Melissa's use of the words "or I was going to do the best I could" (lines 152-153) position her as striving to offer the 'best' to her baby, which is a shift in her talk of breastfeeding being an inevitable act of mothering. Here she draws on the good mother discourse, which is that a good mother gives her "best". Melissa is holding herself to a high standard which is not always the easiest thing. In her talk, her use of "I" repeatedly positions her as having ownership of the task, which is reinforced in her words "my child" (line 152). Melissa is the active agent in her talk and positions her baby as the passive recipient of her efforts. Using the words, "it's not always the easiest thing" (line 154), Melissa draws on a sense of uncertainty accompanying breastfeeding, hinting at the possible challenges and difficulties of the unknown. Despite this, she positions herself as determined by saying, "I was going to put every effort in" (lines 154-155), reinforcing the need to perform as a mother. Her use of the words "every effort" (line 155) position her as willing to labour and struggle to meet the expectations she has placed on herself in her committed position. Melissa's reference to "that was just the

standard" (line 154) for breastfeeding reinforces her rationale for her position. She constructs breastfeeding as the customary and socially accepted practice, making it imperative. In this extract, Melissa's constant use of the words "my child" (lines 152, 153, 155) positions her as responsible in her role as a mother. Drawing on the good mother discourse, she has a duty to ensure her baby receives breastmilk and will give her "best effort".

All six of the mothers referenced a commitment in their preparation for breastfeeding. Cara, a teacher, and mother to a four-month-old baby girl, provided a similar account to Melissa when talking about her breastfeeding expectations, drawing on the phrase 'breast is best'. When her breastfeeding expectations were explored, Cara presented her commitment to breastfeeding by saying, "I'm definitely going to breastfeed, I'm going to try my best to do it" (Cara, Interview 2, lines 114-115). Her words position her as determined and, without a doubt. Extract 2 below continues Cara's talk about her decision to breastfeed, and she introduces an account of her mother's breastfeeding experience to justify her decision.

Extract 2

120 Cara: Um:: and my mom as well. She always told me how she
121 loved breastfeeding. She breastfed all us girls for a year ↑each, and she loved it ↑so
122 ↑much and um:: so I just had this idea in my head that (.) it's ↑normal-
123 Int: Yah=
124 Cara: = that for a mom to feel that way and (.) that's just what you do.

In her talk about breastfeeding expectations, Cara introduces her mother as another woman of significance. In her use of the words, "she always told me how she loved breastfeeding" (lines 120-121), she constructs her mother's account with certainty and lauds her consistency in breastfeeding all three of her daughters. The use of the word "love" (line 121) constructs breastfeeding as an 'act of love' that a mother can take pleasure in. Cara does not say what it is that her mother "loved" about breastfeeding, but she repeats this in

her use of the words, “she loved it so much” (lines 121-122). This is significant for Cara, who has positioned her mother as a role model for herself as she enters motherhood. In her use of her words, “she breastfed all us girls for a year each” (line 121), she introduces a numerical benchmark of one year. Here Cara positions her mother as a good mother, one who finds pleasure in breastfeeding and is committed to feeding each of her babies for a year. Drawing on the account of her mother, Cara constructs the practice of breastfeeding as “normal” (line 122), suggesting that it is customary and the expected practice for feeding an infant. In her use of the words, “so I just had this idea in my head” (line 122), Cara minimises the significance of the account of her mother’s experience, which is that her mother has breastfed for years, to present her decision as almost momentary and made fleetingly. In her use of the words, “it’s normal - that for a mom to feel that way” (lines 122, 124), Cara positions breastfeeding as an intrinsic and instinctual act of motherhood. Cara draws on an essentialist construction of motherhood, which is that she has internalised this expectation implicit in the good mother discourse, which informs her committed position.

Roxanne, a business owner, and mother to a seven-month-old baby boy, provided a similar account in Extract 3 below. Both Roxanne (and Cara above) construct breastfeeding as natural and as the accepted norm. Roxanne talks about her breastfeeding expectations and commitment.

Extract 3

Roxanne: but it was kind of like I just thought it would be something I would do- I did consider it just something that you naturally would do if you ↑could, so: and obviously you know what’s best for your ↑ba↓by, so it was never ↑really an option for me to not breastfeed unless I couldn’t >but at the same time< I wasn’t too stressed if there was an issue and I couldn’t.

In her use of the words “I just thought” (line 46), Roxanne downplays the significant consideration she has given to breastfeeding and positions it as a given act of mothering

using the words “something that you would naturally do” (line 47). Like Melissa (in Extract 1 above), Roxanne’s use of the words “if you could” (line 47) highlights the possibility of being unable to breastfeed. In her words, “obviously you know what’s best for your baby” (line 48), Roxanne reinforces the element of a mother ‘knowing’ instinctively what is best for her baby. She says this is “obvious” (line 48), suggesting it is unquestionable, assumed, and what is expected. Roxanne also uses the phrase knowing what is “best for your baby” (line 48), which positions breastfeeding as the superior offering. From this position of ‘mother knowing best’ (which is associated with what is natural), Roxanne expounds on her commitment using the words, “it was never really an option for me not to breastfeed” (lines 48-49). Here, she positions herself as having no choice, or rather, as there being no acceptable alternative because she invalidates other options. Roxanne’s use of the words “unless I couldn’t” (line 49), introduces an element of uncertainty about her ability to breastfeed, which she makes me, as the interviewer, aware of. Here Roxanne introduces the possibility of being unable to breastfeed, where she would lack the choice to do this, and consequently positions formula as a last resort.

From this context, Roxanne introduces this as the only justification for doing what is sub-standard or not ‘the best’ for her baby. In her use of the words, “but at the same time I wasn’t too stressed” (lines 49), she again downplays the significant consideration she has given to her initial commitment (see lines 48-49). Roxanne repeats her uncertainty about breastfeeding and her ability to breastfeed through her use of the words “if there was an issue” (line 49), and she “couldn’t” (line 50). Roxanne presents the condition that justifies her not to breastfeed, as this would be out of her control because she physically is unable to. Here Roxanne highlights the anxiety accompanying the decision to commit to breastfeeding, as she wants to do it but is aware it might not be as expected. Tracey, the fourth mother interviewed in the research, also takes up this position.

Tracey, who works in finance and is a mother of a three-and-a-half-month baby girl, spoke of her breastfeeding expectations and positioned herself as committed to breastfeeding, as seen in Extract 4 below.

Extract 4

30 Tracey: Yah, so I kind of – ↑although it's a natural process, I know that it can be very
31 challenging for some ladies um:: so right from the get-go, I had – um I'd say – uh::
32 I ↑actually have a really good friend, she's a dietician and she had done
33 breastfeeding for twelve months and uh she ↑actually donated six months' worth
34 of milk after twelve months of feeding her daughter and I just thought – that's
35 incredible, if she can do that, then I at least want to try, and so my goal is twelve
36 months. Um:: (.) and so right from the get-go, once we fell pregnant, I knew that I
37 needed to do ↑whatever I needed to do to:: make it work.

Extract 4 presents Tracey's account of her commitment to breastfeeding. Like the other mothers, Tracey reinforces the construction of breastfeeding as a "natural process" (line 30) but makes me aware that she "know[s] that it can be very challenging for some ladies" (lines 30-31). This is significant as Tracey draws on the experiences of mothers who have breastfed before her as she negotiates her stance concerning what she has heard and seen. She introduces the prospect of breastfeeding being challenging for "some ladies" (line 31) but focuses on the account of a "really good friend" (line 32) whom she positions as successful. Tracey presents numerical benchmarks of feeding through her talk of her friend "breastfeeding for twelve months" (line 33) and then continued to pump breastmilk for six more months, which she donated. In her use of the words "that's incredible" (lines 34-35), Tracey constructs a remarkable account of a mother's commitment and draws on this as a sense of achievement that she "at least want[s] to try" (line 35). This is like the position of Cara, in Extract 2 above, who spoke of her mother breastfeeding her and her siblings for a

year. By introducing a timeline for feeding, Tracey presents the standard she will work to attain, precisely a year, and constructs this as a measure of success as a “goal” of “twelve months” (lines 35-36). The talk of her mothering role is infused with a “goal” oriented focus, and she positions herself as proactive and determined. She sets herself up for success “right from the get-go” (line 31) as she anticipates the effort, she is willing to invest to evidence her commitment. Like Melissa (Extract 1) and Roxanne (Extract 3), Tracey’s words “I knew that” (line 36) construct a rational view that mothers ‘know’ or should know about the imperative of breastfeeding.

In Extract 4, Tracey’s repetition of “I needed to do” (lines 36-37) works to position her as entirely responsible for the task. Here breastfeeding is deemed essential, not optional. Her use of the word “needed” (lines 37) implies that there is a responsibility which is crucial. In referring to her commitment to this task of breastfeeding. She positions herself as taking on the responsibility from when they “fell pregnant” (line 36). Her use of the words “whatever I needed to do to make it work” (line 37) positions her as focused, determined and gearing up for the task at hand. She constructs herself as willing to work hard to meet this requirement.

For all six of the mothers, their initial commitment to breastfeeding was apparent in their talk. They drew on the medical benefits of breastfeeding and the natural discourse. The mothers presented breastfeeding as the ‘best’ they could offer their infants and positioned themselves as ready for the task at hand. Some of the mothers spoke of breastfeeding for one year as a time frame to work towards and their talk was goal-driven, working to present themselves as good mothers. Executing the act of breastfeeding meant the mothers required their bodies to perform effectively. This is the second finding of the research: that a good mother manages her breastfeeding body.

A good mother manages her breastfeeding body

A significant thread in these first-time mothers' talk about breastfeeding is how the mother's body is critical to sustaining the practice of breastfeeding. The mothers in the study spoke about the changes in their breasts during pregnancy and after birth and how managing their milk supply was fundamental to ensure they could offer enough breastmilk for their baby's needs. Their bodies were positioned as essential to offer breastmilk and, as a result, were 'managed' when accompanying challenges could threaten the continuity of breastfeeding. The mothers each spoke of the difficulties they experienced with managing their bodies to breastfeed. Most mothers persisted with various strategies to continue breastfeeding during these challenges.

When her breastfeeding experiences were explored during the interview, Melissa gave an account of her endurance and enactment of good mothering. In Extract 5 below, Melissa presents an account of her interaction with her midwife, who, as a third party, constructs her actions as highly committed in terms of how she persisted with breastfeeding and how her body was positioned as the means to do this.

Extract 5

784 Melissa: She checked the baby and her mouth, did the assessment, then she said, 'Can I
785 see your nipples- like what's going on?' So she looked at them and was like, 'oh my
786 word – like no::, most people would have given up AGES ago'. And I was like, well 'I
787 wasn't going to'. Cause they were ↑literally scabbed, red, cracked and inflamed and
788 bleeding and horrible.

In her reporting of the midwife's words, "like what's going on?", "oh my word – like no most people would have given up ages ago" (lines 785-786); Melissa positions the midwife as shocked at the physical condition of her breasts. The seemingly never-ending list that Melissa presents: "scabbed, red, cracked and inflamed and bleeding and horrible" (lines

787-788) further presents a convincing account of how shocking the state was. The combination of the long list and the midwife's astonishment presented her level of determination as she persisted with breastfeeding against all odds. What is significant in this talk is that the focus is almost entirely on her body, specifically her breasts, which are injured through this process. However, this is not something that dissuades her from continuing her mission. Her body is central to the struggle, which she uses as an example to emphasise her persistence, dedication, and determination to continue breastfeeding. A midwife has probably been exposed to many different cases of breastfeeding challenges, and her shock at the situation further emphasises the extreme circumstances that Melissa faced. Despite the midwife's response noting the severity of the situation, Melissa positions herself as not like "most people" (line 786) who would have given up and her words of "and I was like, well I wasn't going to" (lines 786-787), position her as selfless and determined. In this extract, Melissa invokes the ideal of the 'good mother' through her determination and willingness to have her body used to meet her baby's needs, despite the physical difficulties she has experienced.

Further in her interview, Melissa continued to talk of her breastfeeding experience as "absolute hell" (Melissa, Interview 5, line 812), as it took a few weeks for her nipples to heal. However, her commitment was unwavering. The midwife advised her to use a nipple shield when breastfeeding and she purchased one. The image constructed here, of a woman persisting with an excruciating task despite her pain and extreme suffering at the cost of her body, is extremely powerful. Melissa positions herself as determined and completely self-sacrificing, willing to use her body to serve her child's needs and do what is best. To address the issue of a poor latch and her body's pain, she contacted the private midwife to have a check-up to receive advice on how to address this difficulty.

The other mothers in the study also experienced pain and discomfort in the early days of breastfeeding. They spoke of being unaware of how painful breastfeeding could be, and getting the correct latch became a priority to ensure feeding was manageable. In this

talk, the mother's body was constructed as the mechanism to deliver the result of breastmilk. It became a scrutinised site where the mothers looked to improve and enhance their production abilities. This meant most mothers scrutinised what they ate and drank as their breastmilk quality and supply depended on this.

In her interview, Tracey used the phrase "input equals output" (Interview 4, Tracey, line 935), which constructed her body as a tool or mechanism that requires investment to produce the desired results. Tracey spoke of monitoring her fluid intake (drinking water), taking vitamins, managing her diet, and eating oats for breakfast daily. She constructs a project management approach to ensure her body functions effectively for breastfeeding. In their interviews, Tracey and Sarah spoke at length about how they altered their diets due to their babies' dietary sensitivities. Tracey spoke of her daughter experiencing discomfort (gas and bloating) after breastfeeding, and dairy was constructed as a threat to breastfeeding continuity. Tracey identified that her daughter was intolerant to certain foods she consumed, which were transferred through her breastmilk. She altered her diet without dispute, and her commitment is presented in Extract 6 below.

Extract 6

440 Tracey: So I changed my diet. I cut <u>all</u> dairy – hidden <u>dairy, soy, wheat and nuts</u>. I literally
441 cut it <u>all out</u>. um:: <u>instead</u> of giving her the allergy formula (.) and then um:: (.) after
442 two weeks she::, she was like <u>a changed</u> ↑baby, I <u>can't</u> even explain it, it's ↑crazy.

In her use of the words, "I cut it all out" (line 441), which she had repeated from line 440, Tracey positions herself as self-restrained, with no compromise, summoning a militant stance to manage her diet to ensure she can continue to breastfeed her baby. Here her body is positioned as serving her daughter's needs, and she is willing to inconvenience herself to limit her diet. In using the word "hidden" (line 440) to describe the restricted allergens in food, she positions herself as vigilant and careful, monitoring and scrutinising the food ingredients she eats.

Tracey altered her dietary decisions to continue breastfeeding “instead of giving her (her child) allergy formula” (line 441), reinforcing her committed position. Tracey positions formula as the less desirable option and says breastmilk is her first choice. In this extract, Tracey presents how her body is the mechanism to offer her baby breastmilk, and she is willing to adjust and restrict her diet (“input”) to ensure she can continue to breastfeed. She draws on the selfless position of the good mother, acknowledging her efforts were successful in using the words “she was like a changed baby” (line 442) when she could continue to receive breastfeeding and be settled.

Melissa’s position aligned with Tracey’s “input equals output” (Interview 4, Tracey, line 935) construction of body management to frame how she manages her body to breastfeed. Melissa positioned herself as dedicated to monitoring and managing her body to ensure breastfeeding continuity, as seen in Extract 7. In this extract, it is significant to note how Melissa positions breastfeeding as an investment in her daughter’s future and how she is accountable for this as a mother.

Extract 7

1393 Melissa: and:: ↑so making sure that I <u>am</u> eating healthy – as healthy <u>as possible</u> – treats are
1394 <u>still</u> acceptable but um::: heh:: as ↑healthy as possible for her and <u>making</u> sure that
1395 I’m drinking <u>enough</u> and resting <u>enough</u> so that I’m giving her <u>the best</u>, so she can
1396 have <u>the best food</u> – you know if I am resting properly, I’m giving her <u>the best</u>
1397 emotionally that I can be um:: <u>yah</u> and just <u>making sure</u> we make the best decisions
1398 for – for her so that the way she grows up – <u>you know</u> the life she will have is the
1399 <u>best</u> we can ↑possibly give her – and that’s:: (.) that’s just <u>our</u> focus and <u>our goal</u>
1400 with her.

In her use of the words: to “[make] sure I am eating healthy” (line 1393) and “[make] sure that I’m drinking enough and resting enough” (lines 1394-1395), Melissa’s use of “I” is

focused on her body which is the vessel she must manage to produce breastmilk. In lines 1393 to 1396, she positions her body as an instrument for the singular purpose of breastfeeding. She constructs breastfeeding as a project, detailing the steps she must adhere to. In repeatedly using the words “making sure” (lines 1393, 1394, 1397), she constructs her expectations of herself to adhere to her checklist. In using the words “the best food” (line 1396), Melissa constructs the measures taken to result in high-quality breastmilk, which she holds herself accountable to provide by managing this all.

Melissa places further conditions on the management of her body by restricting “treats” (line 1393) in her diet, stating that they must be “as healthy as possible” (line 1394). Melissa constructs the expectation to manage her “rest” (line 1396), and in her use of the words to “give her the best emotionally” (line 1394), she is holding herself accountable to these high standards, which go over and above what could be deemed as good enough. Her use of words, “give her the best emotionally” (lines 1396-1397), refers to a nurturing component of breastfeeding and the role of a mother to care for her baby’s emotional well-being. This goes beyond the physicality of breastfeeding to include a mother’s role in nurturing her baby and not only being about providing milk, as Melissa draws on the good mother ideology - positioning herself ultimately to meet her daughter’s every need.

Melissa prioritises her daughter in her talk, where she speaks about managing her diet, rest, and emotional state to ‘ensure’ her daughter’s wellbeing. In this extract, her use of the words “for her so that the way she grows up – you know the life she will have is the best we can possibly give her” (lines 1398-1399) position her as responsible for her daughter’s future success. In using the words “our focus and goal” (line 1399), she introduces her partner as part of the decisions they want to make for their baby, but Melissa is responsible for doing this through breastfeeding.

In this extract, Melissa positions her body as the means to give her daughter the “best” (line 1395) breastmilk. It is as though her current decisions about what she eats and

does will affect the quality of her breastmilk and compromise her daughter's future. Significantly, Melissa uses "I" (lines 1393 – 1397) six times in this extract, positioning herself as mainly responsible. Later she includes her partner using the words "we" (lines 1397, 1398) and "our" (line 1399), constructing a shared vision for her daughter's future. In this extract, Melissa introduces the risk of harm to her baby if she does not follow these prescriptions, which could compromise her breastfeeding ability.

In examining the talk of the mothers, most of them went to great lengths to persist with breastfeeding. They subjected their bodies to intense scrutiny, pain, and modifications, to enable breastfeeding continuity. Their bodies were positioned as the mechanism to provide their babies with the 'best' offering of breastmilk. This aligns with the good mother ideology, which is for a mother to position herself selflessly to meet all her baby's needs, and breastfeeding is an activity used to demonstrate this commitment. In their talk about their dedication to breastfeeding, the mothers discussed the value of producing a surplus of breastmilk as an example of the achievement of their lactating bodies. The mothers each spoke of the amount of breastmilk they were producing, comparing their daily supply produced, or comparing the amount of milk they produced to that produced by others. The mothers, attentive to measuring the amount of breastmilk they made, positioned themselves as successful when they produced more than their babies required. In their interviews, Sarah and Melissa each construct an image of their bodies producing a surplus supply, which is examined below.

A good mother produces a surplus supply of breastmilk to 'stock up'

In the production of breastmilk, the mothers spoke about their breastmilk supply as a critical indicator of evaluating their efforts as good mothers through measuring the millilitres of breastmilk extracted and stored. All mothers in the study experimented with a breast pump which was positioned as an essential aid to breastfeeding continuity. As a technological device, the breast pump was used to extract breastmilk stored in labelled containers in the refrigerator or bags frozen in the freezer for future use. In doing this, the

mothers demonstrated a commitment to maintaining a supply of breastmilk for their babies, enabling them to have access to breastmilk when they were not with them (that is, being cared for by others). In this way, they continue to draw on the discourse of good mothering, implicitly reaffirming that breastmilk is 'best' rather than, for example, the alternative formula. This required additional effort, with time allocated after each feed to pump and extract the remainder of the breastmilk from each breast.

Each mother presented different accounts of their breastmilk supply and commitment to pumping. Some mothers found the pumping experience rewarding; for others, it was disheartening. Sarah spent significant time talking about pumping and the amount of breastmilk she was producing. Sarah experienced a surplus supply of breastmilk, more than what her baby boy could consume, seen below in Extract 8.

Extract 8

419 Sarah: I was making a lot of milk (.) Um:: (.) Yah- so like, my freezer is full to the brim, I'm-
420 erm, 'cause I've- I think I've always made more <than he's been able to drink> (.) Cause
421 yah:: I don't know (.) But um:: so it's ↑not like we'd ever be short

In the extract above, Sarah's use of the words "I was making a lot of milk" (line 419) positions her body as bountiful and able to produce an abundance of breastmilk, more than what her son could consume. Her body's production is so extreme that she comments, "my freezer is full to the brim" (line 419). This image of excess: "a lot of", "full to the brim" (line 419), and an inexhaustible supply (line 421), serves to position her as a healthy and productive woman, an exemplary mother within the breastfeeding expectations of good mothering. In her use of the words, "I was making a lot of milk" (line 419), she constructs herself as successful or more than meeting the required norm or standard. She further expands this measure of 'good mothering' success in Extract 9 below.

Extract 9

454 Sarah: Like- but yah:, so I- my ↑top drawer of my freezer's full (.) And my mother-in-law stays
455 in the granny flat and I've started putting milk in her ↑freezer, but I've um- ((short breath
456 laugh sound)) someone's ↑actually coming to ↑collect- for <someone who was looking
457 for donated milk>- so someone's coming to collect the <bags> to↑morrow and then the
458 other half, I've been waiting to give to the:: um:: <the breastmilk bank> for the:: AIDS
459 orpha↑nage.

In the extract above, Sarah details how her bountiful supply of breastmilk has flowed into her mother-in-law's freezer space, with her freezer unable to contain the ample supply. In her display of modesty and causal claims of abundance, Sarah's preceding talk demonstrates that this is, in fact, noteworthy and unusual. In slang terms of "but yah" (line 454), she downplays her abundance. There is a possibility that while Sarah avoids being heard as bragging or boasting, she is also clearly claiming motherly abundance. In her frequent reference to fullness, she creates the image of extreme abundance. Her talk shows her surprise, relief, and pride. She is almost casual in this talk in her words of "like – but yah, so" (line 454) and her talk includes laughter (line 456). While she attempts to remain modest, she positions her body as bountiful and productive (she can produce "bags" line 457) to the extent that she can distribute milk outside of her baby's needs, to the world beyond her baby, specifically to breast milk banks, and AIDS orphanages (lines 458-459). Interestingly, Sarah continues her daily ritual of pumping after her morning feeds, despite producing more breastmilk than her son can consume. Her construction of selflessness as a mother extends beyond her baby, as she enacts the role of a 'good mother' to vulnerable babies with no access to breastmilk.

Sarah's construction of her body as overflowing with surplus supply differed from Keira, who spoke of her significant investment in managing her body to produce sufficient

breastmilk. In Extract 10 below, Keira spoke about her daily routine of managing her body to support her breastmilk supply and constructed her dedication to breastfeeding.

Extract 10

494 Interview: How are you managing with your milk supply?

495 Keira: Okay, I think. Um:: I <u>have</u> to make sure that I'm eating and drinking and I'm
496 expressing now, for the last 2 weeks or so – because I <u>knew</u> I was going back to
497 work – I feed him in the morning when he wakes up and then I go down, get
498 breakfast, get myself some tea and then I come up and then I express after that so
499 that I can get enough milk to store so:: ↑After I've fed him I probably only get about
500 50-ish ml, 50 – 60ml, so it takes me <u>two days</u> to get enough to actually freeze a
501 bag. <u>So</u>, I've probably managed to freeze about 10 bags now, which I'm
502 ↑supremely proud of myself for. But it's taken me a <u>long time</u> to get there.

In the extract above, Keira positioned herself as persistent in her struggle to manage her breastmilk supply. In answering the question, her use of the words "I have to make sure" (line 495) constructs her obligation to ensure she is managing her body, specifically her diet, fluids and to use her breast pump to express milk. Keira presents her morning routine, which is to have her breakfast, her tea and then "express after that so I can get enough milk to store" (lines 498-499). In her talk, she is goal-focused, aiming to store up additional breastmilk so that her baby can continue to receive breastmilk when she returns to work. In her use of the words, "after I've fed him, I probably only get about 50ish ml, 50 – 60ml, so it takes me two days to get enough to actually freeze a bag" (lines 499-500), Keira constructs the process of extracting her breastmilk as being hard work and disheartening, and this is in stark difference with Sarah's accounts (in Extracts 8 and 9). In using the words "I'm extremely proud of myself" (to pump and freeze a total of ten bags) in lines 501-502 and "it's

taken me a long time to get there" (line 502), she presents her efforts as notable, crediting her determination and endurance.

Keira's account emphasises how a body that can generously supply a baby's needs is valued and draws on the natural discourse of breastfeeding. However, the time and additional effort Keira put into managing her breastmilk supply contrast with the construction of breastfeeding as natural and the expectations that it will be done with ease. Managing their breastfeeding bodies and breastmilk supply required attentive dedication and support from significant others. Most of the mothers in the study evaluated their milk supply. They drew on breastfeeding experts' advice and support as essential to continue managing their body's performance and attain good mothering standards. In the following section, I present the third finding: a good mother follows expert-led advice.

A good mother follows expert-led advice

All six mothers in the study were educated, career-oriented women from a middle-class socioeconomic background. The mothers had access to information about breastfeeding and would seek out advice from private health professionals, doctors, or breastfeeding organisations such as the La Leche League. In the interviews, the mothers spoke of the research and advice on breastfeeding they had acquired from various sources such as books, internet articles, organisations dedicated to advocating for breastfeeding, ante-natal classes, and medical professionals such as paediatricians and midwives. The process of researching and studying content on breastfeeding began during pregnancy. Once their babies were born, for most of the mothers, attending regular 'check-ups' with the midwife at the baby clinic was meaningful as it was not just about their baby's medical care but also their own. At clinic visits, the mothers spoke of how they were affirmed, advised, and encouraged by the midwife who advised them on breastfeeding. This was evident in Melissa's interaction with the midwife in Extract 6 above, where she positioned the midwife as a reassuring support for her to continue breastfeeding when faced with the pain of cracked and swollen nipples.

All six of the mothers in the study positioned themselves as receptive to the advice from professionals, valuing the information and guidance provided. Most of the mothers continue to access support from the midwife. In Extract 11, Roxanne's interaction with the midwife is presented and analysed.

Extract 11

362 Roxanne: Yah:: it ↑really was <u>much</u> easier um:: I didn't mention the midwife- she was also a
363 key role player um: we saw her <u>regularly</u> in the first few months of <u>his life</u>.

In the extract above, Roxanne spoke of periods of breastfeeding being difficult and then "much easier" (line 362) and introduced the midwife being "a key role player" (line 363) in this process. In her use of the words "key role player" (line 363), Roxanne constructs the value associated with the midwife as essential for breastfeeding her son. Roxanne spoke of accessing the support of the midwife frequently, through her words, "we saw her regularly" (line 363).

Further in her interview, Roxanne elevates the midwife's recommendation and guidance as significant in saying, "we do whatever the midwife tells us … (*nervous laughter*), we don't like – we don't veer off the programme" (Roxanne, Interview 3, lines 374-375). In using those words, Roxanne positions herself as obedient to the plan. She does not question what she is advised and follows it exactly. The midwife's support is valued; she is a leader who guides, informs, and "tells" them (line 374) what to do. In her talk, Roxanne constructs the guidance and reassurance from the midwife as valuable, following her programme and recommendations. Again, this contrasts with the construction of breastfeeding as a natural response of the mother's body to childbearing and childbirth. Other mothers in the study, like Tracey in Extract 12 below, also valued expert-led advice from the midwife for breastfeeding.

Extract 12

639 Tracey: I kind of use that knowledge with the guidance I get from the midwife because we're
640 still seeing her and she gives us guidance as my daughter grows.
641 Int: °Yah°
642 Tracey: I think without that, I would be floundering.

In the extract above, Tracey's use of "knowledge and guidance" (line 639) positions the midwife as informed and experienced enough to provide her with the necessary information and support for breastfeeding. Her repeated use of the word "guidance" (lines 639, 640) suggests that Tracey highly regards this counsel and direction and is receptive to it. She positions herself as inexperienced and dependent by using the word "floundering" (line 642). In her account, she positions herself as navigating the unknown and stumbling, needing guidance. In contrast, the midwife is framed as key to her ongoing process of mothering, as her words "still seeing her" and "as my daughter grows" (line 640) position her as dependent and in need of the midwife to remain involved in the stages of her daughter's development. This, like Roxanne, is part of the good mothering discourse, drawing on the advice and assurance provided by an expert. In their talk, the mothers positioned the midwife as the expert in infant feeding and other related child-rearing practices, with the necessary knowledge and guidance they require to succeed. For Roxanne and Tracey, their talk is goal-driven, and it is as if the experts are there to hold them accountable for their decisions.

Keira, who was having difficulty managing her breastmilk supply, sought the advice of the La Leche League over and above the private consultations with the midwife. She wanted further-tailored advice from a trained La Leche League volunteer who offered home visits. She spoke of a lactation expert coming to her home to sit with her and offer practical guidance on breastfeeding. Here, Keira's investment in breastfeeding is noted. By seeking additional help, she reinforces her committed position in the good mothering discourse. In

Extract 13 below, Keira presents an intense account of the advice the La Leche League consultant gave her.

Extract 13

152 Keira: The La Leche guys are like:: quite militant heh, in terms of their breastfeeding –
153 they're like hardcore – 'don't ever bottle' and 'don't ever dummy' and 'don't ever-'.
154 So, ↑you try and do that stuff >but at the same time:::< you give them a bottle and
155 then they're crying, you give them a ↑dummy and >then you feel bad< and you feel
156 like 'oh my word I'm going to undo all the hard work I've done'

Keira describes the interaction with a La Leche League lactation support volunteer using talk that is heightened and fast in pace, frequently using emphasis, which accentuates the intensity of what she is saying. In her use of the words, "guys", "quite militant" (line 152) and "they're like hardcore" (line 153), she frames the La Leche support as gearing her for combat or battle. It is as though she is in the form of stringent training or a military boot camp. Her way of saying "don't ever" repeated three times (line 153) constructs a regimented, strict approach, with the bottle and dummy being constructed as threats to breastfeeding success. There is no compromise in the use of "don't ever" (line 153), and she is instructed not to give up trying and to follow orders. In line 154, Keira's use of the words, "so you try and do that stuff", offers her intention to follow the rules and to get things correct. She continues with, "at the same time, you give them a bottle" (line 154) which is the opposite of what she has been told to do. This extract is significant as Keira constructs a tension between the experts' message and her experience of meeting her baby's needs.

Keira constructs her attempts to try to follow the advice given, but at the same time, with her son "crying" (line 155), she gives him a "bottle" and a "dummy" (lines 154, 155). She does the opposite of what she is told but positions her son as central to that decision. Her account of how she has not followed the advice renders her vulnerable to negative

judgement, and it is as though she is confessing these ‘wrongdoings’ and looking to me, as the interviewer, to offer her reassurance. In her use of the words “you feel bad” (line 155), there is the sense that, because she did not stick to the plan provided by the experts, she was undermining the “hard work” (line 156). It is noteworthy that this is a sensitive account for Keira, who refers to the third person in her talk, using “you try”, “you give” (line 154) and “you feel” (line 155), which distances the talk from her agency.

The use of experts for breastfeeding support contributes to the construction of breastfeeding as an essentialist practice within the good mother discourse. To be a good mother, the mothers wish to 'get it all right', following expert-led advice that outlines the steps to success. This is a form of ‘textbook mothering’ where the mothers positioned breastfeeding experts as necessary to succeed in breastfeeding. What is left unsaid is that the mothers rely on advice from professionals to avoid getting things wrong and potentially placing themselves at risk of failing this standard of good mothering. Keira’s interview extract highlighted the anxiety accompanying the decisions mothers in the study must make about infant feeding. In using the words “you feel bad” (Extract 13, line 155), Keira constructs the uncomfortable feelings of guilt and a sense of failure that she, like the other mothers, wants to avoid. This is examined further in their talk of using formula, which is the second part of the findings below.

Using formula and the construction of ‘failure’

In the talk of all six mothers, formula was positioned as the lesser option, with breastmilk constructed as the superior and best choice. Three of the mothers in the study (Cara, Roxanne, and Keira) introduced formula as an alternative and supplement to breastmilk. For these three mothers, there was much contemplation and internal conflict about this decision. Keira and Roxanne spoke at length of the struggles to persist with breastfeeding when their baby was dissatisfied and demonstrated the hard work and additional efforts they invested in breastfeeding. In Extract 14 below, Keira contrasted the more significant effort she invested in breastfeeding by comparing herself to others. Keira

supplemented her breastmilk supply with formula, as the formula was an aid for her to continue offering her son breastmilk. In the extract below, Keira presents her experience of struggling to breastfeed her son. She introduces how both she and her son experienced breastfeeding as challenging.

Extract 14

761 Keira: For some people they didn't have to try but for me it was a real::: (.) I really really had
762 to try hard. So, yah:: So I think I did feel that um:: And again, you know, and I still feel
763 inadequate when he doesn't latch and when he cries every feed, you know. He
764 mostly cries every single feed still. And I'm still thinking 'What am I doing wrong?' and
765 'What can I do?' like, "Why do I second guess myself so much?'. So yah:: But, I just
766 have to think "Okay, he's growing and its fine".

In the extract above, Keira spoke of having to "try really hard" (line 761) compared to others who "didn't have to try" (line 761). In these phrases, Keira constructs her breastfeeding experience as a struggle and hard work, positioning 'other' mothers as having greater success. Keira positions herself to have failed in her use of the words, "and I still feel inadequate when he doesn't latch and when he cries every feed, you know" (lines 762-763) and she is critical of herself. She positions herself as accountable to a standard she cannot meet and blames herself. She does not frame her additional attempts to improve her body's ability to breastfeed in a favourable position, but rather as secondary to her constructed expectations. She castigates herself about this failure: "and I'm still thinking 'what am I doing wrong?' and 'what can I do?' like, 'why do I second guess myself so much?" (lines 765-766). Keira's talk positions her as full of doubt, inadequacy, and unconfident. Keira then contrasts this negativity with the image of her son "growing" and that he is "fine" (line 766) despite these struggles. Keira positions her son's growth and being "fine" as satisfactory and worth the effort she puts into feeding him. In doing this, Keira can negotiate her position as a good mother.

For Cara, her experience of having post-partum depression and feeling physical discomfort when breastfeeding led to her questioning her initial commitment to breastfeeding (see Extract 2). Cara spoke of how she decided to switch to exclusive formula use in Extract 15.

Extract 15

242 Cara: In the beginning, I was very wary of changing over to ↑formula. Uh- >you just don't
243 want to have this thing of 'you've failed' and< 'you didn't try hard enough' or whatever
244 but eventually my mom just said, 'you know what Car: it's::, it's:: your decision what
245 you want to do:: your baby's ↑healthy and will be fine, so::' (.) Yah, so she
246 encouraged [me as well=
247 Int: [Yah.
248 Cara: = to make my own decisions and not to worry about what other people think or::-

In the extract above, Cara's use of "wary" (line 242) positions her as hesitant and cautious about formula. In saying "this thing" (line 243), it is as though by giving her baby formula, she is inviting social critique and scrutiny of her decision, and she wishes to avoid this. Cara speaks as an imagined critic, saying, "you've failed" and "you didn't try hard enough" (lines 243), in the third person who is like an authority figure that she imagines judging and assessing her efforts. In linking the words "failure" and "try hard enough" (lines 243), she constructs a harsh and punishing 'other' who scrutinises her actions.

In her talk, Cara introduces her mother in line 244 as a significant voice in her decision to use formula. Cara positions her mother as an advisor, encouraging her to focus on herself: "it's your decision what you want to do, your baby's healthy and will be fine" (lines 244-245). By invoking the assurance from her mother, Cara permits herself to use formula. She rationalises this decision by drawing on how it would enhance her baby's health, thereby still drawing on the 'good mother' discourse.

Cara continues to position her mother as an authority figure she receives guidance from, saying, “she encouraged me to make my own decisions” (lines 246-248). Cara constructs her mother as giving her the validation and permission to make this significant decision. Here, in a position of feeling out of control, her mother is positioned as the voice of reason to justify her decision to deviate from the ‘standard’ and ‘norm’ of breastfeeding and introduce formula. In her comment on not worrying “about what other people think” (line 248), Cara constructs this judgemental and surveillant ‘other’ of one’s mothering practices. Cara does not say who these people are, but they are framed as significant because she considers what ‘they’ will think of her no longer breastfeeding and using formula.

Although Cara chose to use formula after her daughter was three weeks old, she continued to refer to herself critically in her talk about the decision in the interview. This is evident in her use of the words, “I was meant to breastfeed and I’m not breastfeeding” (Cara, interview 2, lines 593-594), and she holds herself accountable for what she was “meant to do”. She is harsh and punishing of herself, using the interview platform to evidence that this was not a light-hearted decision and that there were feelings of guilt accompanying her decision.

Roxanne, like Cara, also experienced post-natal depression in the early months of her son’s life. Her breastmilk supply was subsequently affected, and she struggled to meet her son’s feeding needs. In Extract 16, Roxanne talks about the feeling of failure and the self-scrutiny for not producing sufficient milk, which led her to introduce formula.

Extract 16

300 Roxanne: Um:: heh heh heh but yah you do, you feel like a failure as this is something
301 you're supposed to be able to do, that you now can't do and your baby (.) um::
302 appears stressed at times because it's not able to get enough milk and it's getting
303 [frustrated at the breast=
304 Int: [°yah°
305 Roxanne: =Um:: and then he also started- I think he started waking up like a little bit more at
306 night when he had been sleeping very well (.) um:: and then you ↑worry he's not
307 getting enough foo::d and there was something in me that didn't want to give him
308 formula ↑even though <that was (.) the simple solution> (.)
309 Int: °yah°=
310 Roxanne: = of his life to date <was- was this feeling that I had failed him> (.) and that I didn't
311 want to give him ↑anything other than [breastmilk
312 Int: [Mm::

In the extract above, Roxanne talks about introducing formula, and here, she provides the reasons that led her to make this decision. Her laughter at the start of the extract (line 300) presents the nervousness accompanying talking about this topic, further reinforcing its sensitivity. Roxanne's words of, "you feel like a failure as this is something you're supposed to be able to do" (lines 300-301) and introduce a harsh critique and sense of inadequacy for not doing what is expected. Her words "that now you can't do" (line 301) are significant, as she has reached the position of recognising her body's limits which is that it is not producing enough breastmilk for her son's needs. Roxanne introduces her son's dissatisfaction with breastfeeding to rationalise the decision to use formula. Roxanne constructed her son's discontent using the words "stress" (line 302) and "frustration" (line 303) and how persisting with exclusive breastfeeding was not working. Significantly, Roxanne refers to her son objectively through the words "it's not able to" (line 302) and "it's

getting frustrated" (lines 302-303), which distances him from her and reinforces the mechanistic discourse of breastfeeding, where her baby is an end user of her body. In drawing on her son being "stressed" (line 302) and "frustrated" (line 303) due to her limited milk supply, Roxanne presents a problem she needs to solve and draws on the good mother discourse, which requires her to take complete responsibility for her baby's nutritional needs. Roxanne continues to talk in detail about the circumstances that led her to use formula. She does not require probing or prompting during the interview to expound further on this experience. In her use of the words "he started waking up a little bit more at night" (lines 305-306), which was a change in his sleep routine, Roxanne adds to the list of difficulties. In her words, "you worry he's not getting enough food" (lines 306-307), Roxanne's position is anxious as she navigates the dissatisfaction of her son and her awareness of her duty, as a good mother, to ensure his nutritional needs are being met.

Roxanne lists these difficulties in her account; however, her words of "there was something in me that didn't want to give him formula, even though that was (*pause*) the simple solution" (lines 307-308) present the tension she felt at compromising her commitment to exclusive breastfeeding. Roxanne's words, "even though that was the simple solution" (line 308), highlight that she has identified the answer to the problem, to supplement her breastmilk with formula. However, the meaning attached to introducing formula is complex. With "this feeling that I had failed him" (line 310), she positions herself as having not performed adequately and having failed the standard of exclusive breastfeeding. Using the words, "I didn't want to give him anything other than breastmilk" (lines 310-311) makes explicit the idealised standard of exclusive breastfeeding in the pro-breastfeeding and good mother discourse. In these discourses, formula is positioned as the lesser substance threatening the maternal identity of being a good mother. Hence, Roxanne has presented a detailed account of her son's problems, difficulties, and discontent to demonstrate that introducing formula was the last resort and a decision that was not taken

lightly. This required her to re-negotiate the standards of exclusive breastfeeding being imperative for good mothering.

Further in her interview, Roxanne shared advice for mothers supplementing with formula and mixed feeding. This is examined in Extract 17 below.

Extract 17

878 Roxanne: = Accept that if your baby's weight is going ↑up and they are happy and thriving,
879 they're probably getting enough, and you're doing a good job.

In the extract above, Roxanne draws on her experience of introducing formula and uses this as a benchmark to advise other mothers in a similar situation. In her use of the words, "accept that if your baby's weight is going up" (line 878), it is as though Roxanne is speaking to herself to offer a directive or proposition that she needs to decide to "accept" and agree that formula was a beneficial decision for her baby. In doing this, Roxanne constructs her son's weight gain to measure success while consuming formula. She continues to speak of her son being "happy and thriving" (line 879), made possible through formula. She has positioned formula as the means to attain good mothering, evident in her words, "you're doing a good job" (line 880), as she offers a general sense of praise for this decision. Formula is positioned as the solution to ensure her son's nutritional needs are being met, as Extract 16 offered a detailed account of his dissatisfaction. In this extract, Roxanne shows me, as the interviewer, how a mother can still be a good mother when introducing formula. In this extract, Roxanne demonstrates how she prioritises her baby's needs above hers (to continue exclusive breastfeeding), aligning with the good mother discourse. She positions herself as responsible for her baby's health needs and expects herself to sacrifice her initial commitment to breastfeeding by introducing formula.

Summation

This chapter has provided a detailed discourse analysis of the breastfeeding expectations and experiences of the six first-time mothers who participated in the study. I

have selected extracts that specifically relate to the research questions: to examine mothers' construction of breastfeeding and how they navigate the dominant discourse of good mothering ideals. This chapter examined how mothers demonstrated good mothering through their commitment to breastfeeding. The mothers constructed breastfeeding as a project and positioned their bodies as sites that they needed to manage to work to meet the standards of good mothering. The findings were that the mothers positioned experts as fundamental for breastfeeding success, especially to receive advice, guidance, and reassurance when they experienced difficulties. Three of the mothers introduced formula, which was positioned as the alternative to breastfeeding. These three mothers had to re-negotiate the standards of breastfeeding as an imperative of good mothering. Feelings of guilt, shame, and inadequacy were part of their construction of a 'failure' to fulfil the ideal of good mothering. The mothers drew on a counter-discourse that positioned their babies as happy and healthy when using formula. The next chapter will present the research discussion, examining the findings with the literature on breastfeeding and good mothering discourse.

Chapter 5

Discussion

This research examined how a sample of first-time South African mothers position themselves as good mothers through breastfeeding. The research aimed to contribute to the literature on good mothering and breastfeeding discourse in South Africa. The research objectives were to examine how first-time mothers construct their breastfeeding expectations and experiences and navigate the dominant discourse of good mothering ideals. I used a qualitative design with purposive sampling to interview six first-time South African mothers. The six interviews took place online due to the COVID-19 Pandemic and the social distancing restrictions instated at the time of the research. The interviews were transcribed in full and Jeffersonian conventions were used to present best the details of the talk to strengthen the analysis. The transcripts were coded, and selected extracts were analysed using discourse analysis to examine how the mothers talked about breastfeeding.

The findings of this research suggest that all six of the mothers drew on the good mother discourse, namely that a good mother is: (1) committed to breastfeeding; (2) project-manages her body, and (3) seeks expert-led advice. When there were difficulties with breastfeeding, the findings were that the mothers had to redefine their expectation of breastfeeding being an imperative for good mothering and navigate feelings of guilt and failure when formula was introduced. In this chapter, I discuss how the findings align with the literature on breastfeeding and good mothering. I further discuss how the mothers manage their construction of good mothering when they introduce formula with the literature.

The good mother is committed to breastfeeding

The findings reveal that all six mothers were committed to breastfeeding as a critical act of good mothering. The mothers justified their position by drawing on the medical discourse promoting ‘breast as being best' for their babies. This message has been

“relentlessly present in discourse” about pregnancy, birth and feeding as an unquestioned standard (Rodgers, 2020, p.140). All six mothers constructed breastfeeding as an investment to ensure their child's physical health and psychological well-being were prioritised for their future. This aligns with the literature that positions breastfeeding as the superior choice, leading to better future outcomes for children and their health needs (Foss, 2010; Gertosio et al., 2016). From this position, the mothers constructed breastfeeding as a crucial part of their dutiful offering as a good mother. This is consistent with Murphy’s (2000) research, where the mothers spoke of breastfeeding as something they owed their babies and that “breastfeeding is the method of choice for the responsible mother” (p.302). Thus, in this research and across the literature, breastfeeding is seen as a significant act of mothering to demonstrate commitment to good mothering ideals (Kukla, 2008). Consequently, all the mothers spoke of their significant consideration for planning for breastfeeding during pregnancy.

In each interview, I asked the mothers about their breastfeeding expectations during pregnancy and how they prepared for this. All the mothers spoke of readying themselves for breastfeeding during pregnancy by consulting information and talking to other mothers, including their own. They constructed this as a quest for knowledge to equip themselves for breastfeeding and wanted to invest their efforts to be prepared. Some of the mothers spoke of their expectation of the duration of breastfeeding and introduced a numerical benchmark to breastfeed for one year as a goal to be attained. This reinforced their long-term committed position.

Contrary to this, during their pregnancy, the mothers shared that they considered the possibility that their bodies might not meet these demands and presented an uncertain position. This is consistent with Machiori’s (2021) findings, where she explains that in the prenatal period, a mother will carefully balance her breastfeeding expectations with the socially constructed standards of mothering. The findings align with previous research that notes there is pressure to fulfil these expectations when breastfeeding is positioned as a

benchmark of good mothering (Avishai, 2007). The implication for the mothers was that breastfeeding was constructed as an act that they must succeed in to prove their maternal position that they are ‘good enough', which is consistent with the findings of Kukla (2008).

In this research, the six mothers constructed breastfeeding as the ‘natural’, assumed offering, and drew on the past experiences of their mothers who breastfed them, consistent with the findings of Marshall et al. (2007). The mothers drew on the natural discourse, which framed breastfeeding as an intrinsic or instinctual act, reinforcing the expectation that it is what mothers should do. In her review of breastfeeding material, Wall (2001) discussed how the natural discourse infers an inherent ability for mothers to breastfeed easily. This natural discourse positions breastfeeding as the expected feeding decision (Marshall et al., 2007). In the discourse of nature, Hausman (2004) argues that breastfeeding is constructed as an “idealised form of infant nurture” (p.278). The assumption accompanying this construction is that a mother will find pleasure in the selfless offering of breastfeeding, where her body is the source of her infant’s nutrition (Wall, 2001). This discourse often leads to the romanticisation of breastfeeding that negates the lived experiences of mothers (Wall, 2001).

The ideals of the natural discourse were contrasted with the breastfeeding experiences that the mothers spoke about. The mothers experienced that their initial commitment to breastfeeding was tried and tested, and they constructed breastfeeding as requiring hard work and determination. The mothers held themselves accountable for their commitment and presented themselves as determined and persistent. Schmied and Lupton (2001) found that mothers were prepared to persist with breastfeeding for the identity of a “breastfeeding mother” (p.238). This is consistent with Lupton’s (2011) position that mothers embody a solid conviction to breastfeed when they adopt the construction that breastmilk is essential for their baby's optimum development. The discourse of breastfeeding as natural consequently infers that offering an alternative (formula) is sub-optimal. Further constructions of formula are that it is artificial and of a lesser standard which could compromise prioritising the baby’s optimum development (Wall, 2001). The implication is

that the six first-time mothers held high expectations of themselves to breastfeed and positioned themselves as accountable to these standards.

In her research, Knaak (2010) found that when navigating these medical and natural ideals, mothers "invest an extraordinary amount of physical and emotional energy into ensuring they are successful with breastfeeding" (p.350). In their research, Marshall et al. (2007) found that the mothers spoke of their breastfeeding experiences with an “underlying aim of preserving their idea of themselves as a good mother” (p.2156). Drawing on this discourse implies that mothers need to feel confident that they are doing well to maintain a positive maternal identity (Marshall et al., 2007). The ideals held within the good mothering discourse have been criticised by feminist research as breastfeeding is constructed as evidence of good mothering (Wolf, 2011). This is discussed further in the following section, which examines how the mothers constructed breastfeeding as a project to manage.

A good mother manages her breastfeeding body

All six mothers were career-driven women on maternity leave at the time of the interviews. In this postnatal period (the early months following birth), the findings were that most mothers dedicated their bodies to breastfeeding. This was evident in the account of Melissa, who persisted with breastfeeding even though she spoke of her breasts experiencing pain and discomfort, and she did not waver in her commitment. Schmied and Lupton (2001) found that the mothers in their research positioned their searing pain and discomfort during breastfeeding as a sign of commitment. In the accounts of the breastfeeding challenges and struggles, the mothers' bodies were positioned as central for the act of breastfeeding to be accomplished. This is consistent with previous research, which has found that a mother demonstrates her persistence, dedication, and determination in breastfeeding using her body (Avishai, 2007; Stearns, 2009; Waltz, 2014). In the research by Waltz (2014) and Machirori (2021), the authors present the construction of the ‘full-time mother’, where mothering and childcare are framed as a full-time job, which aligns with the intensive mothering discourse. Most of the mothers in this research spoke about managing

the breastfeeding process almost militantly, enforcing self-discipline to remain focused on producing breastmilk. These findings were consistent with previous research in that most mothers drew on their workplace strategies and skills in breastfeeding (Waltz, 2014). The implication of this construction is that the mothers drew on workplace management discourse and spoke of problem-solving and various techniques to ensure their bodies were optimised to perform, as mothering had become their 'full-time job'.

The construction of breastfeeding as a project, and the body as a site to be managed, dominated the talk of the mothers, who spoke little of finding the breastfeeding experience between mother and baby pleasurable. This differs from previous research, where breastfeeding has been framed as a harmonious act of bonding (Schmied & Lupton, 2001). Instead, the mothers in this study presented their hard work, efforts, and investment in their lactating body as evidence of their commitment to breastfeeding and good mothering practices. In their research, Avishai (2007) and Lupton (2011) discuss similar findings with mothers from middle-class and career-oriented backgrounds. Avishai (2007) argues that the mothers framed breastfeeding as a project to achieve to comply with the broader middle-class standards of good mothering. Previous research has examined how this group of mothers tend to be more vigilant about adapting their lifestyle to conform to advice and guidelines and to monitor their bodies (Avishai, 2007; Lupton, 2011; Waltz, 2014), and this was consistent with the findings of the research as the sample included mothers from middle-class backgrounds.

In their interviews, Sarah, Melissa, and Tracey spoke about their lactating bodies as sites requiring monitoring and evaluation. The project management discourse was present in their talk as they operated from their position as full-time mothers who strived to succeed in their roles. Burns et al. (2012) found that the project-management discourse constructs breastfeeding as a “manufacturing process” (p.1744). This discourse positions the breast as a tool to be managed and the body as the machine to be optimised (Burns et al., 2012). The implication is that the discourse renders the mother invisible as her body is monitored,

evaluated, and modified to ensure the required breastmilk output is sufficiently produced (Burns et al., 2012). In Tracey's interview, her use of the phrase "input equals output" (Interview 4, Tracey, line 935) encapsulated the project-management discourse that drew on mechanistic constructions of the lactating body. Like the other mothers, the implication was that Tracey scrutinised what she ate and how much she drank to enhance her production abilities. The discourse positions the mother's body as central to serving her baby's needs. Consequently, the mothers restricted their diets and altered their lifestyle choices to maintain breastfeeding as their priority.

In her account of how she managed her body, Melissa spoke of her self-restraint and self-control. She spoke of monitoring her eating, drinking, rest, and emotions and ensuring she did all this 'enough'. Melissa presented her significant investment in breastfeeding as something she expected of herself. Like the other mothers, the implication is that Melissa tailored her very being to meet her baby's needs. Most of the mothers spoke of having high expectations of themselves to ensure they were doing enough to ensure their vessel (body) managed to produce breastmilk. The talk of optimising the lactating body is noted in Stearns's (2009) research, where the mothers increased their daily fluids and were attentive to the nutrition in the meals they consumed because their goal was to produce "quality milk" (p.66). The research findings align with Lupton's (2011) research, where the mothers were "extremely vigilant about what they ate and drank" (p.6), referring to doing only what was "best for their babies" (p.6). This project management discourse constructs breastfeeding as a production process that is monitored, managed, and evaluated to work towards achieving these ideals (Avishai, 2007). Avishai (2007, p.136) refers to the intensity of these efforts as "pervasive mothering standards", which was present in this research.

By drawing on a project management discourse in breastfeeding, the mothers monitored their output (breastmilk) and measured the amount they were producing to evaluate their performance. In their interviews, most of the mothers were preoccupied with the product of breastmilk, over the breastfeeding experience which previous research has

constructed as significant for bonding and attachment (Wall, 2001). The mothers in this research ascribed significant merit to the breastmilk they produced, and the amounts were used to evaluate the performance of their lactating bodies. This is discussed further in the following section, which examines how the mothers spoke about their breastmilk supply.

Producing surplus milk and stocking up

All six mothers in the study spoke of how much breastmilk they produced. Most of the mothers spoke of targeted amounts they aimed to achieve, and their talk was infused with a sense of pride when these amounts were attained. This was closely aligned with the ideal of the good mother being able to meet her baby's nutritional needs through exclusive breastfeeding (Avishai, 2007). Consistent with previous research, the mothers were concerned about their breastmilk supply; however, feeding them solely from the breast meant they could not observe measured amounts (Marshall et al., 2007).

Most of the mothers (before giving birth) either purchased or borrowed a breast pump as a technological device and used it to extract their breast milk. The extracted breastmilk was stored in the fridge or the freezer for later consumption. The mothers spoke of the value of having ample breastmilk for their babies. This was also found by Stearns (2009), where mothers kept additional supplies in their freezer to ensure breastmilk was available when the mother was absent. Using a breast pump further reinforces the mechanistic discourse of breastfeeding as a production process (Avishai, 2007). The mothers positioned the breast pump as a device that offered them both reassurance (to see that they were producing breastmilk) and as a measure of their body’s performance (as the mothers were able to monitor the measured amounts they produced). In this research, most mothers used a breast pump daily to extract and store additional milk. This reinforced their position as good mothers because pumping meant they were preparing for and thinking ahead for their baby’s needs. The additional work of pumping again contrasts with breastfeeding, framed as a natural act of mothering. It is, instead, a time-consuming and labour-intensive process (Avishai, 2007). The mothers demonstrated good mothering by presenting their additional

effort by pumping and storing breastmilk for their babies. Again, these findings demonstrate the intensity of mothers' investment to ensure breastfeeding continuity, aligning with the intensive mothering discourse (Avishai, 2007).

In their interviews, Sarah, Tracey, and Melissa spoke positively of their bodies producing a surplus supply of breastmilk, ensuring their babies were exclusively fed breastmilk. For Sarah and Tracey, additional breastmilk was extracted and stored for later use. The stored breastmilk was valued as a prized substance, aligning with previous research that constructs breastmilk as liquid gold (Burns et al., 2012). Sarah specifically spoke about her choice to routinely pump and store the extra breastmilk she produced after she breastfed her son in the morning. Sarah constructed her body as bountiful through her account of the stored breastmilk bags overflowing from the freezer and emphasised that her son could not consume it all. In her talk, Sarah framed this as a problem to solve. She spoke of donating the stored breastmilk to orphan babies, as a vulnerable group who would significantly benefit from having breastmilk (drawing on its medical benefits). This act of generosity reinforced her good mothering position, extending beyond her duty to meet her baby's nutritional needs. In the literature, Ryan, Bissell, and Alexander (2010) examined how mothers who donated their surplus breastmilk entered an altruistic position by being able to sustain the nutritional needs of other babies. Ryan et al. (2010) found that this group of mothers presented a positive maternal identity as they spoke of doing something meaningful by doing more than what their babies required of them (aligned with good mothering standards).

The research found that the mothers ascribed significant value to the amount of breastmilk they produced. Specifically, a surplus supply meant the mother's body succeeded in its production purpose and was used to measure success. This is consistent with Knaak’s (2010) research on how breastmilk production is constructed as a source of pride for mothers. Alternatively, this standard of good mothering meant that the mothers who did not

produce a surplus supply of breastmilk, namely Roxanne and Keira, questioned their body's ability to perform in breastfeeding.

Keira presented her ritualistic pumping as laborious, time-consuming, and selfless, as she sought to extract the breastmilk remaining after feeding to store for later use. Her experience differed from Sarah, as she constructed it as taking a long time to extract enough breastmilk to fill a bag. Keira highlights her sense of accomplishment for her efforts, being proud of herself for persisting with pumping. Sarah and Keira's talk about positioning the breast pump to measure their lactating body's performance is consistent with previous research where mothers use this process to evaluate themselves (Avishai, 2007; Hausman, 2003). The mothers who used the breast pump scrutinised the amount of breastmilk produced and either appraised or questioned themselves as good mothers based on the amount of milk they produced. The focus on managing their lactating body was evident in their talk. Consequently, through this discourse, the mother's body becomes objectified for its functionality.

In this project management discourse, the role of the mother is to manage her body to ensure it performs the task at hand (Stearns, 2009). This again contrasts with the discourse of breastfeeding being a natural act when considering the significant investment, monitoring and self-discipline mothers drew on to produce the desired results (Blum, 1993). There is a further implication of this project management discourse, specifically that Avishai (2007) and Waltz (2014) found that the perpetuation of this discourse positions the mother as the owner of her breastfeeding equipment but as lacking the skills to execute and use her machinery, without the input of support (such as the technological device of the breast pump), and expert advice. Consequently, to increase the effectiveness of the production process, the mothers looked to experts for advice and to inform their feeding decisions. I will discuss this in the next section.

A good mother follows expert-led advice on breastfeeding

The first-time mothers in the study spoke about medical and expert-led advice as essential to aid them in making their feeding decisions. These findings align with Fenwick et al. (2013), who found that midwives armed new mothers with as much information as possible to support breastfeeding. All six mothers in the study were educated, career-oriented women from middle-class socioeconomic backgrounds and had access to privately paid medical advice. They also sought information through various sources, and programmes that support new mothers, and used various appliances (bottles, formula, feeding equipment) to support breastfeeding. For most mothers, attending regular check-ups with the midwife at the baby clinic was meaningful, as it was not just about their baby's medical care but also their own. This is a shared finding in breastfeeding research where these interactions in this "medical space" are a form of pastoral offering to the mothers (Mahon-Daly & Andrews, 2002, p.67).

In this research, the midwife was positioned as the expert, whom mothers invited to offer guidance and feedback at the private consultations. The midwife was a revered figure of knowledge and authority who could guide, inform, and tell them what to do. The mothers positioned themselves as obedient to the advice and plans offered to them, and this contributed to mothers feeling reassured and given a 'road map' for success. Burns et al. (2012) found that in this context, there is a consistent assumption that new mothers want to be assessed for their breastfeeding skills and how they deliver their services to their babies to receive feedback on their mothering. The research found that the mothers' use of experts for breastfeeding support reinforces good mothering ideals. To be a good mother, mothers wish to get it all right and look to expert-led advice that outlines the steps to success. This is a form of textbook mothering whereby mothers look for a plan with guidance to reassure them they are on track. The mothers spoke of expert advice as necessary to avoid getting things wrong, which would compromise their breastfeeding success and potentially place themselves at risk of being deemed not to be a good mother.

In their talk, the mothers positioned the midwife as the 'expert' in infant feeding and other related child-rearing practices, with the necessary knowledge and guidance they require to succeed. The time spent with the midwife was framed as key to their ongoing mothering process, specifically to offer hands-on support for breastfeeding advice and feedback. In the research by Burns et al. (2012), the authors found these interactions reinforced a mechanistic discourse as the midwives spoke of the importance of their skills to support mothers to "operate" their bodily "equipment" and maintain a good supply of the "product" (p.1742). Mahon-Daly and Andrews (2002) argue that this discourse objectifies and medicalises breastfeeding, which removes some of the “power and infant control away from the mother” (p.64). Breastfeeding advice has become increasingly standardised and medicalised and does not consider the mother's context and lived experiences (Knaak, 2010).

In this research, Keira sought further advice from the La Leche League, an organisation known for its advocacy for the highest standards of breastfeeding that is exclusive, long-term, and directly from the breast (Kukla, 2008). Keira presented the advice she was given (to feed directly from the breast, with no bottle or a pacifier) as contradictory to her experiences of feeding her baby. This contributed to a turbulent and insecure position. As with the mothers in Avishai’s (2007) research, who sought additional expert-led advice and were tasked to follow breastfeeding plans, they were left feeling “drained, tired and upset about their failed bodies” (p.147). The mothers in this study were no exception, positioning expert advice as necessary to manage and guide their breastfeeding. However, they were left questioning their adequacy when they could not follow the advice strictly as provided. The findings confirmed that a good mother positions expert guidance as a key feature of parenting that includes an array of professionals (midwives, lactation experts) who are the experts that mothers look to for making decisions about child-rearing (Hays 1996, cited in Knaak, 2010). However, Foss (2010) argues that the advice of experts (within medical discourse) limits the practical advice that can be offered for breastfeeding and

invalidates the reality of breastfeeding challenges for mothers. Consequently, mothers have misaligned expectations that lead to discrepancies between the initiation and duration of breastfeeding resulting in self-doubt and feelings of inadequacy (Foss, 2010). In the following section, I will discuss the difficulties with breastfeeding and their implication for good mothering standards.

Challenges with breastfeeding and the good mother discourse

The findings provided a rich understanding of the mothers' lived experiences of breastfeeding and what this meant for them. The natural discourse of breastfeeding was challenged when mothers found it required persistence, labour, and time, and it was deemed all-consuming. This aligns with Schmied and Lupton's (2001) research that breastfeeding was physically demanding. The authors note that none of the mothers "had been able to imagine or prepare for the intensely embodied nature of breastfeeding" (Schmied & Lupton, 2001, p.239) and spoke of how much their lives were confined to the demands of their babies when enacting intensive mothering standards. From this position, Nelson (2006, p.15) frames breastfeeding as an "engrossing personal journey" that mothers undertake to navigate the complexity of these contradicting discourses.

In this research, none of the six mothers initially planned to combine breastfeeding and formula feeding (mixed feeding). All six mothers highlighted the immense pressure to persist with breastfeeding, consistent with previous research (Andrews & Knaak, 2013). With the expectation that their bodies 'should' perform, Cara, Keira, and Roxanne spoke of struggling to produce enough breastmilk and having trouble with their emotional well-being. Formula was presented as the necessary alternative to supplement their breastmilk supply and to meet their baby's nutritional needs. Mahon-Daly and Andrews (2002) argue that the medical management of mothers' bodies meant that if breastfeeding was not working, the mothers were encouraged to bottle feed for the safety of their babies. The authors examined how introducing the bottle (formula) was considered safe when mothers did not produce enough breastmilk (Mahon-Daly & Andrews, 2002). The implication of using formula was

that it contributed to mothers feeling guilty, inadequate, and ashamed because this threatened their position as a 'good mother'. I will discuss this further in the following section.

Formula and the construction of ‘failure’ in good mothering

As much as the scientific evidence declares that formula is a substantiative substitute for breastmilk, all the mothers still questioned its use. No mother outwardly shamed or talked against other mothers choosing to use formula, but when presented as a personal choice, it was debated and contained a moral dilemma. Drawing on the medical discourse with the assumption of 'breast being best' meant introducing formula introduced an element of risk by offering a baby the lesser option (Ludlow et al., 2012). As with previous research, the mothers who used formula did so due to experiencing challenges with breastfeeding, and formula was the next best offer for their babies (Murphy, 2000). The mothers who considered and then introduced formula, namely Cara, Keira, and Roxanne, provided detailed accounts to me as the interviewer of this decision, making it explicit that this was not lightly considered. They each spoke about their initial resistance to the introduction of formula, which was presented as an inevitable decision due to circumstances that were not within their control. The implication is that mothers must justify this decision, holding themselves accountable to their initial ideal that exclusive breastfeeding equates to good mothering. Ludlow et al. (2012) found that the mothers who used formula defended their decision to maintain their identity as good mothers.

In this research, Cara ended breastfeeding and exclusively formula-fed her daughter after three weeks of struggling with low mood. Cara was confronted with the normative expectations that mothers should feel content and happy with their decision to breastfeed and enjoy this harmonious act (Schmidt et al., 2022), and she experienced the opposite. In their research, Larsen and Kronborg (2012) examined how the decision to end breastfeeding was framed as crucial, and the mothers spoke at length to justify how they came to this decision and what it meant to them. In her interview, Cara presented her wariness to use formula and the intense scrutiny of her decision to stop breastfeeding. Like mothers in other

research, by introducing formula, Cara questioned whether she had tried hard enough and if she would be deemed to have failed in her role as a mother.

Schmidt et al. (2022) found that the expectations of breastfeeding in good mothering discourse can create internal conflict for mothers, as introducing formula deviates from these normative standards. Schmidt et al. (2022) argue that mothers are not passive recipients of the messages they constantly receive from society about their infant feeding decisions and that the message held in intensive mothering discourse is that "good mothers are never good enough because they can always try harder" (Collins, 2021, cited in Schmidt et al., 2022, p.10). From this position of feeling out of control and not good enough, Cara looked to her mother for permission to use formula and to reassure her that deviating from the normative standard was okay. This was done by emphasising that her baby would be fine on formula. The role of significant others in offering reassurance as part of deciding to introduce formula is also noted in previous research (Ludlow et al., 2012). The implication is that Cara requires permission to deviate from what is expected of her, and this reinforces that while a mother is positioned as responsible for her baby, she is still subject to the social critique of her feeding decisions. This creates uncertainty for new mothers positioned as vulnerable to judgement for their feeding decisions.

In her interview, by supplementing her breastmilk with formula, Keira constructed her body as inadequate, having failed a standard of good mothering. She castigated herself and, like Cara, positioned herself as accountable to a standard she could not meet. Keira spoke at length about the struggle to produce sufficient breastmilk and the measured amounts she monitored when she used her breast pump. By asserting insufficient milk supply, the current (and previous) research examines how these mothers perceived this as out of their control (Murphy, 2000). In her strife to improve her body's ability to breastfeed, Keira did not frame her additional attempts in a favourable position but rather as secondary to the expectations she had constructed. This was shared by Roxanne, who spoke of the tension she felt at compromising her commitment to exclusive breastfeeding by supplementing with formula

and spoke of feeling that she had failed her son. All three mothers stressed the difficulties that led to their decision to introduce formula. This was not without significant consideration and other attempts to continue exclusive breastfeeding. These findings differed from the research by Ryan et al. (2010), who found that several mothers took a more lenient view towards the ideal of exclusive breastfeeding, which allowed them to supplement with formula.

The current and previous research examined how mothers experience loss and disappointment when they do not meet the ideals held within breastfeeding and good mothering discourse (Schmidt et al., 2022). Their expectations of breastfeeding were challenged by their lived experience. This meant that for the mothers in this research, introducing formula made them question themselves, their bodies, and their identities as good mothers. The pro-breastfeeding discourse is problematic when the act of breastfeeding is moralised, as this can lead to mothers questioning their mothering, rendering them vulnerable to feelings of guilt and inadequacy (their own and those of others) if they do not breastfeed (Knaak, 2010; Hauck & Irurita, 2003; Larsen et al., 2008). Ludlow et al. (2012) argue that the connection between a mother's identity and infant feeding decisions is significant, as when mothers introduce formula, they are positioned as morally accountable to themselves and others, and she is questioned in her duty of care (Murphy, 2000). As a result, Machirori (2021) argues that mothering identities are constantly renegotiated within the discourse of breastfeeding and good mothering. The identity work that mothers do to balance good mothering ideals is actively mediated. Weedon (2004) explains that this identity work takes place when people (mothers) repeatedly perform these ideals held within the discourse until this becomes internalised (like second nature) and part of their reality. Consequently, mothers must negotiate the many contradictions they face to maintain a positive maternal identity (Marshall et al., 2007). This means drawing on a counter-discourse when introducing formula so that their good mothering extends beyond the standard of exclusive breastfeeding. In the counter-discourse of breastfeeding, Marshall et al. (2007)

argues that the construction of breastfeeding as synonymous with good mothering is more contested than discussed. By introducing a counter-discourse, mothers rationalise their decision to use formula as the necessary means to sustain and enhance their baby's health, thereby still drawing on the good mothering discourse. In the following section, I will discuss this counter-discourse in further detail.

Forming a counter-discourse

In this research, the mothers did not challenge nor resist the premise of the good mother discourse that they are regarded as responsible for the well-being of their babies. The mothers who could not maintain exclusive breastfeeding were confronted with managing (or balancing) their initial breastfeeding expectations and ensuring that their baby's nutritional needs were met. Following their decision to use formula, the mothers continued to position breastfeeding as the ideal and 'best' offering but were faced with accepting the limitations of their circumstances. In this decision-making process, Ryan et al. (2010, p.954) found that the mothers undertook "moral work" to justify their decision to use the formula.

In this research, the mothers re-negotiated the standard of breastfeeding being an imperative of good mothering. This is noted across the literature and presented as a counter-discourse to the pro-breastfeeding discourse. In her research, Holcomb (2017) found that the mothers drew on three strategies to maintain a positive maternal identity when using formula: firstly, that formula was not their first choice; secondly, they spoke of their efforts to maintain breastfeeding; and thirdly, they drew on the overall satisfaction and happiness of their baby and themselves following their decision. In this research, similar constructions were used to rationalise the decision to use formula as a counter-discourse.

The baby is happy and developing well

In their interviews, both Roxanne and Keira presented accounts of their babies struggling with their limited breastmilk supply, and formula was positioned as the solution. This is consistent with the findings of Marshall et al. (2007) where mothers demonstrated

good mothering by recognising that their babies were unsettled and not gaining weight and used formula to substitute their breastmilk supply. Keira presented her observations that her son was growing and deemed ‘fine’ when using formula, and this reassured her. For Cara and Roxanne, both mothers spoke of their babies being happy and doing well on formula. Roxanne constructed her son's weight gain as a measure of success after she decided to supplement with formula. The mothers thus drew on a counter-discourse of their baby being happy, healthy, and growing, to assure them in their decision. This is consistent with the findings of Larsen and Kronborg (2012), who found that it was essential for mothers to see evidence that their baby was thriving when using formula, thereby unharmed by their decision. Murphy (2000) found these positive observations were used to discredit the discourse of formula being risky and the lesser offering. Consistent with this research and previous findings, when their babies were deemed to be happy and growing, this alleviated the mothers’ initial concerns about using formula and was a decision that prioritised their babies' needs. Faircloth (2009) examines how mothers who use formula engage in identity work to reposition their initial view of breastfeeding being synonymous with good mothering. This is deemed to be complex as they resist and contest the discourse tailored to their lived experiences (Faircloth, 2009). The implication is that mothers navigate powerful discourses (pro-breastfeeding and good mothering) that prescribe how they should feed their babies. Where counter-discourses are available for mothers to draw on, this offers mothers a redemptive opportunity to reposition themselves as good mothers while using formula (Símonardóttir & Gíslason, 2018).

The research found that this sample of first-time South African mothers embodied the pro-breastfeeding position as a core belief of good mothering. Their bodies and selves were pivotal to being the source of their baby’s health and well-being. They each took on a ‘full-time’ mothering obligation imbued with intensive mothering standards (Waltz, 2014). Johnson and Swanson (2003) emphasise that good mothering ideals are socially and historically constructed, reflective of sociocultural standards, and are not biologically

determined. The good mother discourse implies that breastfeeding is essential and that these good mothering ideals ascribe “responsibility for the conditions of motherhood to the individual, not the system” (Johnson & Swanson, 2003, p.23). Brookes et al. (2016) argue that when breastfeeding is constructed as essential, it does not consider the lived realities of many women’s everyday life experiences. Mothers who cannot meet these expectations experience maternal guilt, shame, and stress affecting their well-being and health (Fierheller, 2002; Taylor & Wallace, 2012). The findings in this study were that none of the mothers actively challenged breastfeeding as a necessary act of good mothering even when formula was introduced.

This chapter discusses how the breastfeeding period, post-birth, is a crucial time for how mothers will present themselves, and they need to carefully balance their expectations with those of the good mothering ideology (Machiori, 2021). For the mothers in the study, success with breastfeeding was a source of pride for them, and like Knaak (2010, p.350) highlighted, it is a “marker of their own mothering capability”. The mothers framed their mothering identity through their constructed successes and failures in breastfeeding. They were significantly influenced by breastfeeding ideals and constantly measured themselves against these medical and social standards. The findings of this research highlight how mothers draw on their feeding experiences to reframe their initial expectations of breastfeeding being imperative. This means that these socio-cultural norms that position breastfeeding as an essential act of good mothering create a state of intensive mothering that renders mothers vulnerable to feelings of shame and guilt, positioning themselves as ‘failures’ if they cannot breastfeed successfully.

Chapter 6

Conclusion

The research examined how first-time South African mothers position themselves as good mothers through breastfeeding. The six first-time mothers provided in-depth accounts of their lived experiences of breastfeeding. As discussed in the previous chapter, the findings of this research suggest that all six of the mothers drew on the good mother discourse. The findings were that the mothers first demonstrated their commitment to breastfeeding during pregnancy and following birth. All six mothers used the word 'best' to construct breastfeeding as the superior choice, drawing on the natural and medical discourse that promotes its many benefits. Secondly, the mothers positioned their bodies as central to demonstrating good mothering through breastfeeding. They drew on project management strategies to monitor, evaluate, and optimise the production process. This contributed to a mechanistic breastfeeding discourse where using a breast pump as a technological device further aided the extraction process for storing surplus milk for later use. The mothers managed their bodies, altered their diets, and set high expectations for themselves to continue to offer the babies breastmilk. The third finding was that the mothers sought expert advice on breastfeeding from various sources and consultations with experts. The mothers spoke of the midwife's feedback with value and constructed as necessary for mothers to achieve their breastfeeding goals. Consequently, they positioned the midwife as a revered figure who would provide them with steps to follow to achieve their good mothering and breastfeeding ideals.

The mothers' lived experiences of breastfeeding were complex in navigating their feeding relationship with their baby and managing their bodies while considering the expectations they placed on themselves. When the mothers faced breastfeeding challenges, the findings were that they had to redefine the construction of breastfeeding as an imperative

for good mothering. Three of the mothers introduced formula, which was positioned as the alternative to breastfeeding. These three mothers had to re-negotiate their ideal of exclusive breastfeeding as a standard of good mothering. Drawing on a counter-discourse, these mothers positioned their baby as happy and healthy in using the formula, offering reassurance for their decision. Simultaneously, these mothers continued to navigate their construction of failure and feelings of inadequacy in using formula and experienced guilt and shame.

The mothers in the study constructed their successes and failures in breastfeeding, by constantly measuring themselves against good mothering standards in the activity of breastfeeding. Constructing breastfeeding as essential contributes to intensive mothering which renders mothers vulnerable to a negative maternal identity when these standards are unmet. The value of breastmilk from a medical discourse is recognised within this research; however, the pro-breastfeeding and good mothering discourse becomes problematic when breastfeeding is used as an act to evaluate a mother's commitment and how she prioritises her baby's well-being and health.

The strengths and limitations of the research study

The strength of this study is that it has contributed to the South African research on the discourse of good mothering and breastfeeding, albeit with a small sample of middle-class women who utilised the services of a clinic and midwife. It examines how this group of first-time South African mothers drew on the standards of the dominant discourse of good mothering, specifically through breastfeeding. These findings align with previous literature, as discussed in the previous chapter. Previous research in the Global North and South Africa has examined the impact of these discourses on first-time mothers (Avishai, 2007; Lee, 2007; Waltz, 2014). The research offers insight into how first-time mothers in South Africa navigate the dominant discourse of mothering and infant feeding.

In reflecting on the quality of the research, I have revisited the scientific elements of qualitative research. In this research, credibility, dependability and transferability were evidenced by the detailed description of the sampling, data collection, analysis and reporting processes. The interviews were transcribed verbatim for the data analysis process and selected extracts have been included to evidence this. In analysis the extracts, I used constant comparative analysis (recommended by Silverman, 2013) to compare and look for similarities and differences across all six of the interviews. This contributed to avoiding anecdotalism, as I selected extracts that best represented the accounts of all six mothers' interviews. The transferability of the research was enhanced by providing a detailed description of the research sample and the context of the site from which the mothers were recruited. This will inform future researchers who can examine whether the findings can be transferred to similar participants in similar contexts. I provided a detailed table of the participants' demographics which can be considered in future research. The dependability of the research was enhanced by providing a detailed account of the research process in the Methodology Chapter. I have provided a detailed description of the sampling and recruitment process and included the supporting documents in the appendix that future researchers can use, which enhances the dependability.

As a researcher, I was aware of my subject position as a first-time, White mother from a middle-class background. Throughout the research process, I have considered the value of reflexivity. I specifically considered how my presence influenced the interview process, as mothers may have felt they could relate to me based on my demographics of similar ethnicity and age, contributing to the data quality in the interview process. My position as a researcher, and the nature of the topic, may have influenced the mothers to spend more time demonstrating their good mothering through breastfeeding, as this is a sensitive period, and all six mothers had young babies at the time of the research. I have considered how this has been both a strength and limitation in this research, as the mothers may have

found my presence reassuring and contributed to the data quality, or they may have spoken about their experiences in a particular way that they deemed meaningful to me.

Recommendations

This study examines how first-time mothers navigate the dominant discourses of breastfeeding and good mothering. I have examined how these ideals have become standards mothers use to measure their mothering and breastfeeding success. In this research, I present the significant influence that health professionals have on first-time mothers. I recommend that midwives, doctors and lactation specialists be mindful of how these dominant discourses have an impact on new mothers following the findings of this research. I recommend that health professionals emphasise mothers' individuality and unique context in discussing infant feeding and mothering. In reviewing how mothers spoke of pregnancy being a time in which they learnt about breastfeeding, which contributed to their initial expectations, it would be beneficial for midwives to include further information about formula use during ante-natal classes. The research shows that all mothers cannot breastfeed exclusively and therefore use alternative milk, namely formula, to supplement their breastmilk supply. Some mothers terminate breastfeeding due to difficulties beyond their control and exclusively formula-feed their babies. Normalising how individual contexts impact infant feeding decisions would contribute to mothers feeling less judgement when using formula. Mothers could therefore be better empowered in owning their infant feeding decisions.

Regarding the recommendations for future research, it would be beneficial to examine how mothers from different socioeconomic and ethnic backgrounds in South Africa construct breastfeeding and good mothering. The good mothering discourse examined in this research is noted for its dominance in more Westernised contexts. Future research could also examine the influence of partners on first-time mothers breastfeeding expectations and experiences and how partners' views impact the construction of breastfeeding and good mothering ideals.

In concluding this chapter, I would like to return to the acknowledgements at the beginning of this dissertation, thanking each person who contributed to this research and for all the support I have received. I want to conclude this dissertation by reminding all mothers of their intricate worth to their babies, which is not limited nor defined by the socially constructed ideals held within the dominant discourse of good mothering.

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Appendix 1: BREC Permission letter

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

30 April 2020

Miss Jennifer Leigh Bloch (210511052)
School of Applied Human Sc
Howard College

Dear Miss Bloch,

Protocol reference number: BREC/00001183/2020
Project title: Being a good mother: examining the discourses of first-time breastfeeding mothers
Degree Purposes: Masters

EXPEDITED APPLICATION: APPROVAL LETTER

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your application.

The conditions have been met and the study is given full ethics approval and may begin as from 30 April 2020. Please ensure that outstanding site permissions are obtained and forwarded to BREC for approval before commencing research at a site.

This approval is subject to national and UKZN lockdown regulations and the general BREC circular emailed by the Research Office on 23rd March 2020 and repeatedly since.

This approval is valid for one year from 30 April 2020. To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2015), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

The sub-committee's decision will be noted by a full Committee at its next meeting taking place on 09 June 2020.

Yours sincerely

[redacted]

Prof D Wassenaar
Chair: Biomedical Research Ethics Committee

Biomedical Research Ethics Committee
Chair: Professor D R Wassenaar
UKZN Research Ethics Office Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Email: BREC@ukzn.ac.za
Website: http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx

Appendix 2: Gatekeeper permission letter

The Baby Clinic Letterhead

Date:

To whom it may concern,

Confirmation of gatekeeper permission to conduct research for UKZN Research Psychology Master's student Jennifer Bloch (210511062)

This letter serves to grant permission to UKZN Research Psychology Masters student Jennifer Bloch to recruit her sample from my clients for her research project titled: *'Being a 'good mother': examining the discourses of first-time breastfeeding mothers.*

I run a private baby clinic within the area of Durban offering infant and post-natal care and support to mothers and their babies. I have been informed of the research aim and process and sample the researcher is hoping to access and recruit to be part of the study.

Please do not hesitate to contact me if you have any questions.

Regards,

Midwife

Appendix 3: Confidentiality agreement between gatekeeper and researcher

Confidentiality agreement

This is a confidentiality agreement between Midwife - and student researcher, Jennifer Bloch (210511052).

I, _____, agree to protect the identity of the mothers to which I will provide the information of the research study.

This means that I will not reveal the names of the mothers who may possibly take part in the research study. In addition, no further form of discussion will take place between the researcher and myself, the gatekeeper, about the recruited participants.

Date: _____

Place: _____

Signature: _____

Appendix 4: Study Information Letter

Hello,

I would like to invite you to take part in my research study which seeks to explore the breastfeeding experiences of first-time mothers.
I am interested to hear about your experience of breastfeeding, as it is the topic I am exploring for my Master's Research Thesis.

The title of the study is: *Being a 'good mother': examining the discourses of first-time breastfeeding mothers.*

Why am I being asked to participate?

For this study I am specifically looking for new mothers, living in South Africa, who are accessing private healthcare for the birth and postnatal care of their baby. I aim to recruit about 3-4 mothers, who are 18 years or older who have given birth to a healthy baby and who have initiated breast feeding, with a baby between the ages of 3-6 months. I am interested in your experience of breastfeeding, whether it was a few attempts or whether you are still breastfeeding now.

Voluntary participation in the study

Your participation in the study is voluntary. This means that it is your decision to take part in the study and you are able to withdraw at any time, without giving a reason, and without any negative consequences. If you would like to withdraw from the study, please contact the researcher and your data will be removed from the study.
You will be required to sign an informed consent form (attached in the envelope) which ensures you understand the process and consent to participate.

The interview process

The interview will be conducted via an online, videoconferencing application called Zoom. This requires that you have access to reliable internet and a device (computer, laptop or cell phone) that will allow you to talk with myself, the interviewer. The interview will not take place in person due to the current public health requirement to maintain social distancing as a measure of protection against the COVID-19 virus.
Following your willingness to participate, I will e-mail you a link to the Zoom platform. I will explain all the steps involved via the telephone and answer any questions you may have. The interview will be conducted with you by me on a date and time that is at your convenience. The interview will last about 60 minutes. I will ask you questions about your experience of breastfeeding and being a mother. There are no right or wrong answers. You are encouraged to express yourself freely. You are not obligated to answer all of the questions and if there is a question you would not like to comment on, that is okay.

I understand the demands of motherhood and feeding and sleep routines, so please know that the interview will accommodate any of your infant's needs. It is about you and will be centred around your schedule and routine.

Recording

With your permission, the interview will be recorded so that I can write out the conversation to remember what was said. Zoom has a feature which records the audio of the interview. This recording will be stored on my laptop, within a password protected folder for a period of five years, after which it will be permanently deleted.
I will kindly ask you to sign a recording permission form (attached in the envelope), to ensure I have your consent to record the conversation.

Benefits and risks to taking part in the study

Participating in this study may benefit you by talking about your experience. I hope that the findings can be used to better understand and support new mothers who plan to breastfeed. The information generated from this research thesis also contributes to the literature on breastfeeding within the South African context.

I have identified no immediate risk or disadvantage to participating in the study. However, should you experience any distress, or wish to receive counselling support, the details of Focus on the Family, a counselling service provider will be given to you. I have also included the details of an infant and toddler stimulation group- Bub Club, which also offers social support for mothers. Bub Club are offering sessions via online platforms, such as Zoom, during this time of practicing social distancing. Please find the details of these organisations included at the end of the letter.

Confidentiality

I am bound to adhere to the ethical requirement of confidentiality throughout the research process. This means that no one, besides me will be able to identify you or your contact details. To maintain confidentiality, I will conduct the interview in a private room, so no one else will be able to listen to the conversation. Following the interview, you will be allocated a pseudonym (a different name) to be used in the study. The audio file will be labelled using your coded name, e.g Participant 1- 'Jane'. The pseudonyms will be used in the final research report and the name of the baby clinic will not be mentioned, as a further measure to protect your identity. I will be the only person to listen to the audio-recording and it will be kept within a password protected folder on my computer.

The process after the interview

If you would like to receive a report of the findings, I will send the summary to you once the thesis is complete and a report of the findings it generated.

Data management & storage

The data collected in the study will be kept in a secure location, specifically, a locked cabinet in the research supervisor's office on the premises of the Pietermaritzburg campus of the University of KwaZulu-Natal. According to the university's rules and regulations, these documents must be stored for the duration of five years, after which they will be shredded.

Ethical approval

This research study has received ethical approval by the University of KwaZulu-Natal's Biomedical Research Ethics Committee (BREC) (approval number BREC/00001183/2020). The purpose of the committee's ethical approval is to ensure that as a participant, your interests are protected. If you have any ethical issues to raise about the study you may contact Professor Mary van der Riet, the research supervisor, or the UKZN BREC. The contact details have been provided below:

Contact details
Research supervisor
Prof Mary van der Riet
Discipline of Psychology
School of Applied Human Sciences
University of KwaZulu-Natal, Pietermaritzburg Campus
Work: 033 260 6163
E-mail: vanderriet@ukzn.ac.za

Biomedical Research Ethics Committee
Research Office, Westville Campus
Govan Mbeki Building
University of KwaZulu-Natal
Private Bag X 54001, Durban, 4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2602486 - Fax: 27 31 2604609
Email: BREC@ukzn.ac.za

Interest in participating in the study / Queries

If you are willing and interested in taking part in this research study, please contact me and I will communicate with you further about the study. Alternatively, if you have any questions you would like to ask me, please also feel free to contact me.
Cellphone number:
E-mail:

I look forward to hearing from you. Your experience is valuable, and it would be a great honour to hear more about it.

Thank-you very much.

Kind regards,

Jennifer Bloch
UKZN Psychology Research Masters Student
Cell:
E-mail:

Counselling Services:

Focus on the Family, is a registered not-for-profit organisation that provides "care, advice, support and encouragement to families at every stage of life."

"Counselling may be helpful for you if you are feeling anxious, unhappy, or unfulfilled or when you have experienced personal trauma in your life. You may have tried to cope with your problems on your own but have found it difficult. Our trained counsellors and therapists can help you develop skills to improve your life and/or relationships and help give guidance that is needed to make the best possible decisions. Our Counselling is offered at affordable rates."

Offer counselling services – all details can be found on their website

https://www.safamily.co.za/counselling/

Services include: face-to-face, telephonic and email counselling.

Hours of operation are Monday to Friday, 9am to 4pm.

Address: 32 Old Main Road, Hillcrest

Telephone number: 031 716 3300

Email: counselling@fothf.co.za

Other Crisis Support Services that are free of charge and available 24/7

- **LIFE LINE**: 0861 322 322
- **CHILDLINE**: 0800 055 555
- **SUICIDE CRISIS LINE**: 0800 567 567 or SMS to 31393

Mother support services:

This is Bub Club...if you are a mum, WE are your tribe! Bub Club is where you will find support, friendship, advice, fun and laughter! Join THE club...Bub Club!

The services offered to mothers include:

- New baby preparation classes
- Ante-natal preparation classes
- Doula services
- Mama and Baba Massage Classes
- Mama and Baba Enrichment Classes
- Mama and Toddler Enrichment Classes

Contact details: Samantha Salter (Qualified Doula) 076 329 0217

Address: Junior Clubhouse, Kloof Country Club, 26 Victory Road, Kloof, KwaZulu-Natal 3610

Website: https://www.bubclubsa.com/

Facebook page: https://www.facebook.com/mommyandbabyclasses

Appendix 5: Informed consent form

Informed Consent:
The following statements confirm your agreement to participate in the study:

- I understand the purpose and procedures of the study and have been informed of what is expected of me, specifically to participate in an interview.
- I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.
- I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without having to provide a reason.
- I understand that my name will be kept confidential and no one, besides the researcher will be able to identify me. I understand that no identifying information about me will be published.
- I understand that my data will be securely stored for a period of five years and may be used for future research. Following that time period, the data collected will be permanently deleted.
- If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher.
    - If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study, then I may contact the research supervisor or the University of KwaZulu-Natal's Biomedical Research Ethics Committee (BREC).

(Informed consent form- to be completed by the participant and returned to the researcher)

I……(*full names of participant*) hereby confirm that I understand the content of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT DATE

……

Appendix 6: Consent to record interview

(to be signed by the participant and returned to the researcher)

UNIVERSITY OF KWAZULU-NATAL

Audio-recording permission

To be able to understand what was said in this interview and remember it, the researcher would like to record the interview using the recording feature within the Zoom, online, videoconferencing application. Once the interview is finished, the researcher will listen to the recording and write down, word-for-word, what was said.

The recording will be saved on the researcher's computer within a password protected folder that only the researcher will have access to. The researcher will not use your name in labelling the audio-file, rather you will be given a code name- for example Participant 1, in order to protect your identity. No one else will listen to the recording. After 5 years, according to the University of KwaZulu-Natal's rules and policies, the recording will be permanently deleted.

I hereby provide consent to:

- **Audio-record my interview**

☐ I AGREE

SIGNATURE OF PARTICIPANT **DATE**

……

Appendix 7: Interview guide

Semi-structured interview schedule

Introduction

Thank-you very much for providing me with your time today so that I can conduct an interview with you about your experience of breastfeeding and motherhood. I would like to begin the interview by asking you a few general questions about yourself, your birth and your baby.

Section 1: General questions

1.1 Can you tell me about yourself?

- 1.1.1 How old are you?
- 1.1.2 Are you in a relationship (married, partnership)?
- 1.1.3 What were you doing before you had a baby? (career)

1.2 Can you tell me about the birth of your baby?

- 1.2.1 Where did you give birth?
- 1.2.2 Who was there at the birth?
- 1.2.3 How did you give birth? (natural or caesarean section)
- 1.2.4 Did you take maternity leave? If so, for how long?

1.3 Can you tell me about your baby?

- 1.3.1 How old is your baby?
- 1.3.2 Did you have a baby boy or girl?

Section 2: Breastfeeding

2.1 Before your baby was born, what were your thoughts and feelings about breastfeeding?

- 2.1.1. Did you do any research on breastfeeding?
- 2.1.2 If so, what did you read, or who did you speak to?

2.2. What expectations did you have of breastfeeding before you gave birth to your baby?

2.3 Can you tell me about your first experience of breastfeeding?

- 2.3.1 Where were you? (hospital, clinic, or home, etc.)
- 2.3.2 Who was with you and what did they say or do?
- 2.3.3 How were you feeling?

2.4 How did your experience of breastfeeding continue?

2.5 From your experience of breastfeeding, what decisions did you make about feeding your baby?

- 2.5.1. Did you continue to exclusively breastfeed, supplement with formula, or only use formula and stop breastfeeding?
- 2.5.2. What/who influenced you to make that decision?
- 2.5.3 How did you feel about the decision you made?
- 2.5.4 What did your healthcare provider have to say about your decision?
- 2.5.5 What did your close family have to say about your decision?
- 2.5.6 What did your friends have to say about your decision?

2.6 How did your expectations of breastfeeding compare to your experience?

2.7 How do you feel about breastfeeding now, following your experience?

Section 3: Motherhood

3.1 What do you think makes someone a mother?

3.2 How do you feel about being a mother?

- 3.2.1 Can you tell me more about your experience so far?

Section 4: Breastfeeding and motherhood

4.1 As a mother, how do you think breastfeeding relates to your understanding of what it is to be a mother?

- 4.1.1 Can you tell me more about this?

4.2 What is the value of breastfeeding in the role of being a mother?

- 4.2.1 Can you explain to me how you came to understand this?

4.3 How do you think society responds to the practice of breastfeeding by mothers (in general)?

- 4.3.1 Can you provide me with some examples?

Section 5: Reflection

5.1 Reflecting on your breastfeeding experience, how would you liked to have been informed about breastfeeding?

- 5.1.1 Can you tell me what advice or information you would have liked to have heard?
- 5.1.2 Can you tell me who you would have like to have told 5.2 How would you have liked to have been supported in your decision to (or not to) breastfeed?

5.3 How do you think mothers should be given information about breastfeeding?

5.4 How do you think mothers should understand what their role is when it comes to feeding their infant?

Conclusion

Thank-you very much for taking the time to tell me about yourself and share personal details about your breastfeeding experience. It has been very informative to hear your story.

Is there anything else you would like to add that you feel would contribute further to the questions I have asked you about breastfeeding and motherhood?

Thank-you again. I appreciate your time.

End of the interview.

Appendix 8: Jeffersonians conventions

Conventions: (Jefferson, 2004)

[	Square brackets are used when the speakers talk overlaps.
=	The equal sign is used at the end of a sentence and at the beginning of the next sentence to show how the talk continues with no gap
(.)	A full stop within brackets indicates a very short pause.
°word°	The degree sign on either side of a word indicates that it was said quietly
.	A full-stop on its own infers a longer pause.
word	A word underlined/underscored indicates greater amplitude/emphasis of the word.
::::	Multiple colons indicates that a sound within a word has been prolonged/elongated in the speech.
(( ))	Double brackets are used to indicate additional information about the talk – such as sounds, non-linguistic behaviours that the speaker has done/used.
WORD	Words in capital letters indicate loudness and greater emphasis in volume.
↑	An increase in intonation or pitch of the word.
↓	A decrease in intonation or pitch of the word.
< >	The pace of speech has decreased/become slower.
> <	The pace of speech has increased/become faster.
hhh	Breathing out sound
.hhh	Breathing in sound
Heh heh	Indicates laughter