Maternal & Child Nutrition

DOI: 10.1111/mcn.12179

Original Article

# 'This little piranha': a qualitative analysis of the language used by health professionals and mothers to describe infant behaviour during breastfeeding

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**Abstract**

Exclusive breastfeeding for the first 6 months of life offers the recommended best start in the life for a newborn baby. Yet, in Australia only a small number of babies receive breast milk exclusively for the first 6 months. Reasons for the introduction of formula milk are multi-factorial including access to appropriate support and the woman's experience of breastfeeding. The language and practices of health professionals can impact upon how a woman feels about breastfeeding and her breastfeeding body. One aspect of breastfeeding support that has had scarce attention in the literature is the language used by health professionals to describe the behaviour of the breastfeeding infant during the early establishment phase of breastfeeding. This paper reveals some of the ways in which midwives, lactation consultants and breastfeeding women describe the newborn baby during the first week after birth. The study was conducted at two maternity units in New South Wales. Interactions between midwives and breastfeeding women were observed and audio recorded on the post-natal ward and in women's homes, in the first week after birth. The transcribed data were analysed using discourse analysis searching for recurring words, themes and metaphors used in descriptions of the breastfeeding baby. Repeated negative references to infant personality and unfavourable interpretations of infant behaviour influenced how women perceived their infant. The findings revealed that positive language and interpretations of infant breastfeeding behaviour emerged from more relationship-based communication.

*Keywords:* infant behaviour, breastfeeding, language, infant personality, relationship focus, discourse analysis.

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## Introduction

Exclusive breastfeeding is recommended as the most beneficial form of infant feeding for the first 6 months of an infant's life and thereafter for 2 years, or as long as it is mutually agreeable (NHMRC 2003; AIHW 2012). Several factors can influence the length of time a woman will breastfeed including family and social circumstances, the health of the baby and other dependants, employment, the woman's own health needs, the type of birth she experienced, her previous experiences of breastfeeding, partner support and the culture within which she lives (Gatrell 2007; Miller 2007; O'Brien *et al*. 2009; Mannion *et al*. 2013). Anxiety about breast milk supply, infant positioning, nipple trauma, pain, mastitis and infant distress are common problems experienced by women during the early establishment of breastfeeding (Cooke *et al*. 2003; Sheehan *et al*. 2013; Omer-Salim *et al*. 2014). Personal enjoyment of breastfeeding can have an impact on the length of time a woman will choose to breastfeed and is a modifiable variable in breastfeeding confidence (Meedya *et al*. 2010; Mannion *et al*. 2013; Howell *et al*. 2014).

 

A woman's interpretation of her infant's enjoyment of breastfeeding is also reported to be a significant component in a woman's satisfaction with breastfeeding (Leff *et al*. 1994; Schmied & Barclay 1999; Sheehan *et al*. 2003; Manhire *et al*. 2007). Interpretations of infant behaviour, feeding style and enjoyment can influence confidence with breastfeeding and even the woman's attitude towards her infant (Grassley & Nelms 2008). Research by Grassley & Nelms (2008) identified that a woman's interpretation of her infants' behaviour was 'a crucial aspect of maternal confidence' (p. 857) with breastfeeding. Women also use the behaviour of their infants to gauge the quality and quantity of their milk supply (Hill *et al*. 1997; Dykes & Williams 1999; Mozingo *et al*. 2000; Dykes 2002; Lewallen *et al*. 2006; Grassley & Nelms 2008). However, women report difficulties in interpreting their infants' behaviour and report at times feeling as though they cannot 'make their baby happy' (p. 850) when breastfeeding (Grassley & Nelms 2008).

Some time ago, qualitative research conducted by Schmied & Barclay (1999) captured both positive and negative interpretations of breastfeeding infants' behaviour in the language used by women during in-depth interviews. Some women described their infant as absolutely loving breastfeeding whereas others interpreted their infants' behaviour in negative ways, with one woman describing her infant as the 'rotten little sucking leech' (Schmied & Barclay 1999, p. 331).

A meta-synthesis of qualitative papers exploring women's experience of breastfeeding (conducted by the authors) identified repeated references to an infant's capacity to breastfeed. The analysis revealed that a number of women felt that their infant was just not able to breastfeed (Mozingo *et al*. 2000; Raisler 2000; Baker *et al*. 2005; Manhire *et al*. 2007). Some described their infants as intrusive, destructive, demanding and restricting their own freedom. These descriptions were in stark contrast to accounts of breastfeeding infants as 'perfect' and of breastfeeding as a 'joy' and a 'special time'. When women used negative language, it reflected a particular interpretation of newborn infant behaviour (Burns *et al.* 2010).

Little has been written about the language used to describe infants during pregnancy, birth and the post-natal period. This paper examines how health professionals and mothers talk about, and interpret, newborn infant behaviour related to breastfeeding. We draw on data from a larger previously reported study into the language and practices adopted by health professionals during the provision of breastfeeding support. This subsequent analysis was prompted by the observation that the language used to describe the breastfeeding infant, by some health professionals, was often negative, and at times seemed to influence the woman's ongoing interpretations of her newborn infant. Specifically, this paper addresses the following questions: What words and metaphors do health professionals and women use when referring to the newborn breastfeeding infant? and What impact does the language used by health professionals have on a mothers' own interpretation of her newborn and its behaviour?

## Method

This study was underpinned by a social constructionist epistemology, situating an understanding of reality within a social and cultural frame (Berger & Luckman 1966; Crotty 1998). A post-structuralist approach informed the methodology (Sarup 1989; Weedon 1997) and discourse analysis (McHoul & Grace 1993; Fairclough 2001; Wodak & Meyer 2009) was used to examine the way in which language

**Key messages**

- Breastfeeding should be viewed as a relational activity rather than a purely nutritional activity.
- Health professionals should avoid ascribing personality traits onto newborn babies.
- Negative interpretations of infant behaviour by health professionals during breastfeeding can influence a mothers own interpretations of her newborn infant.

(discourse) shaped the beliefs and practices of participating midwives and post-partum women when discussing the infant.

Discourse analysis allows for the examination of interpersonal exchanges between individuals, in this case midwives and women, to explore the language and discourses embedded within participant conversation (Phillips & Hardy 2002, p. 59). Consideration of the words, phrases and metaphors used during the early establishment of breastfeeding can provide a greater depth of understanding regarding the discourses influencing midwifery and lactation consultant language and practices. Careful examination of the particular words, phrases and metaphors that women use during this time can also enhance our understanding of the ways in which women are influenced by, and are 'adapting' to, social, cultural and institutional systems (Anderson & Jack 1991, p. 19). Other midwifery researchers have similarly applied discourse analysis to reveal the powerful discourses impacting on breastfeeding women e.g. in the workplace (Payne & Nicholls 2010) or when living in a non-breastfeeding culture (Ryan *et al*. 2010).

### Participants and recruitment

This study was conducted at two maternity health services in New South Wales and was approved by the Ethics committees at both Local Health Districts as well as the University of Western Sydney Research Ethics Committee. Participants included antenatal educators, midwives, lactation consultants and women who were in the post-natal unit or receiving midwifery care at home within the first week after birth. Midwives at each health facility were informed about the study via face-to-face meetings and invited to express an interest in participation. Those who were nominated were subsequently approached for further discussion and information sharing. Written and verbal consent were then obtained. Pregnant or breastfeeding participants were approached during antenatal education sessions or on the post-natal ward or prior to a post-natal home visit. During antenatal education sessions, the woman's support person was also provided with study information and consent was sought to observe and record the sessions before proceeding. All participants were encouraged to ask questions as often as they liked before and after signing the consent form and were reminded that they could withdraw from the study at any time. Consent forms were signed after the participants had read the information statements and had all their questions answered. A total of 286 people participated in this study.

### Data collection

Data collection techniques included digital recordings of antenatal education sessions on breastfeeding for pregnant couples ($n = 9$ sessions, 124 women and their support person), recording midwife–mother interactions around breastfeeding in the early days after birth ($n = 85$ interactions with 77 women), focus groups with midwives ($n = 4$ with 40 midwives), interviews with senior staff ($n = 11$) and interviews with individual women 4–6 weeks after birth ($n = 23$). The breastfeeding interactions were observed in the hospital (75%) as well as in the home environment (25%). There was a total number of 81 continuous hours (4863 min) of audio recorded observational data collected over an 8-month period of observation at two sites during 2009. Additional information on the research design can be found at Burns *et al.* (2013).

### Data analysis

Discourse analysis involved closely examining the communication between midwives and women around the sociocultural practice of breastfeeding. The method of discourse analysis adopted for this study was informed predominantly by the work of Norman Fairclough, Teun van Dijk, Ruth Wodak and Michael Meyer (Fairclough 1992; van Dijk 2009; Wodak & Meyer 2009). Initially, the transcripts were read to get a feel for the data and to identify the apparent representations of the infant and dominant discourses. Following this, the data were examined more closely for recurring words, metaphors, ideas, beliefs and themes. The textual representations of the infant were coded across the full data set including the antenatal education sessions, post-natal observations and individual interviews.

The team of researchers in this study were midwives and as such belonged to the group being studied. This placed the researchers at both an advantage and a disadvantage. The advantages included the ease of access to the study sites and participants' early acceptance of the researcher because of a shared familiarity. The disadvantages of this shared knowledge included the possibility of missing something valuable because of overfamiliarity with the midwifery role and midwifery communication. In order to minimize these disadvantages, the research team used reflexivity, in addition to regular meetings, to discuss the data collection and ensure that important aspects were not missed. Moral and ethical challenges, which arose as part of this observational study (such as the woman checking with the researcher about what the midwife had said), were viewed as additional opportunities for reflexivity (Burns *et al.* 2012a).

## Findings

In total, nine antenatal education sessions and 85 midwife–mother interactions around breastfeeding in the early days after birth were observed. Seventy-seven women participated in the observational component of the study and of those, 45 were having their first baby, 74 women had a singleton pregnancy/birth and the caesarean section rate was 34%. In total, 36 midwives were observed during breastfeeding interactions and nine midwives were observed providing breastfeeding education during pregnancy. A further 40 midwives participated in focus groups or interviews. Their experience as a midwife ranged from midwifery student to lactation consultant/midwife with more than 30 years of experience. All direct quotes from participants have been identified within single quotation marks or are indented. The sources for all direct quotes have been noted except when individual words have appeared extensively throughout the data set.

Interpretations of infant behaviour began in the antenatal period when the midwifery educators offered their predictions of what the infant would be like at birth. Commonly, the newborn was constructed as 'born to breastfeed', merely needing to be placed in close proximity to the breast in order to commence effective feeding. However, following birth, especially when difficulties with breastfeeding emerged, midwives shifted from the depiction of the infant as a 'breastfeeding genius' to one where the infant was assigned a 'problematic personality'. Midwives adopted the role of interpreter of infant behaviour and were observed at times 'blaming' the infant when difficulties arose (often in an effort to improve the woman's own confidence in her capacity to breastfeed). There were only a small number of midwives who constructed breastfeeding as a connected relationship between the mother and infant.

### *A 'breastfeeding genius': the antenatal construction of the infant*

During pregnancy, the midwives offering parenting education constructed the infant as an 'all knowing' individual who was 'clever' and who had a 'job to do' when it came to breastfeeding. One of the antenatal educators referred to infants as knowing that their 'job in life is to make milk' [Parenting Education session (PEd) 1]. Breastfeeding difficulties were situated, antenatally, as predominantly connected to the woman's lack of skill and knowledge. Interestingly, physical impediments for breastfeeding (such as tongue tie) seemed absent from antenatal promotional/educational discourse.

The message that the 'baby shows mum how it is done' (PEd 8) and that the infant does not operate in line with a particular routine or 'timing' was reinforced during this time. The importance of baby-led feeding was reiterated often and women were reassured that their infant would always love them, even if it seemed that they were resisting latching to the breast.

Some parenting educators made reference to the breastfeeding infant's focus on being fed 'when and where' they wanted. The infant was at times constructed as selfishly demanding its needs be met, to be fed and loved and cuddled (PEd 1, 2, 3, 8). Several of the observed parenting educators depicted infants as potentially getting 'impatient', getting 'antsy' and 'expecting' the milk to be there when they wanted it (PEd 1–4, 6, 7, 8).

> Sometimes when your breasts get really full on that third day, baby gets a bit antsy, about going onto the breast.

Because it's been this lovely soft little nipple for the last three days, then all of a sudden the breasts are full of milk and the nipple gets really hard. . . . On that third day, baby wants everything to be perfect. They want the milk to be there, the nipple to be exactly the same (PEd 3).

The suggestion that newborn babies also have the capacity to 'think' and 'decide' whether to breastfeed was suggested during pregnancy classes as well as a linking between infant behaviour and infant personality (PEd 2–4, 6, 8).

### *A post-natal problem: the infant as an individual with active agency*

During the post-natal period, faith in the infant's ability to 'know' how to breastfeed and take the lead role in the process of breastfeeding rapidly diminished. Alternatively, the infant was positioned as a separate individual whose physical attributes, personality and decisions impacted significantly on whether breastfeeding progressed uneventfully or not.

Midwives quickly adopted the role as 'infant interpreter' and offered many 'explanations' of what the baby was thinking: 'Look at her sleeping on the job, she just feels comfortable there' (Midwife, Interaction 21). With this alternate perspective, midwives commonly implied that infants were 'deciding' whether to 'cooperate' with breastfeeding or not. The phrase 'he/she is just thinking about [whether to latch and breastfeed]' was common during early breastfeeding.

Infants who 'cooperated' with the midwife, and the woman, and performed their 'job' effectively were labelled 'good', 'clever' and 'smart'. However, those newborns deemed to have made the 'decision' not to cooperate were positioned in a negative way.

Getting himself into a tizz and he's not even doing anything. He's just thinking about it . . . He might have decided he's not going to muck up any more (Midwife, Interaction 16).

When the breastfeeding infant was assessed to be 'uncooperative' or 'underperforming in their job/role', some midwives, as well as the mother or family, began to ascribe undesirable personality traits onto the newborn. Infants were described by some midwives as being 'cross', 'cranky' and 'angry' during breastfeeding because the milk was not flowing quickly enough (Interaction 2, 12, 16, 21, 23, 66, 70, 72). In addition, midwives commonly talked about infants 'complaining', having 'temper tantrums', getting themselves into a 'tizz' and using their mother as a 'dummy' (Interaction 1–3, 16, 18, 48, 70, 72).

### *The 'impatient' or 'lazy' breastfeeding baby*

Across the data sets, the most frequent personality trait ascribed to newborn infants was impatient and/or lazy. References to infant impatience were commonly focused on describing the baby's displeasure at not receiving instant gratification (i.e. milk) to their first sucking efforts; 'they're impatient . . . they want it right now' (Interaction 1). Some infants were deemed 'lazy' if they were not sucking long enough or not acquiring sufficient amounts of breast milk at each breastfeed. Occasionally, the infant was even cast as having an 'impatient personality' that resulted in their inability to bring the milk 'in' because of a lack of sufficient sucking and disinterest in doing the 'work' required to retrieve breast milk.

The following excerpt is from an interaction between a woman, who on day five was receiving midwifery support at home, and a midwife who constructed the infant as 'impatient'. The interaction demonstrates the positioning of the newborn infant as a separate individual, operating independently of his mother and with the capacity for active agency. The passage of transcribed text, while lengthy, provides an insight into the negative positioning of the infant and the influence on the mother from this interpretation. In this scenario, 'blaming the baby' for the problems with breastfeeding did not subsequently enhance the woman's confidence with her ability to breastfeed, instead the woman ended up blaming herself for passing on her 'impatient' personality to her offspring '. . . dad would say it's your mums personality' (Interaction 16).

Interaction 16:

Midwife: Why are you bringing yourself off mister? [then to the woman] Going on much easier now that your nipple's softened. (Context: the midwife had hand-expressed some breast milk for the woman).

Woman: Yeah and that's what I thought last night. It's just it's all so hard.
Midwife: Yeah. When you're too hard and his little chin it was just making it too hard for him to get on, but he's now actually going on quite easy. You've just got to keep him on. What he's trying to do is work that next let down and he's too impatient to do it.
Woman: Come on. Because yeah it seems to take forever to feel it come down as well.
Midwife: Yeah, he's just impatient. That's what it is. He's wanting instant reward. No you keep sucking, that's the only way we're going to let down.
Woman: Come on bub.
Midwife: It's two sucks, stop, get cranky.
Woman: Let go and then hurt mum. Come on ... Mummy's not sad, come on. Open ... Come on darling. That's it.
Midwife: He will come. Come on. If he mucks up too much on one side, just pop him onto the other. Just switch feeding because whilst he's been feeding on this one this one has let down, so it's just sitting there. Often when they muck up too much just pop them over.
Woman: He seems to like my left breast better for some reason.
Midwife: Okay, let's pop him onto the other side. I'll just put this under. You can just go back to the other one if you need to.
Woman: I know darling but mummy wants to feed you. Yeah. Oh.
Midwife: It's a hard life for little boys. I'll just pop that right under there. Okay . . . [later in the interaction].
Midwife: Getting himself into a tizz and he's not even doing anything. He's just thinking about it. Whose personality's he got? Who's impatient in your house?
Woman: I don't know.
Midwife: Who've you taken after?
Woman: Yeah he wasn't this bad in the hospital but he certainly wasn't easy to attach. He sort of had a wriggle.
Midwife: Because he's not wanting to do the work.
Woman: No.
Midwife: He's his own worst enemy here. He'll get going but he's only prepared to do so many sucks and then he comes off and gets the cranks because it's not continuing. Oh he actually started again then himself. That's what we want. He might have decided he's not going to muck up any more. I'll get a blanket for you to put over him so he doesn't get cold. I'll put this over him. He's doing it properly . . . [towards the end of the interaction].
Midwife: It's just a bit trying to avoid him getting too easily frustrated and cranky.
Woman: Dad would say it's your mum's personality.
Midwife: [Midwife laughs].

The impact of this type of negative construction of the baby was evident in the interview data collected some 4–6 weeks after birth. There were a number of occasions where women were noted to repeat the same language that the midwife had previously used in their interactions with the woman, in those early days after birth. The following extract is an example:

I think they just wanted to make sure he had a certain amount. I think that was their main priority. Yeah. . . . Well he kept coming off and the first woman just said he's just a little bit lazy with his feeding. But that wasn't true because (a) he's a big boy and you know hungry and (b) a couple of days down the track I realised that that wasn't the problem at all (laughs). That doesn't sound very good, but yeah I mean it wasn't like it was the midwives' fault or anything, but I mean he was having . . . I was having trouble latching on right from the beginning. We had to actually express some of the colostrum so he had the proper amount . . . In fact I think a couple of them said that to me that he is "lazy" . . . At the time I believed them because I thought maybe that was why that was happening, why he wasn't latching on properly (Woman, Interview 11).

### *'This little piranha'*

While the woman in the interview earlier was able to reject the midwife's interpretation of her baby's behaviour, this was not always the case. At times, the words the midwives used to describe infants became part of the woman's own vernacular when describing her baby. The following excerpt from a recorded interaction was collected in the hospital prior to discharge:

Your nipples are a bit tender because you're not used to having this little piranha hanging off them every five minutes (Midwife, Interaction 13).

Six weeks later, the woman was interviewed in her home and was asked to describe her early breastfeeding experience.

With the latching on and that, she's a bit like a piranha. She grabs straight on (Woman, Interview 1).

Comparing the newborn breastfeeding infant to a fish whose teeth and jaws are destructive and whose appetite is insatiable positions the newborn baby as potentially an 'enemy'.

### *Breastfeeding as a battle or fight*

In interactions such as the ones described earlier, the breastfeeding infant was at times positioned as an antagonist. At the extreme end of this discursive positioning, words such as 'battle' or 'fight' were used to describe breastfeeding (Interaction 2, 3, 16, 21, 37, 50, 51, 53, 72, 78, 81). The breastfeeding infant was constructed as 'fighting at the breast' or 'fighting at the nipple' (Interaction 2, 16, 21, 72, 80). Words commonly used to describe the 'damage' infants did to nipples included e.g. 'ripping', 'dragging', 'cracking', 'blistering', 'chewing' and 'pleating'. In this context, infant behaviour was constructed as 'doing damage with every feed' and 'hurting' the mother.

Well it looks like she's damaging your nipple. That's what you just need to think about, really trying to get that good attachment (Midwife, Interaction 79).

Interaction 14:

Woman: Bubby what's wrong bubby.
Midwife: Oh, quick, you need to break the suction or else she will *rip that nipple right off*.

### *Gendered discourse: 'he's just being a boy'*

There was also evidence that the gender of the infant impacted upon the interpretation of behaviour and the baby's intrinsic motivation for breastfeeding. Midwives had a tendency to cast male infants as more 'problematic' than females. Male infants were often depicted as 'ravenous' or 'lazy', 'cheeky' or 'loud little men'. Comments such as 'he does the boy thing, he expects it to just pour out, he doesn't like working for it (Interaction 9)' and 'these boys have got an endless appetite (Interaction 15)' were common during the post-natal period. The following excerpt is an example of this kind of discourse:

Interaction 70:

Midwife: Okay? Babies will cry. They'll cry about everything, that's how they talk. They talk with their eyes and they cry.
Woman: Oh okay.
Midwife: So it doesn't mean something bad. Just means that he's complaining, and he's allowed to complain. So you're going to complain all you like. Yeah you're complaining, see it's not coming quick enough mum, hurry up mum, I don't want to do this mum, my jaw's sore mum.
Woman: Yep, yep, all right.
Midwife: Okay? So he's a boy, so he'll probably complain more than a girl.
Woman: Yeah and he was 13 days late so . . .
Midwife: Oh there, so you're a lazy fellow?
Woman: Yeah.

In contrast, being of male gender was sometimes depicted as a good thing for breastfeeding. For example, some midwives said 'little boys especially, let me tell you. They like to get on the booby (Interaction 28)' or 'he says you're not getting rid of my booby that quick (Interaction 70)'. At times, midwives even made comments about male babies and breastfeeding, which contained overt sexual connotations (see Interaction 18).

Interaction 18:

Midwife: But it will only do your milk supply good him wanting . . .
Woman: I did and then I thought I'll give him the dummy and see if he settles. I thought I can't let you sleep sucking on my boob.
Midwife: He says I wouldn't mind, I'm a boy.
Woman: They're getting a bit sore.
Midwife: Boys like their boobies.
Woman: I thought they're getting a bit sore, mummy needs a little bit of a rest.
Midwife: Don't want your clothes off but you want your boobies.

These types of discourse constructed male infants variously as either better or worse at breastfeeding depending on their performance. In contrast to this, a gendered discourse in the representations of female infants was not detected.

During focus group interviews some staff described the disillusionment they saw in women's eyes, during

the first few days after birth, when they realized that their baby was not 'nice and placid' like they had imagined but rather was a 'demanding' individual whom they had no control over. Some women, at interview 6 weeks after discharge, described breastfeeding as demanding and some felt they had not been able to get into a routine or regain control over their life.

### *Breastfeeding: all about the mother–infant connection*

In a small number of observed post-natal interactions, eight in total, it was evident that midwives interpreted infant behaviour quite differently to their peers. Instead of constructing the infant as impatient or being uncooperative, they positioned the baby as an instinctual being who was learning how to breastfeed along with the mother. In these interactions, alternative patterns of communication were observed with midwives positioning the mother as an expert in the care and knowledge of her infant (Burns *et al.* 2013). These midwives approached breastfeeding as predominantly about the relationship between the woman and her infant. By prioritizing the relationship, and constructing the infant as connected to their mother, these midwives introduced different interpretations of breastfeeding infant behaviour.

The following example demonstrates a normalizing of infant behaviour after the woman articulated a negative impression of her infant:

Interaction 45:

Midwife: You just bring baby straight to the breast and let baby feel where the breast is.
Woman: She doesn't know how to suck.
Midwife: That's alright. She's very clever, you watch. She will have a little lick and a little feel and she'll smell it.
Woman: Actually she sucked this nipple this morning very well but this one is not so.

Midwives and lactation consultants who prioritized relationship encouraged women to observe their infant's behaviour and tune into the cues and follow the baby's lead (Interaction 34, 35, 45, 49).

The language used by these midwives facilitated 'tuning in' behaviours in the mother and reinforced that the infant was learning to breastfeed, just as much as the mother was. Behaviours such as 'licking at the breast (Interaction 49, 50)', maintaining proximity to the breast and 'feeling the breast with her cheek (Interaction 45, 61)' were identified as performance clues that the infant is on a journey of discovery. In this context, infants were positioned as 'learning' how to breastfeed.

Midwives working within this approach also took opportunities to dispel common misconceptions about infants and breastfeeding. These midwives actively engaged in counteracting negative constructions of the breastfeeding infant. For example, when women at times made negative comments about their baby, these midwives reframed the comment to highlight the normal newborn behaviour being displayed. This had the corresponding effect of influencing the mothers to make a more positive interpretation of her baby.

Interaction 49:

Woman: He's a stubborn little bugger
Midwife: He's having a little lick with his tongue and feeling whether it's there. He may still come back or you may need to relatch him but he had a feel and he's checking it out . . . He's thinking about it, isn't he? Slowly
Woman: Yes. You don't make decisions real quick do you mate? A bit like your father [laughs]. Takes him for ever to make a decision
Midwife: That's great. You've stimulated him and offered it to him now and he just may not be quite ready yet and it's okay if you're comfortable just to do some skin-to- skin with him. You may find that he'll just crawl across and hop on . . .
Woman: He has a little – like he just does two or three and then he stops. Maybe he's just having a little rest.

In the context of early breastfeeding language and practices, these intersubjective exchanges revealed the importance of appropriate midwifery language. By 'normalizing' the infant's behaviour, descriptions of negative personality and behaviour traits were avoided. This approach did much more than simply influencing the proximity of the mother and infant during the hospital stay and enhancing opportunities for skin-to-skin contact, rather it altered the actual communication style adopted by individual midwives and mothers. This ultimately enhanced mother–infant connectivity and synchro-

nicity and increased maternal confidence with breastfeeding (Burns *et al.* 2013). In this approach, health professional language provided a variety of more realistic and positive interpretations of infant behaviour, which influenced the mothers' own understanding of her baby.

## Discussion

This study has revealed the various ways in which newborn infants were constructed in the language of midwives, and sometimes mothers, during pregnancy and the first week after birth. Midwives took one of two broad positions in relation to breastfeeding. In adopting the first position, midwives viewed the infant as an individual, agentic being, who was separate from the mother and who had the capacity to make decisions and choose to behave either in a 'helpful' or in a 'problematic' way. This approach was focused on the infant and his/her independent contribution to the breastfeeding partnership. The second position revealed a shift in focus away from the infant as an independent being towards the interconnectedness of both the mother and infant. Within this approach, the midwife positioned herself as a supportive resource for the mother, who was viewed as an expert on her own infant. This approach appeared to enhance mother–infant synchronicity.

In constructing these positions, midwives drew upon professional and lay discourses about infants, their bodies and breastfeeding. Construction of the infant as an antenatal genius, who had 'read all the books' appeared to set women up for a difficult adjustment to breastfeeding. Post-natally, the infant was commonly constructed as a separate being who required expert control or expert interpretations of their behaviour. On the one hand, midwives constructed the infant as born with this inherent 'knowledge' to breastfeed, but on the other hand, viewed the infant as needing to be brought under control. Within the hospital context, the 'expert' (midwife) was available to interpret the infants' 'thoughts' and decisions for the mother. Midwives appeared to deflect any 'blame' for breastfeeding difficulties away from the mother and onto the infant while inadvertently casting the infant as an independent decision maker who lacked the capacity to behave in a controlled and predictable way. An examination of contemporary social and institutional discourses, identified by commentators such as Lupton (2014), reveals a similar positioning of the infant as an out-of-control being who needs to be encouraged towards more civilized behaviour (Lupton 2014).

### The 'untamed' infant

An analysis of media portrayals of infants and young children, in Australian popular media, revealed the sometimes conflicted views of infants as either 'angelic' and 'pure' or 'uncontained' and 'animalistic' (Lupton 2014). Pictures of infants as 'sleeping angelic beings' (Lupton 2014) are abundant in the media and notions of purity and cleanliness surround popular cultural depictions of newborns. Yet, newborn infants continually challenge this notion by behaving in a way that is 'uncontrolled', 'demanding' and 'leaky' (Lupton, 2014, p. 9).

Representations of 'uncivilized' infants appear in debates surrounding the acceptance of infants and small children in public spaces (Smyth 2008). Depictions of children as 'unregulated' or 'unsocialized devils', with a 'bad nature', 'unruly' or 'uncivilized' can be found in media debates about their presence in restaurants, cafes and on airline flights (Lupton, 2014, p. 6).

Midwives seem to be drawing on these discourses when interpreting infant behaviour. They may be challenging the cultural myth that babies are angelic beings by providing women with an alternative (yet more negative) reading of their infants' behaviour. In doing this, midwives inadvertently set the infant up as an antagonistic and uncivilized creature. In addition to this, the cultural tendency to sexualize women's breasts influenced midwives' interpretations of male infant behaviour in this study.

### Gender stereotyping and the sexual breast

Print and visual media have played a major role in portraying the breasts as sexual apparatus and in particular as objects of male desire (Baumslag & Michels 1995; Dykes & Griffiths 1998; Ward *et al*. 2006; Dykes

2007; Palmer 2009). It has been argued that the sexualized focus on the female breasts has contributed to a waning interest in breastfeeding in Western countries and has decreased the visibility of breastfeeding in public spaces (Dykes & Griffiths 1998; Hoddinott & Pill 1999; Hausman 2003; Dykes 2007; Wallace & Chason 2007; Atkin 2013). Sexual connotations applied to breastfeeding not only encourage women to cover up and avoid public performance of breastfeeding, but also portray the newborn male infant as a sexually motivated being.

This 'sexualized breast' discourse was apparent in the interpretation of male infant behaviour by some midwives. The notion that male infants 'like' to breastfeed more than female infants reflects this stereotyping. When health professionals draw on this metaphor, it is an indication of how prevalent the discourse is within the community and it further normalizes a sexualized view of breastfeeding. Previous research by Scott *et al*., in Australia, actually demonstrated that male babies were weaned earlier than female infants (Scott *et al*. 1999) indicating a degree of conflicted maternal (or paternal) feelings about breastfeeding a male infant.

### The breastfeeding battleground

The construction of the infant as an independent decision maker also led to the perception that infants choose whether to 'cooperate' with breastfeeding or not. Consequently, at times, breastfeeding was referred to as a 'battle' between mother and infant, a battle between the owner of the breastfeeding 'equipment' and the 'consumer' (Burns *et al.* 2012b). The idea that babies can 'think and decide' whether to 'cooperate' with breastfeeding may be linked to a health professional urgency to 'get the baby fed' (Furber & Thomson 2006). The notion that infants 'fight' at the breast, transforms breastfeeding into a 'battleground' (Schmied & Barclay 1999; Hegney *et al*. 2008). Midwifery language such as this can interfere with the mother–infant relationship and ultimately the length of time a woman will breastfeed for. Stearns (2009) argues that women view breastfeeding as 'body work' and look for evidence in the baby's body of successful breastfeeding such as an effective suck, swallowing sounds and weight gain. Surprisingly, infant enjoyment of breastfeeding is not mentioned as an indicator of breastfeeding success.

The findings from this study resonate with those of others who have found that during breastfeeding the infant and the woman often represent two competing subjectivities (Bottorff 1990; Schmied & Lupton 2001; Hegney *et al*. 2008). Construction of the mother and infant as competing or antagonistic individuals denies the interdependent nature of the breastfeeding relationship. Dykes & Flacking's (2010) work on the importance of relationship in neonatal intensive care units concludes that, in order for breastfeeding rates to improve, the encouragement of breastfeeding 'relationships', and not nutrition, must be considered as central and crucial. While physical separation of mothers and babies is declining in health facilities, our work supports the argument by Dykes and Flacking that 'notions of separation are still evident in the ways in which breastfeeding is described and conceptualised' (p. 734).

### Maternal–infant connectivity through breastfeeding

The findings from this study have demonstrated that the representations of newborn infants, offered by health professionals, can have a profound effect on a woman's own interpretation of her infant. The transition period from birth to new parent is a time when couples are most sensitive to the comments made by others about their newborn baby (Vehkakoski 2007). In our study, the adoption of a more relationship-based discourse, by a small number of midwives, had the effect of reorienting language towards more positive interpretations of infant behaviour. This crucial change might have positive implications for mother–infant relationship formation and indeed attachment security.

In the light of research demonstrating a link between maternal sensitivity to infant distress and secure parent–infant attachment (Ainsworth 1978; Koren-Karie *et al*. 2002; Oppenheim *et al*. 2004; McElwain & Booth-Laforce 2006), the proliferation of negative descriptions of infant behaviour, in the language of health professionals, is especially

concerning. If infant distress or behaviour is dismissed as merely the result of 'problematic' personality traits or gendered stereotypes then maternal responses to infant distress may be less than optimal. If a mother interprets her infant's behaviour as an exercise in active agency, whereby the infant is choosing to cooperate or not with breastfeeding, or is being lazy, this has the potential to influence her empathic responses to her infant. A review of the literature by Baker & McGrath (2011) demonstrated a connection between maternal responsiveness to infant distress and a woman's perception of her infants' temperament. Mothers who struggled to correctly interpret their infants cues can be at greater risk of developing negative-control parenting styles (Baker & McGrath 2011; Mesman *et al*. 2012). McElwain and Booth-Laforce (2006) have demonstrated that maternal sensitivity to infant distress, at 6 months, can be predictive of attachment security. Indeed, the way in which a mother conceptualizes her infant can influence her care-giving behaviour (Oppenheim *et al*. 2004). The construction of the infant as a separate disconnected individual, in midwifery language, may also be contributing to this trend.

Schmied *et al*. (2011) conducted a meta-synthesis of women's perceptions of breastfeeding support, identifying the negative experience of 'disconnected encounters' and women's desire for support provided in an 'authentic' relational way. We would argue, along with Dykes & Flacking (2010), that increasing the discursive references to breastfeeding as a relationship will do much to improve health professional discourse, and mother–baby connectivity, in the first week after birth.

### Strengths and limitations

In this study, we have used discourse analysis to unpick the language adopted by midwives and lactation consultants, and at times women, when describing newborn infant behaviour during breastfeeding. This methodology facilitated the discovery of the nuanced language apparent in health professional communication, around breastfeeding, when the newborn was discussed. The impact of health professional language on a mothers' own interpretations of her newborn baby were also highlighted. This study was conducted at two sites in New South Wales, in predominantly clinical hospital environments. Given the breadth of the interactions observed and recorded, it is expected that these, or similar, findings will be reflected in other sites in New South Wales and Australia, and perhaps even in other Western environments. However, applicability in other contexts may be limited.

### Implications for midwives and lactation consultants

- A focus on breastfeeding as a relational activity rather than a nutritional activity can infuse positive mother and baby affirming language into health professional discourse.
- Health professionals providing breastfeeding support should avoid the tendency to 'blame' the infant for breastfeeding difficulties.
- Health professionals should refrain from ascribing personality traits onto infants.
- Gendered discourses relating to breastfeeding can be misleading and counterproductive.

## Conclusion

The findings from this study have demonstrated that the language adopted by midwives can impact on a woman's early interpretations of her infant's behaviour. Popular representations of infants as smiling, happy, docile and clean can promote unrealistic images of normal newborn behaviour. Midwives, in this study, perhaps in seeking to provide an alternative reading of infant behaviour, inadvertently suggested that infants had undesirable personality traits or problematic 'behaviours' and at times this negatively influenced maternal interpretations of their newborn.

The majority of midwives, in this study, adopted a position as 'infant interpreter' when supporting women who were breastfeeding. They constructed the infant as a separate 'independent' decision maker and the negative language used by midwives at times became incorporated into a woman's own vernacular.

This appeared to interfere with the development of mother–infant synchronicity and connection and instead set breastfeeding up as a 'battle' between two opposing forces. Sociocultural and biomedical discourses influenced health professional language and practices during this period and especially within the hospital context.

These findings have revealed that the integration of a more relationship-focused approach to breastfeeding support infused positive and normalizing interpretations of infant behaviour into health professional language. A small number of midwives constructed the woman as the 'expert' and the infant as an 'interconnected participant' in the breastfeeding relationship.

Given that the post-partum period marks a critical time for the initiation and establishment of breastfeeding, as well as for the development of sensitive mothering, we would argue that the incorporation of a relationship-focused (rather than an 'individual' nutrition-focused) approach to breastfeeding promotion and support can offer long-term advantages for both mothers and infants.

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