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## Understanding process and context in breastfeeding support

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## interventions: The potential of qualitative research

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## Abstract

Considerable effort has been made in recent years to gain a better understanding of the effectiveness of different interventions for supporting breastfeeding. However, research has tended to focus primarily on measuring outcomes and has paid comparatively little attention to the relational, organisational and wider contextual processes that may impact delivery of an intervention. Supporting a woman with breastfeeding is an interpersonal encounter that may play out differently in different contexts, despite the apparently consistent aims and structure of an intervention. We consider the limitations of randomised controlled trials for building understanding of the ways in which different components of an intervention may impact breastfeeding women and how the messages conveyed through interactions with breastfeeding supporters might be received. We argue that qualitative methods are ideally suited to understanding psychosocial processes within breastfeeding interventions and have been under-used. After briefly reviewing qualitative research to date into experiences of receiving and delivering breastfeeding support, we discuss the potential of theoretically-informed qualitative methodologies to provide fuller understanding of intervention processes by focusing on three examples: phenomenology, ethnography and discourse analysis. The paper concludes by noting some of the epistemological differences between qualitative methodologies and the broadly positivist approach of trials, and we suggest there is a need for further dialogue as to how researchers might bridge these differences in order to develop a fuller and more holistic understanding of how best to support breastfeeding women.

### Key words:

Breastfeeding support; process evaluation; qualitative research; phenomenology; ethnography; discourse analysis

### Key messages

- Supporting women with breastfeeding is a complex process and requires sensitive interaction and attention to contextual issues
- Women are likely to make sense of and experience breastfeeding support interventions differently, depending on their cultural context and prior experiences and preferences
- Research into the effectiveness and helpfulness of support interventions for breastfeeding has tended to focus on measuring outcomes and there is a need for more research into intrapersonal, relational and organisational processes involved in delivering interventions
- Qualitative research methods are ideally suited to examining intervention processes, but have been under-used in evaluations of breastfeeding support interventions

## Understanding process and context in breastfeeding support

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### interventions: The potential of qualitative research

#### Introduction

Interventions to support breastfeeding are many and varied, with evidence that some forms of support can increase the duration of breastfeeding (Renfrew et al. 2012; Sinha et al. 2015), though not always (Hoddinott et al. 2011). The focus of intervention studies has usually been on measuring outcomes, using randomised controlled trials (RCTs). However, RCTs usually focus only on establishing causal relationships between interventions and outcomes, and rarely illuminate the nature of the relationship and *how* interventions might contribute to outcome (Elliot, 2010; Pawson & Tilley, 1997; Thomson & Trickey, 2013). Therefore, less is known about the interpersonal and organisational processes that may be key to successful breastfeeding interventions, and how interventions to support breastfeeding are experienced by women. In this paper we discuss the limitations of evidence gained from measuring large-scale outcomes in RCTs and argue that greater use of qualitative research can enhance understanding of key processes in supporting breastfeeding. Our focus is primarily on high income countries as this is where the majority of the English language research on support for breastfeeding has been conducted. However, several of our arguments, particularly about the context-dependent nature of most interventions, have broader relevance.

#### The complexities of supporting breastfeeding

Due to continued concern that rates of breastfeeding, particularly beyond the early weeks in developed countries, do not meet UNICEF/WHO (2003) recommendations (WHO 2015), interventions to support breastfeeding have proliferated. They may be delivered antenatally, postnatally or both, and may focus on organisational change and staff training or on direct support

to mothers. Some, such as the Baby Friendly Initiative, may involve all or several of these (UNICEF Baby Friendly Initiative UK 2012). Direct support, the focus of this paper, can vary considerably, hence the concern with researching best practice. Support comes in a variety of guises and may be offered by health professionals or volunteers (e.g. peer supporters); via group, individual or family consultations; by phone, face-to-face, or via written information; over shorter or longer time periods; in community or healthcare settings; proactively or reactively and may or may not be 'hands-on'. Training given to supporters also varies and whether the emphasis is on information provision, technical support or emotional support. The breastfeeding challenges addressed by support interventions can include expectations, positioning at the breast, pain, concerns about milk supply and strategies for managing others' responses to breastfeeding (see Feldman-Winter 2013 for overview of support interventions for breastfeeding).

This range of interventions is not surprising given the complexities of breastfeeding (Hoddinott et al. 2011). Infant feeding practices have different meanings in different contexts (Burns et al., 2010) and some mothers may struggle to manage perceived tensions between breastfeeding and the needs, expectations and comfort of others (Leeming et al. 2013). Moreover, an extensive literature demonstrates how frequent framing of infant feeding decisions in moral terms can leave mothers, certainly in high income countries, feeling potentially judged and obliged to account for themselves to others, including infant feeding supporters (e.g. Miller et al. 2007; Ryan et al. 2010; Thomson et al. 2015). This may be particularly difficult where women interpret unanticipated difficulties with breastfeeding as failure at something that should be 'natural' (Larsen et al. 2008; Williamson et al. 2012). Therefore, those who support mothers face dilemmas such as how to promote the health benefits of breastfeeding whilst not undermining the maternal identity of women who formula-feed (Trickey & Newburn, 2014). As such, breastfeeding support needs to be considered a complex intervention (Thomson & Trickey, 2013), involving relational aspects that warrant close attention by researchers, including the language used and messages conveyed. These

issues are not usually directly examined by outcome studies and, as Thomson and Trickey (2013) suggest, might be addressed more fully by wider use of qualitative methodologies.

### The outcome research paradigm and its limitations

RCTs are generally considered the gold standard for assessing the effectiveness of healthcare interventions (Moore et al. 2015), based on the assumption that the most useful data about interventions are outcomes (such as rates of initiation, exclusivity and maintenance of breastfeeding) for those who receive a particular intervention, compared to outcomes for those who do not. A further assumption is that where participants are randomly allocated to intervention or control from a sufficiently large and representative sample confounding factors will be eliminated and findings will be generalizable to a wider population (Walach & Loef 2015). Therefore the results of RCTs are attractive to policy-makers and budget holders (Shaw et al. 2014), where the aim is not to explain the processes through which interventions may or may not facilitate change, but instead to predict the likely effectiveness of an intervention across a population.

Systematic reviews of findings from RCTs have drawn a number of conclusions about the effectiveness of support for breastfeeding: for example that interventions within primary-care settings which combine antenatal and postnatal elements are more likely to lead to higher rates of breastfeeding (Chung et al. 2008; Patnode et al. 2016); that peer support may be of more value in low and middle income countries than in higher income countries with routine postnatal care (Jolly et al. 2012); and that face-to-face support may be of more value than telephone support (Renfrew et al. 2012). However, there are limits to the applicability of these findings. RCTs generally proceed as if the particular intervention being trialled is a homogenous entity which is delivered similarly across participants, and may ignore variation in implementation (Thomson & Trickey, 2013). Assumptions of homogeneity also gloss over the way in which breastfeeding support is an interaction between individuals that is not as easily defined as, say, a drug intervention. Despite increased emphasis on

assuring and assessing implementation fidelity in trials of public health interventions (e.g. Moore et al. 2015), support and guidance is an intersubjective phenomenon that is likely to be experienced differently by participants, particularly in different cultural and subcultural contexts (Shaw et al. 2014). Those using healthcare services are not passive recipients but are active in negotiating and influencing the nature of the intervention (Pawson et al. 2004) and may take up or resist aspects of an intervention in varied ways. Skilled breastfeeding supporters are therefore likely to adapt their support to the needs of different clients in ways that may be difficult to specify at the outset of a planned intervention. This suggests the value of researching how standardised interventions may be delivered and experienced differently, especially where the intervention is delivered in cultural settings which differ considerably from those in which the intervention was developed.

Assumptions about homogeneity of interventions become even more questionable where systematic reviews combine findings from several RCTs into categories of intervention and compare these. For example, although face-to-face support was found by Renfrew et al. (2012) to be more effective than telephone support, the authors advocate caution interpreting this finding as the two forms of communication can vary considerably. The appropriateness of each may depend on factors such as prior relationships, support needs, practicalities such as transport, and whether phone contact increases accessibility of support out-of-hours. Therefore, although aggregated outcome data may be of value for making decisions at a population level, further research may be needed to help practitioners understand how interventions might be received by different mothers and when and where different aspects of support might be more or less helpful.

Outcome data tell us only about the end-point and not how it was reached. The story of how a mother sustained breastfeeding (or did not), of her relationships with those supporting her and others, and how she responded to the different components of support, may tell us more about how to support women in similar situations than measuring the beginning and end points. Furthermore, a focus on outcome measurement requires researchers to define desired outcomes, when these



may be valued differently by different stakeholders (Sanders et al. 1998). In the case of breastfeeding support, whilst there may be broad agreement among service providers about the desirability of outcomes such as increased duration or exclusivity of breastfeeding, interventions may achieve more than this. Women may value approval and validation of their mothering skills (Dykes et al. 2003; Sheehan et al. 2009). Becoming a 'good mother' with a contented, thriving baby and family seem more important outcomes for many mothers than breastfeeding per se (Hoddinott et al. 2012; Marshall et al. 2007). And, within a Western cultural context where breastfeeding might sometimes be seen as embarrassing or even disgusting (Dowling et al. 2012), feeling good about breastfeeding may be an important outcome. Therefore, it is useful for evaluation studies to incorporate open-ended exploration of participants' views on the outcomes that were valuable for them and how these were achieved, in addition to measuring achievement of outcomes specified by researchers. It might also be useful to explore mothers' reasons for *not* engaging with aspects of an intervention, and whether this was because these aspects worked against outcomes that were important to them. For example, Hunt and Thomson (2016) found that expectations of judgement and anticipation of a rules-based approach discouraged mothers from engaging with peer support.

### Investigating process in breastfeeding support

Within healthcare research there is now greater recognition of the need to understand intervention processes as well as outcomes. For example, the UK Medical Research Council (MRC) recommends collecting data as part of RCTs which illuminate *how* interventions achieve their effects, why they fail, and how interventions can be optimised (Craig et al. 2008) and has recently developed guidance for process evaluation (Moore et al. 2015). This follows the development of 'realist evaluation' (Pawson & Tilley, 1997) which aims to explain mechanisms by which healthcare interventions achieve their effects in particular contexts, and places particular value on theoretical understanding of how complex social processes influence outcome. Although process evaluation can include

objective measurement of predicted components of change mechanisms, a crucial element is exploring the subjective experience and perspectives of stakeholders. However, as Renfrew et al. (2012) note, with a few exceptions, the perspectives of stakeholders (e.g. mothers) on intervention processes have so far received limited attention within trials of breastfeeding support interventions. These perspectives may be extremely useful in explaining varying trial outcomes (Hoddinott et al. 2011).

Despite the relative absence of stakeholder perspectives within trials, there is growing emphasis elsewhere on understanding women's breastfeeding experiences from their own perspective (see Afoakwa et al. 2013; Burns et al. 2010 for reviews). This includes understanding experiences of standard postnatal support from healthcare professionals and peer supporters. Two reviews of English language research prior to 2007, focusing on mothers' experiences of breastfeeding support in mostly high income countries (McInnes & Chambers 2008; Schmied et al. 2011) and several studies since have identified factors related to whether or not support offered is considered helpful. For example, the use of inflexible, directive, standardised advice, particularly if there are any inconsistencies in this, seems particularly problematic (McInnes & Chambers 2008; Schmied et al. 2011), whilst support that is viewed by mothers as mother-centred and responsive to their needs appears to be strongly valued, especially if it facilitates mothers' own decision-making (Hoddinott et al. 2012; McInnes & Chambers 2008; Schmied et al. 2011; Sheehan et al. 2009). The perceived quality and authenticity of the relationship with supporters seems important (McInnes & Chambers 2008; Schmied et al. 2011) and, for some research participants, any sense of exposure, critical judgement or surveillance by health professionals seems particularly difficult (Leeming et al. 2015; McInnes & Chambers 2008; Palmér et al. 2012; Sheehan et al. 2009). Mothers view useful interventions as those that build confidence in breastfeeding and self-esteem as a mother, as well as helping with technical aspects of feeding and providing realistic discussion of potential breastfeeding difficulties (Bäckström et al. 2010; Hoddinott et al. 2012; Schmied et al. 2011; Sheehan et al. 2009). Investigation of the perspectives of those supporting breastfeeding has highlighted some of the

challenges of offering effective support including: maintaining consistency whilst responding to women's individual needs, choices, vulnerabilities and concerns; time restrictions; poor continuity of care; inappropriate professional norms; and inaccessibility of training (e.g. Bäckström et al. 2010; McInnes & Chambers 2008; Nelson 2007; Tennant et al. 2006). However, this literature on mothers' and supporters' perspectives is not well integrated with outcome studies. Much of the research above has explored experiences of varied standard care, rather than trials of particular interventions, and it is not always clear how breastfeeding support was delivered and structured. Therefore it is difficult to know how factors outlined above might have impacted women's responses to breastfeeding interventions evaluated in trials.

Some evaluations of breastfeeding interventions *have* sought participants' perspectives, often using post-intervention questionnaires (e.g. Ekstrom et al. 2006; Graffy & Taylor 2005). However, although able to provide information about the acceptability of different aspects of an intervention from a sizeable sample, questionnaires provide only a brief retrospective snapshot of process, shaped by the use of a limited number of pre-determined questions. There may be important aspects of a woman's experience of an intervention which she may not frame in terms of the researcher's query. Nor does a questionnaire enable close examination of interactions between those delivering and receiving interventions. A limited number of studies have demonstrated the value of more extensive exploration of how women and supporters engage with a particular intervention. For example, through interviews with mothers, midwives and peer supporters Ingram (2013) explored in detail, from varied viewpoints, aspects of breastfeeding peer support that were perceived as helpful and/or challenging to deliver. Using both interview, survey and observational data, Hoddinott et al. (2006) showed how women not only considered potential gains when deciding whether or not to engage with postnatal breastfeeding groups or one-to-one peer support, but also weighed up perceived risks such as being undermined, pressured or having their privacy invaded. However, such studies which give a central role to participants' experiences when evaluating specific

breastfeeding support interventions (e.g. Dennis 2002; Fox et al. 2015; Memmott & Bonuck 2006; Raine 2003; Thomson et al. 2012b) are still the exception rather than the rule.

In order to understand further why some breastfeeding interventions seem more successful than others, researchers have also begun to explore implementation processes from the perspective of service-providers. For example, in the UK Hoddinott et al. (2010) used interview, observational and survey data from varied stakeholders to identify aspects of organisations (e.g. leadership, communication) and community context (e.g. social class) that impacted implementation of breastfeeding support groups positively and negatively in different settings. Similarly in the US Nickel et al. (2013) used interviews and the concept of 'organisational readiness to change' to examine staff perceptions of barriers and facilitators when implementing UNICEF/WHO's Ten Steps for Successful Breastfeeding. Thomson et al. (2012a) collected data via interviews with a range of professionals that demonstrated the importance of credible leadership for implementing a community Baby Friendly Initiative in the UK, and showed the ways in which credibility was achieved.

### The value of qualitative methods for investigating process

Much of the research discussed in the section above is qualitative. Although quantitative data may provide useful information about interpersonal and organisational processes in interventions (Moore et al. 2015), qualitative methodologies are particularly suited to this because of their concern with understanding, describing and interpreting the *nature* of psychosocial phenomena. Qualitative research aims to understand 'how' rather than test 'whether'. It also tends to assume that knowledge is context-specific and therefore incorporates methods for attending to the way in which particular psychosocial processes arise in particular contexts. However, collecting brief qualitative data about satisfaction or acceptability within a clinical trial (e.g. via questionnaires), though useful, does not make maximum use of the potential of qualitative research to explore

intervention processes. Fuller use of specific qualitative methodologies can provide researchers with alternative theoretical concepts for thinking about the fluid and complex nature of psychosocial aspects of interventions (e.g. 'discourse', 'narrative', 'lifeworld', 'intersubjectivity', 'embodiment') so that understanding of intervention processes is not restricted by reliance on mechanistic assumptions about linear cause-and-effect. There are now several qualitative methodologies in use in healthcare research, each with particular aims and theoretical frameworks. Below, we briefly discuss three of these (Phenomenology, Ethnography and Discourse Analysis), and how they could guide the researcher towards more detailed exploration of what goes on between people, and how this might be experienced, when practitioners implement breastfeeding interventions.

## Phenomenology

### Overview

Phenomenological research explores detailed first-person accounts in order to understand lived experience holistically and in some depth (Langdridge 2007). Phenomenology rejects the idea of examining a phenomenon such as an infant feeding intervention objectively, as if it is a fixed entity. Instead the aim is to understand how this phenomenon appears in the consciousness of those engaging with it (Brooks 2015). Therefore there is a commitment to participant-led methods of collecting detailed data (e.g. unstructured or semi-structured interviews and open-ended diaries) and an inductive rather than theory-led approach to analysis (Howitt 2016). Some phenomenological methodologies (e.g. Giorgi 2009) aim for rich description of participants' experiences as lived pre-reflectively, whilst other phenomenological approaches (e.g. Smith et al. 2009) argue for the importance of interpretation and are concerned with how participants make sense of meaningful personal experiences, sometimes relating this to broader contextual issues (e.g. Langdridge 2007), or to phenomenological ideas about the nature of the lifeworld (lived experience) such as temporality or embodiment (Davidsen 2013).

### Use of phenomenology in breastfeeding research

Phenomenological methods are becoming more established within maternal and child health research (e.g. Thomson et al. 2011) and have highlighted important features of the lived experience of breastfeeding – for example, that breastfeeding may be experienced as confirming or challenging maternal identity (Palmer et al. 2010, 2012, 2014; Williamson et al. 2012), as requiring determination (e.g. Bottorff 1990; Hauck et al. 2002; Palmér et al. 2010), and as an activity scrutinised by others (McBride-Henry 2010; Palmer et al. 2012, 2015). Phenomenological research has also drawn attention to the shifting ways in which the breastfeeding body can be experienced (Dykes & Williams 1999; McBride-Henry et al. 2009; Palmer et al. 2010, 2015; Ryan et al. 2011) and the complexity of emotional responses to breastfeeding (e.g. Guyer et al. 2012; Mozingo et al. 2000; Palmer et al. 2012, 2015).

### Value of phenomenology for investigating breastfeeding support interventions

Phenomenological studies have explored relations with breastfeeding supporters as part of the intersubjective experience of breastfeeding (e.g. Hauck et al. 2002; Guyer et al. 2012; Mozingo et al. 2000; Palmér et al. 2012) and have explored the meaning and experience for practitioners of challenges in providing support to breastfeeding women (e.g. Nelson, 2007). However, the phenomenological approach has been less visible in studies explicitly investigating novel interventions to support breastfeeding. This is not surprising given the tension between the emphasis on researcher control within trials, and phenomenology's aim to explore subjective experience from the participant's perspective in an open-ended manner. Using a phenomenological lens to research a breastfeeding intervention means shifting the research question from the researcher's concern with 'does it work?' or even 'how does it work?', to 'what was it like to take part and what did the experience mean?'

Exploring retrospective accounts of any one group (e.g. intervention recipients or providers) is best considered as only one line of enquiry (Elliot, 2010). Individuals may not be able to articulate

some aspects of their experience or may have an emotional investment in particular interpretations. Moreover, a fuller understanding of interpersonal and social processes in supporting breastfeeding women might be gained by the addition of ethnographic and discursive methods. However, we would argue that ignoring the lived experience of participating in an intervention places significant limitations on understanding what has taken place.

## Ethnography

### Overview

Ethnography focuses on cultural interpretation of a setting or interaction. Detailed descriptions of situations are used to understand implicit and explicit meanings and relevant cultural constructions within the area of study (Dykes & Flacking 2016). Although there is no clear accepted definition of ethnography it usually involves the researcher participating in people's daily lives to conduct an in-depth study of accounts and actions within their everyday context (Hammersley & Atkinson 2007). Methods of data generation are particularly sensitive to social context and researchers attempt to view the world through the eyes of the participants to understand how their social worlds are interpreted and experienced (Mason 2002; Miles et al. 2014). Data are usually unstructured rather than predetermined and can be generated from a range of sources but these often involve observation and informal conversations (Hammersley & Atkinson 2007). Participant observation involves the researcher immersing him/herself in the research setting and systematically observing dimensions of that setting, such as interactions, relationships, actions, and events (Lofland et al. 2006; Mason 2002).

### Use of ethnography in breastfeeding research

This emphasis on collecting data in 'natural' everyday settings and the open-ended exploratory nature of ethnography means it has (like phenomenology and discourse analysis) mostly

been used for examining existing care practices and 'treatment-as-usual' relations between women and healthcare professionals. Examples include studies observing community midwives and health visitors (Marshall & Godfrey 2011; Marshall et al. 2007) and practices on postnatal wards (Dykes, 2005a; 2005b) in Northern England, and nursing practices in a neonatal unit in North America (Cricco-Lizza, 2011, 2014, 2016). The detailed understanding that comes from such studies can provide useful insights which inform breastfeeding support such as the way in which breastfeeding involves labour intensive care-work (Dykes, 2005a) and the complexity of the different roles women attempt to fulfil whilst breastfeeding - striving to maintain their identity as good mothers, within differing perceptions of this, whilst also maintaining identities as wives and workers (Marshall et al. 2007). Cricco-Lizza (2014)'s ethnography demonstrated the complexity of nurses' emotions and the largely unrecognised emotional labour required to support women in a busy, stressful neonatal intensive care unit, highlighting the range of coping strategies used.

#### Value of ethnography for investigating breastfeeding support interventions

Ethnography is less commonly used for exploring novel, more structured interventions that are being studied within RCTs. However, Hoddinott et al. (2010) used a realist version of ethnography within a cluster randomised controlled trial to produce an explanatory model for variability in the implementation and effectiveness of breastfeeding support groups. This demonstrates ethnography's potential for understanding the varying and complex systems and cultures within which interventions are implemented. Additionally, Young and Peltó (2016) suggest that formative ethnographic research can enhance understanding of key cultural features of a local context *prior* to intervention.

There are a number of challenges to using more traditional versions of ethnography as part of clinical trials because ethnography has its roots in naturalistic enquiry which involves the researcher studying actions and accounts within an existing context (Savage, 2006). The very nature of an intervention means that this has been disrupted or changed. However, overcoming these



challenges and finding ways to use ethnographic methods alongside trials would enable better understanding of the meaning and impact of interventions, of what goes on between those delivering and receiving the intervention and of the social context within which the intervention is being implemented (Tumilowicz et al. 2015).

## Discourse Analysis

### Overview

Discourse analytic approaches are generally informed by a social constructionist perspective which demands an alternative stance on language to much of the realist perspective pervasive through health promotion research. For discourse analysts, participants' language is more than just a way for individuals to describe and communicate internal thoughts or feelings. Instead language is used in varied ways to construct different versions of events and social realities (Burr 2015). Access by researchers to the way in which language constructs versions of social 'reality' is invariably gained through a discourse analysis of talk and text. Whilst there are varying strands of discourse analysis (e.g. Discursive Psychology; Foucauldian Discourse Analysis), the overall concern is with the ways in which language and discourse constitute versions of our social world. From this perspective, a discourse may be thought of as a set of linguistic resources that constructs a particular version of something in the social world, such as an object, event, or category of person. For example, depending on the language used, breastfeeding can be made to appear as a lifestyle choice or an uncontested, normative aspect of mothering. A central consideration of the discursive approach is that language is performative in that it holds a function for the speaker/author of the discourse. Discourse analysis is applicable to different methods of data collection from open-ended interviews to naturalistic data and analysis of written text (policy documents etc.). As such it can be combined with ethnographic methods.

## Use of discourse analysis in breastfeeding research

Discourse analysis is relevant for breastfeeding research in its focus on the discourses and constructions that are inherent in health promotion around breastfeeding and mothers' subjectivities in relation to infant feeding. It is therefore of no surprise that many of the discourse analysis papers in breastfeeding research look at the ways in which breastfeeding is constructed through health promotion materials and interactions. Many of these have noted the moral discourses that work through much breastfeeding promotion and discussion of breastfeeding practice (Ryan et al. 2010; Wall, 2001). Discourse analysis has been used as a methodology to explore discourses around managing breastfeeding (Payne & Nicholls 2010), constructions of the breastfeeding infant (Burns et al. 2016), and managing decisions around infant feeding in particular populations (Hoddinott & Pill 2000).

A stream of research has focused on the discourses inherent in the teaching and promoting of breastfeeding in prenatal classes. For example, Locke (2009) examined the two competing discourses of prenatal breastfeeding classes - the seemingly oxymoronic construction of breastfeeding as the 'natural' skill that also needed to be 'taught'. Similarly, research by Fenwick et al. (2013) revealed that the language and practices of midwives were often limited to convincing women to breastfeed rather than engaging with them in conversations that facilitated exploration and discovery of how breastfeeding might be experienced within the mother–infant relationship and broader social/cultural context. Burns et al. (2012) have also examined how midwives construct breastfeeding in interactions with breastfeeding mothers, noting the discourse of breast milk as "liquid gold". They argue that this discourse privileges the nutritional aspects of breast milk over both the practice of breastfeeding and the support needs of the breastfeeding mother.

## Value of discourse analysis for investigating breastfeeding support interventions

Although not commonly used for exploring the structured interventions evaluated by RCTs, discourse analysis provides tools for reaching a deeper understanding of what varying support

interventions communicate about infant feeding and *how* they do this. Fine-grained analysis of the interactions within an intervention can show how the promotion and support of breastfeeding is being negotiated and performed in practice. Discourse analysis is also readily applicable to both deconstruct and assist with the design of information sheets and health promotion materials. By mapping the key discourses around breastfeeding for a variety of demographics, discourse analysis offers the opportunity for tailored interventions which pay close attention to the language used by practitioners.

### Concluding comments

Understanding how women can be best supported to breastfeed is a priority for researchers concerned with maternal and child nutrition, and the past couple of decades have seen an explosion of research in this area. However, we suggest that research is still constrained by a limited range of research questions, methodologies and theoretical standpoints. Researchers could more frequently be asking questions about the lived experience of participating in and implementing different forms of breastfeeding support, the meanings of interactions intended to be supportive from the perspectives of different stakeholders, and the different versions of infant feeding that are talked into being by the language used in particular promotional and supportive interventions. Research in the neighbouring field of psychotherapy effectiveness has long benefitted from process research, using a range of qualitative and quantitative methods to examine, for example, significant events in therapy, aspects of therapeutic relationships, varying therapist practices and interactional sequences (see Hardy & Llewellyn 2015 for an overview). It is our hope that similar advances can be made in understanding interpersonal processes in breastfeeding support interventions. We would endorse the recent guidelines within the UK for examining process within public health interventions (e.g. Moore et al. 2015), but argue that this should not be limited to measuring theoretical change mechanisms hypothesised by researchers. Use of qualitative methodologies and engagement with

participants' meanings enables unanticipated insights into the impact of different aspects of an intervention which may challenge the original theoretical concepts underlying an intervention.

However, it is important to recognise some of the challenges of expanding process research by greater use of qualitative research. In particular, qualitative methodologies are unlikely to share the positivist assumptions of outcome research. Their strengths arise from being more in tune with interpretivist epistemologies and there is a danger that if qualitative research is 'shoehorned' into an RCT then the full potential of an alternative epistemological position is lost (Morse, 2005; Savage 2006). For example, if the aim of a trial is to establish decontextualized and generalizable 'truths' regarding the effectiveness of a breastfeeding intervention, then it is unlikely that any qualitative data collected will be used to illuminate ways in which the intervention may have very different meanings for participants in different contexts. Epistemological differences have perhaps contributed to the tendency for separate streams of research focusing, on-the-one-hand, on women and practitioners' experiences and practices in relation to non-specified breastfeeding support using qualitative methods and, on-the-other-hand, trials of specific support interventions using largely quantitative measurement of outcomes. However, this risks the formation of research 'silos' where a more holistic understanding of the usefulness of support interventions and variations in how they are received and enacted is foregone in favour of retaining methodological consistency.

Integrating process and outcome research and quantitative and qualitative findings, either from one study or several remains a tricky issue requiring further discussion (Moore et al. 2015; Shaw et al. 2014). Some breastfeeding support researchers have drawn on a realist approach to evaluation in order to either embed qualitative process enquiry alongside an RCT in a single project (Hoddinott et al. 2010) or as a suggested framework for synthesising quantitative and qualitative findings across several studies (Thomson & Trickey, 2013). Such approaches are particularly useful for contextualising the findings of RCTs in a manner which develops theoretical understanding, and the use of an overarching theoretical framework such as realist synthesis can enable more coherent

integration of research findings. However, we also need to be careful that the unique value of different methodological approaches is not lost if subsumed within a theoretical framework which may not quite fit. For example, the inductive approach of methodologies such as phenomenology can be valuable as an alternative to more theory-driven realist synthesis, and much of the value of discourse analysis lies in its recognition that participants' talk does not simply represent and illuminate mechanisms of change (as might be the case in a realist synthesis) but is in itself constitutive of change. Therefore, researchers might also consider ways of drawing together disparate findings which embrace differences in methodological, epistemological and ontological assumptions and treat these differences as a set of interchangeable lenses through which the world can be viewed tentatively. As such it becomes possible, even within one research programme, to see what might be gained by tentatively viewing a breastfeeding intervention through a 'cause-and-effect' lens, trying to draw general conclusions that might be applicable in other settings too, before then using a more interpretivist lens to explore the nuances of meaning, language and interaction and the way in which the intervention may in fact be a slightly different phenomenon to different participants in different contexts. This, though, requires reviewers and funders, as well as researchers, to be open not just to a variety of methodological approaches but also to broader definitions of 'good' research and to recognise that criteria for quantitative research may not be appropriate for qualitative research. There is continued debate about quality criteria for qualitative healthcare research (e.g. Dixon-Woods et al. 2007; Walsh & Downe 2006), which is not surprising given the different aims and assumptions of different qualitative approaches. However, one criterion in deciding the value of research into breastfeeding support ought to be whether or not the findings will help practitioners to recognise the varied ways in which women might respond to their attempts to support breastfeeding and to adjust their interventions accordingly.

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