Women's Experience of Breastfeeding in the Current Japanese Social Context: Learning from Women and their Babies

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Abstract

This study is about Japanese women's experience of breastfeeding in the current Japanese social context. The research question is; what factors hinder or encourage women to breastfeed their babies in the current Japanese social context? It aims to explore the theory-practice gap in breastfeeding by developing a holistic picture of breastfeeding from women's point of view.

The study was based on a Japanese way of knowing 'ZEN-JIN-TEKI'; the way of understanding a phenomenon as a whole. Adapting the principles of an emergent design in naturalistic inquiry, the research was undertaken in a step-by-step approach. Exploratory work was undertaken in order to explore the nature of the topic in the field, and to develop an analytical framework that could be used for qualitative data collected in Japanese language. Three women were interviewed at 3-4 months in the postnatal period, and their emotions were identified as key to understanding breastfeeding from the women's point of view. The limitations of exploring breastfeeding by a one-stage type of interview approach were also identified.

More focused explanation of breastfeeding was undertaken to explore breastfeeding within women's time and space. Six women's experience of breastfeeding was followed-up from the first postnatal visit until baby's first birthday, by monthly interviews. The series of interviews was represented in the form of women's narratives. As a result, breastfeeding was clarified as 'a mother and her baby in tune' and 'bodily performance', and 'baby's fourth month' appeared the time to be required for developing the sense of 'in tune' in the individual life setting. The meaning of support was illuminated as a Japanese concept of 'MI-MAMORU' ('MI' means 'seeing', 'MAMORU' means 'protecting').

The women required a small number of people, who could respect the women and their babies' time and space, and share the uncertainty of breastfeeding as well as help with housework and other child care. The final discussion was undertaken introducing the sociological concepts of 'embodiment' and 'craft', which enabled the discussion of women's emotions and reasons, and theoretical and local knowledge, and the biophysical and socio-cultural elements of breastfeeding as a whole.

The implications of 'ZEN-JIN-TEKI' approach were discussed in relation to philosophical framework of midwifery, in which the attachment and the involvement to the setting were the key to understanding the women's experience from their perspectives. 'ZEN-JIN-TEKI' approach could be developed examining one's own view of time and space including the personal belief of life and the personal aspiration of relating to others.

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Glossary: The Japanese concepts

The following Japanese terms and phrases will appear in the text and I did not translate them into English due to the concept differences across two cultures. The key Japanese concepts are listed in the following order: the Japanese phrase, the function of the word; noun (n.), verb (v.), adjective (adj.), and the meaning in Japanese and the closest concept in English.

'AWASE-BUNKA' (n.): 'AWASE' means 'negotiating or synthesising different ideas into one or creating into a new idea', 'BUNKA' means 'culture', which is used to describe the feature of Japanese way of knowing.

'BO-NYUU' (n. and v.): 'BO' means 'a mother' and 'NYUU' means 'milk', which means the act of breastfeeding in English, the women used the word of 'BO-NYUU' as a noun and also a verb to describe breastfeeding and breast milk

'BO-NYUU-EIYOU' (n.): 'BO-NYUU' means 'breast milk', 'EIYOU' means 'nutrition', which means breastfeeding and were used in official documents or medical discourse.

'DAN-NYUU' (n. and v.): 'DAN' means 'to refuse', 'NYUU' means 'milk'. It means to stop breastfeeding by baby's age.

'JINKOU-EIYOU' (n): 'JINKOU' means 'artificial', 'EIYOU' means 'nutrition', which means bottle-feeding. It is used in official documents or medical discourse.

'KE-GARE' (n.): 'KE' means 'natural energy' and 'GARE' means 'the condition of that trees were going to die'. It means that people's energy are in the condition of imbalance.

'KOKORO' (n.): 'KOKORO' is believed to exist in people's lower belly. It is the space in which people reflect own 'self'. The highest state of 'KOKORO' is explained as selflessness.

'KONGOU-EIYOU' (n.): 'KONGOU' means 'mixing', 'EIYOU' means 'nutrition'. It means mixed-feeding, again used in official documents or medical discourse.

'MEGURI-AWASE' (n.): 'MEGURI' means 'the condition of circling', 'AWASE' means 'come across'. It represents the Japanese multidimensional model of time. People's encounter to other people is took place whereby time and space are circling. This is used for describing the difficulty to come across the right person in the right timing and in the right place.

'MI-MAMORU' (v.): 'MI' means 'seeing', 'MOMORU' means 'protecting', which is the philosophical act of supporting others by seeing.

'MITE-MINUFURI' (adj.): 'MITE' means 'seeing' 'MINUFURI' means 'pretending not to see'. It is a tacit manner, not to make other people to feel embarrassed.

'OTTU-PAI' (n.): A Japanese metaphor, which is used to describe breastfeeding or their mother's breasts generally by children, but also women use this term when they described breastfeeding from children's point of view.

'SHI-KATA-GA-NAI' (adj.):'SHI-KATA' means 'natural law', 'GA' is a conjunction, 'NAI' means 'not', it means to accept something happened as a exception of natural law as a part of human life.

'SKIN-SHIP (n.): A Japanese word, presumably invented with the combination of two English words; 'skin-to-skin contact' and 'relationship'.

'SOTSU-NYUU' (n. and v.): 'SOTSU' means 'to depart', 'NYUU' means 'milk', it means to stop breastfeeding by baby's accord; 'graduating from breastfeeding'.

'YO-YUU' (n.): 'YO' means 'extra' and 'YUU' means 'broader or expand'. It describes the person has the time and space to reflect own self.

'ZEN-JIN-TEKI' (adj.): 'ZEN' means 'a whole or inclusive', 'JIN' means 'human', 'TEKI' is the word to make a noun in an adjective form. It means understanding others as a whole. It is translated into 'a holistic approach' in the thesis.

Chapter 1
Introduction

This thesis is about Japanese women's experience of breastfeeding in the current Japanese social context. The research field was undertaken in a community in Tokyo, where the researcher was born and raised, and is working as a community midwife. The researcher is a Japanese midwife who is interested in the different ways of knowing across cultures; trying to explore the meaning of research in midwifery using her own cultural setting, and seeking the possible reasons behind the research-practice gap in breastfeeding practice. The research question was; 'what factors or elements hinder or encourage women to breastfeed their babies in the current Japanese social context?' The aim of this study was to describe the holistic picture of breastfeeding practice and to illuminate the problem of breastfeeding from the women's point of view. In this research, the researcher set her role as a practitioner researcher. The meaning and actual role was developed through the interactions with women in the field, which will be discussed in relation to researcher's reflexivity and the Japanese concept of 'KOKORO' (reflecting 'inner-self') in each stage of research. This research was for a PhD study in the U.K. undertaken from 1998 until 2006, whereby the researcher travelled between Japan and the U.K. The time and physical location influenced the researcher's reflections, which defined the destination of the discussion and the location of knowledge.

In this chapter, I will describe the background of my thesis from the following three points; the background to my research question, the key aspects of my thesis, and overview of my thesis.

The research question and my practice as a Japanese midwife

In this section, I will give my own reflections on the current breastfeeding and midwifery practice in Japan.

I trained as a nurse-midwife by completing a four year university nursing degree course in Tokyo. I worked in a delivery unit and postnatal ward in a big general hospital in Tokyo from 1986. I was expected to improve my skills of delivering a baby without perineal tearing, which was called 'EIN-HOGO' ('EIN' means 'perineal', 'HOGO' means 'protection'). 'EIN-HOGO' was considered important to become a skilled midwife as well as leading the women to get through their birth with breathing techniques and using comfort measures.

One day, the gynaecologist sent a mother from the outpatient section to the postnatal ward. The woman had mastitis and the doctor asked if any midwives could treat it by breast massage. When I saw her, her breasts were very hard, and no breast milk was coming from the area where the hard lump had developed. I massaged her breasts, and at the end I could get rid of the white granules, which blocked a milk duct, and then the breast milk was flashing out like a fountain. Over the next three days, she came back for breast massage. I talked to her about very general things such as where she lived and how her child caring was going on. She took one hour to visit hospital and said, 'There are a number of midwives working in hospital, but there are few who work in the community and look after breastfeeding'. This experience led me to facilitate the breastfeeding follow-up system in the outpatient ward, which any women could return to for breast care. However, considering the women's physical energy to travel to hospital, the community based care sounded the real ideal.

In 1995, I left the hospital and started to work in my community, and found that the women's perception towards breastfeeding had shifted. Some of the women were very uncertain about breastfeeding. The women used formula milk, even though they had enough breast milk. On the other hand, some women had no problems to breastfeed their babies and continued breastfeeding for a long time such as 18 months or sometimes three years. I wondered why some of them were comfortable and the others were not comfortable with breastfeeding. In my

community, I had to talk to various people, which I found not easy to make other people understand the reason why community midwives were important for women. I started to consider the way of improving communication across people from the different disciplines, which led me to think about taking higher education. In Japan, when people went to study abroad, North America was a common destination. However, I believed that midwifery should be different from nursing. My intuition made me choose the U.K. as a place of exploring midwifery.

Since 1996, I have been involved in the U.K. higher education. I always felt a dilemma when I explained about breastfeeding practice in Japan to people who were coming from other cultures. When I talked to midwives in the U.K., I was asked; 'what is the breastfeeding rate in Japan?' I replied, 'It is ... 45% at one month...' to which they said, 'It is not so much different from the U.K.'. In my mind, a lot of things were different, but I always failed to explain what I knew about breastfeeding in my culture. I started to look at the national survey and compare the numbers between the U.K. and Japan. I found even a simple definition of breastfeeding was different across cultures.

As a part of my Master's dissertation, I did a small qualitative study to investigate why Japanese women mixed-fed their babies. In this research, I experienced a problem of translating Japanese data into English. Some Japanese concepts were not found in English. The qualitative research technique of coding and categorising did not fit well with analysing Japanese transcriptions. The most remarkable part of the research was I had to confront the fact how little I knew about women's experience of breastfeeding.

My experience of studying in the U.K. stimulated my curiosity of breastfeeding practice and the meaning of research in midwifery practice. For example, informed-choice and evidence-based practice were introduced in Japan by academic scholars, but were not applied in practice. Looking at the practical knowledge in Japan, the nature of the knowledge and the communication

strategy seemed to differ from the Western approach. When I talked with one of the hospital midwives, she said to me, 'why are you researching breastfeeding? We know enough about it. Don't waste your time with research. Do practice.' Looking at breastfeeding practice in the U.K. context, the women seem to have difficulties to choose or to try it. Japan and the U.K. had the different problem of breastfeeding, but the problem of a theory-practice gap in breastfeeding seemed commonly found in women's lives.

Whilst I did my PhD research, I worked at a maternity home in the east part of Tokyo. It was facilitated by a midwife who was 78 years old and her mother had worked there as a midwife. I learnt a lot from seeing her practice. I perceive that Japanese midwifery is fortunate to have those senior midwives from whose practice I can learn about the profound knowledge and philosophy in midwifery. This experience convinced me to believe that midwifery was all about practice. In addition, she has been to China for studying to develop a theoretical knowledge from her practice. I respect her attitudes; even though in her age, there is no retirement in midwifery.

From my experience, I could say three important aspects of Japanese midwifery practice:

• Seeing others' practice was the core of learning, which should be learnt through 'KOKORO', (which will be discussed in chapter 5).
• The studying exists as a professional accountability, which makes midwifery practice as a lifelong learning profession.
• The application of knowledge is different, which the personal biography such as age, personal belief and philosophy is considered as a part of midwifery practice.

I consider that research helps to make sense of everyday midwifery practice. It could be used for improving the communication across different cultures. Although Japanese midwifery has a long history and the autonomy to work as an

independent practitioner, the contribution to academic knowledge was little. The language difference is a barrier. However, it could be based on the assumption that pregnancy, childbirth, and breastfeeding are universal life events, whereby midwifery practice should be universal. Through studying in the U.K. academic environment, I developed self-awareness of discussing the cultural difference; some of the midwifery practices are universal, but some aspects are social and cultural. This thesis is about breastfeeding, but also developed for illuminating the cultural differences of knowing, seeing and believing.

Thesis on breastfeeding

In my midwifery practice, I perceive breastfeeding as a part of women's everyday life events, which exists as a part of women's reproductive health cycle. This idea has been developed since I started to work in my community. I increasingly came to consider the importance of understanding breastfeeding with women's everyday life context, through which I can advise the best possible way of breastfeeding (or sometimes I have to suggest adding formula-milk) for each woman and her baby. My research aimed to clarify a research-practice gap in breastfeeding; therefore I could improve breastfeeding care in midwifery overall as well as in my community practice.

When I developed the original research plan for PhD study, I spent a substantial amount of time exploring the meaning of research. In other words, my research was about breastfeeding but also became a study to research the way of researching breastfeeding. I had three working assumptions to investigate a theory-practice gap in breastfeeding in the current Japanese context. If the current knowledge of breastfeeding was considered good enough in quality and quantity, a theory-practice gap would be stemmed from two reasons; the knowledge or the theory itself would be wrong or still some important knowledge were missing from the research (Sandelowski 1998, personal communication). I developed my third assumption; the knowledge was not used in the right context

or the context was not used as a part of knowledge. I found my third assumption was a challenge to the Western notion of knowledge creation, in other words, Western research philosophy.

In my thesis, I step back from what I have known about breastfeeding and tried to explore the meaning of breastfeeding from women's point of view, which seems to be missing from the previous breastfeeding research. My primary research question was explored through two empirical phases, which was designed basing on the Japanese philosophical assumption 'ZEN-JIN-TEKI' ('a holistic' in English). My research idea was explored, consolidated, and again studied in a more focused approach. As I designed my research as an emergent design, I will develop my thesis as a form of reflective writing, which could illuminate the features of inductive thought.

As I chose a qualitative approach, language came to a central issue in this research. Through a cross-cultural discussion, I developed a positive attitude towards the language difference between Japanese and English, as it stimulates my self-awareness and reflection to look at the nature of topic. The very first simple difference was found in the term 'breastfeeding'. In Japanese, it calls 'BO-NYUU':'BO' is written in a Chinese character 'a mother' and 'NYUU' is 'milk'. Breastfeeding in a Japanese context is 'mother's milk'. Breastfeeding in English makes people perceived women's breasts, thus the Western controversy of breastfeeding is about women's breasts. In my empirical work, a Japanese concept of 'YO-YUU' ('YO' means 'extra' and 'YUU' means 'broad') was illuminated by the women. It meant that the women were able to have their own time and space to reflect their feeling and actions, whilst other people help to their housework and child care. Japanese language has the words that could deliver the meaning of time and space in one concept, although those concepts could not translate into English. In my research, the language itself is considered as a representation of 'a culture', whereby the discourse about breastfeeding could be influenced by the cultural and social assumptions around women's

bodies and child caring.

I found the concept of 'culture' was a difficult term to use in my research. When the same behaviour was found in the different geographical locations, people easily anticipated that would be imported from other societies. Where the same behaviours appeared within the same location, it simply termed 'a traditional culture' (Kojima 1989). The current globalisation and high technology made it possible for people to access various lifestyles and other cultural values, which became more difficult to clarify 'a local culture' (ibid.). In addition, when 'culture' was embedded in people's normal life such as 'a habit', it was difficult to illuminate it (Edmondson and Kelleher 2000). In this thesis, I used the term of 'culture' whilst I examined the nature of topic in relation to the research field. I took my role to some extent as a historian, whereby breastfeeding was examined in relation to time; past and present, and present to the future. It is considered a way of illuminating the cultural features of breastfeeding practice. I set my assumption; breastfeeding could exist as a part of women's ordinary life, which is influenced by their environment. Thus breastfeeding was studied looking at the women's broader life context, which were collected by interviewing women's experience of it. It would enable me to discuss the future obstacles of breastfeeding and the midwife's role in supporting breastfeeding in future.

As I chose a qualitative approach for my research approach, the literature review was undertaken as a form of indicative reading; both Japanese and Western literature was reviewed through the entire research work. It was used for stimulating and evaluating my research ideas, illuminating the essence of breastfeeding, and conveying the key findings accessible across cultures. In my thesis, my background work will focus on reporting the review work from the Japanese literature since my empirical work was undertaken in a Japanese setting. I also considered that systematic review and critical review work from the Western research papers has been well conducted such in the Cochrane library review or an individual researcher (e.g. Hoddinott 1998), which I did not intend to

replicate in my research project. However, I provide a brief critical discussion of the Western research literature based on my own detailed reviewing of the literature.

My research was about investigating breastfeeding with developing a profound understanding of context, which led me to decide to use my community where I was born and raised for my research field. I considered my community as microcosms of my knowing and learning about life, people and society, which I could make of the empirical data utmost. I will put forward my thesis with the following Japanese proverb:

'He who knows does not speak
He who speaks does not know'

My thesis is about breastfeeding and also about the Japanese ways of knowing and believing in midwifery practice.

Overview of the thesis

The thesis is presented in four parts, which aims to demonstrate the step-by-step approach in my study as it was undertaken.

The first part presents the background work; formulating my research question into designing a methodology. The second part reports on the exploratory work; the findings of three interviews, and the process of identifying the further focus of the research. The third part presents the second phase of empirical work, following-up women's experience of breastfeeding by monthly interviews. The series of interviews are represented in the form of women's narratives. The last part reports the key finings from the follow-up study, and then discusses the implications and limitations of the study.

The structure of the thesis

Following the introduction, chapter 2 will present the materials that I used for developing my research question, which based on the discussion about the national survey in the U.K. and in Japan and the health promotion issues of breastfeeding. Chapter 3 will report on the result of reviewing the meaning of breastfeeding within Japanese historical context; the history of Japanese midwifery will be described, which gives the background of understanding the role of midwives in breastfeeding practice. Chapter 4 will look at Japanese medical system, the meaning of health and illness, and the medical discourse of breastfeeding. Chapter 5 will explore the philosophical aspect of research and represent 'ZEN-JIN-TEKI', which includes the review work of the meaning of knowledge and the features of Japanese communication. Chapter 6 will provide an overview of methodology; the adapted principles of naturalistic inquiry, the meaning of open interview, the idea of a case-oriented analysis, the framework of representation, the idea of a practitioner researcher, and the features of research field.

Chapter 7 and 8 will report on the first phase of the empirical work. Chapter 7 will begin with describing more detailed research design for exploratory work, and demonstrate the result of analysing three interviews by a case-oriented approach. Chapter 8 will bring three cases into a coherent discussion of breastfeeding. The key themes and findings obtained from studying across cases will be represented as women's narratives. It informs the process of evolving the further research question: 'what is the real essence of breastfeeding?', and designing further empirical work for exploring breastfeeding within women's time and space. The final section of chapter 8 will play the role of transition between phase one and phase two, which discusses the theoretical consideration of a longitudinal study approach and an ethnographic approach.

From chapter 9 to 11, the phase two; more focused explanation of breastfeeding

will be reported. Chapter 9 will describe the detailed research design and practical and theoretical considerations of doing a follow-up study of breastfeeding with an ethnographic approach. Chapter 10 will represent the six women's narratives into four sections. The first section will report on the first thematic narrative, a breastfeeding woman's experience, with full context; which I set as a master case for the study whilst it provides the broader context of understanding women's time and space in child caring in the current Japanese social context. The second section will report on two breastfeeding women's experience, which explores the further elements of breastfeeding. The third section will report on the two cases of mixed-feeding women, whilst mixed-feeding appeared as a result of 'not having enough breast milk'. The last part will look at a woman's experience of early shifting into bottle-feeding, which illuminates the feeling of isolation and the meaning of support for child caring. In chapter 11, six women's narratives will be brought into a process of synthesising so that a profound understanding of breastfeeding is developed. As a result of long engagement with the women's lives, the interaction between the women and myself created a phenomena, which I could discuss the real essence of breastfeeding introducing the sociological concepts of 'embodiment' and 'craft'.

Chapter 12 will return to my initial concern of a theory-practice gap in breastfeeding and discuss the implication and limitation of the study as well as the possibility of using 'ZEN-JIN-TEKI' across cultures.

Part One: Background Work

Chapter 2
Establishing a research framework

This chapter will report on my background work for developing my research question and seeking a possible research approach. In this chapter, I will review breastfeeding practice from three perspectives; national statistics, global health promotion issues, and the woman's choice in breastfeeding in a Western context. I will provide brief thoughts about my personal framework as a midwife, which also influences the process of developing my research question.

2-1. Understanding breastfeeding practice

2-1-1. The prevalence of breastfeeding: a comparative discussion between the U.K. and Japan

I started to develop my critical thought about breastfeeding practice initially by comparing the breastfeeding rate between the U.K. and Japan. I identified that the national survey was framed by cultural assumptions about the phenomena. Very simple things such as the definition of breastfeeding were differently described, which meant a comparative discussion was not a simple task such as comparing the numbers.

I firstly looked at the prevalence of breastfeeding practice in Japan. The breastfeeding rate was collected every 10 years in a national survey titled 'a growth of infants and pre-school children's survey' (Mothers' and Children's Health and Welfare Association 2004). It was based on a random sample of all Japanese mothers who gave birth in the year. The data were collected by a self-completed questionnaire. In the original questionnaire, the women were asked to check the breastfeeding and artificial feeding by the indicative baby's age. For

example, when the baby was fed by both breastfeeding and formula milk at three months, the woman made two ticks at the month, which was categorised as mixed-feeding in the final report. The timing of starting weaning food was asked in a separate section. For example, the survey in 2000 was based on 2,736 mothers; 83.1% of the women introduced some weaning food at 5-6 months, and 57% reported to complete weaning at 12 months of baby's age. This means that 43% women practiced some form of breastfeeding with weaning. By 18 months, 98% completed weaning (ibid.). This survey showed that a substantial number of Japanese women continued breastfeeding until and over 12 months of baby's age.

Table 1 shows the survey results from 1960 to 2000 (Mothers' and Children's Health and Welfare Association 2004), which were reported for three infant feeding methods:

- Breastfeeding ('BO-NYUU-EIYOU' in Japanese, 'BO' means 'a mother', 'NYUU' means 'milk' and 'EIYOU' means 'nutrition'): The women who fed their babies by breastfeeding only.
- Mixed-feeding ('KONGOU-EIYOU', 'KONGOU' means 'mixed'): The combination between breastfeeding and formula milk feeding
- Artificial feeding ('JINKOU-EIYOU', 'JINKOU' means 'artificial'): The women who fed their babies using powder milk only.

The breastfeeding rate showed that Japanese society experienced a huge decline between the 1960s and 1970s. Looking at the 1970s breastfeeding rate by baby's month, the breastfeeding rate increased from 30.3% at two up to three months into 31.0% at three up to four months. It shows that the Japanese breastfeeding practice does not always follow the one way direction from breastfeeding into the other feeding methods.

Table 1 - Feeding of Infants by Age 1960-2000 in Japan (Mothers' and Children's Health and Welfare Association 2004)

Year	Months	Breast feeding (%)	Mixed-feeding (%)	Artificial feeding (%)
1960	1 up to 2 months	70.5	9.0	20.5
	2 up to 3 months	62.1	12.2	25.7
	3 up to 4 months	56.4	16.5	27.1
	4 up to 5 months	N/R	N/R	N/R
1970	1 up to 2 months	31.7	42.0	26.3
	2 up to 3 months	30.3	35.3	34.4
	3 up to 4 months	31.0	28.1	40.9
	4 up to 5 months	27.8	24.2	48.0
1980	1 up to 2 months	45.7	35.0	19.3
	2 up to 3 months	40.2	29.4	30.4
	3 up to 4 months	34.6	24.9	40.5
	4 up to 5 months	29.8	18.0	52.2
1990	1 up to 2 months	44.1	42.8	13.1
	2 up to 3 months	41.5	34.1	24.4
	3 up to 4 months	37.5	29.4	33.1
	4 up to 5 months	35.3	23.0	41.7
2000	1 up to 2 months	44.8	44.0	11.2
	2 up to 3 months	42.3	36.6	21.1
	3 up to 4 months	39.4	30.5	30.2
	4 up to 5 months	35.9	24.5	39.5

In the U.K. survey, the prevalence of breastfeeding was defined including the women who breastfed their babies partially or exclusively. I compared the breastfeeding practice followed by the U.K. definition of breastfeeding, which means the women who engaged with breastfeeding partially or exclusively. Table 2 shows the result of the comparison:

Table 2 - The percentage of partial and exclusive breastfeeding rates in 2000 in the U.K. (based on Hamlyn et al 2000) and in Japan (based on Mothers' and Children's Health and Welfare Association 2004)

	Birth	1 week	6 weeks	4 months	6 months
The U.K (%)	69	55	43	28	21
			1 up to 2 months	3 up to 4 months	4 up to 5 months
Japan (%)	N/A	N/A	88.8	69.9	60.4

Chart 1 and 2 were developed in order to represent the three categories of feeding methods. The U.K. survey followed the definition of breast milk only, breast milk and other milk, and other milk only.

Chart 1 - Milk feeding status in the U.K. in 2000 (based on Hamlyn et al 2000)

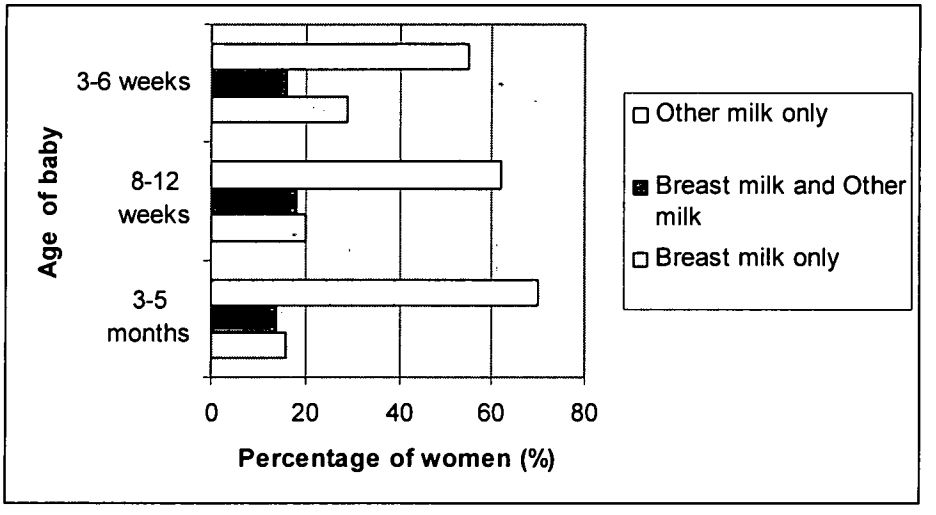
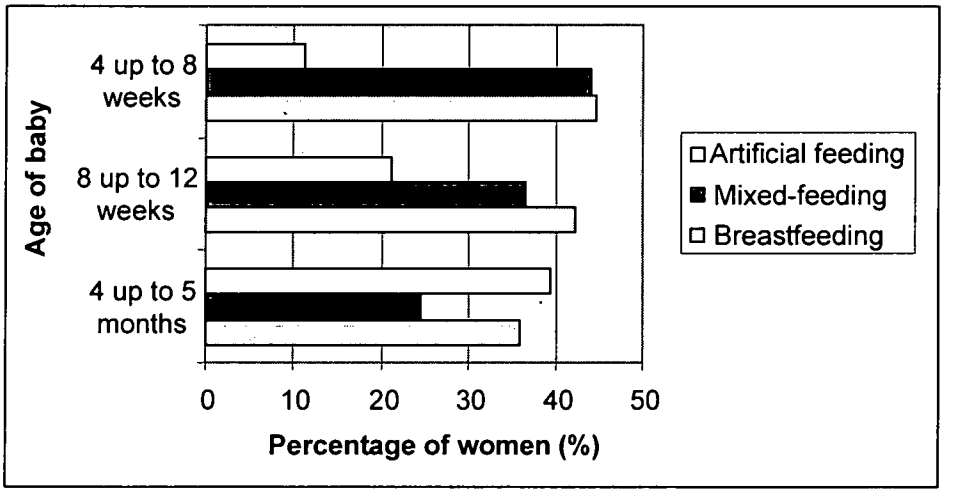


Chart 2 - The feeding of infants in Japan in 2000 (based on Mothers' and Children's Health and Welfare Association 2004)



The U.K. survey described the fact that the women who practiced breastfeeding often shifted directly into bottle-feeding rather than mixed-feeding due to the impracticality and disfavour of breastfeeding (Hamlyn et al 2000). On the other hand, Japanese women seemed to continue mixed-feeding, which showed the fact that substantial numbers of women practiced breastfeeding longer than the British women.

When I talked with the British midwives, they were likely to say that the U.K. is

based on mixed-feeding culture as most industrialised societies are. However, from the comparison, the U.K. could be considered more to bottle-feeding culture rather than mixed-feeding, and Japan could be considered a mixed-feeding culture. In the U.K., breastfeeding at birth was actively discussed as a woman's choice. In contrast, the Japanese survey did not show the data of breastfeeding at birth, which would represent the cultural assumption that all women started breastfeeding at birth. Looking at the Japanese terms to describe the division of infant feeding methods in Table 1, 'artificial feeding' was officially used rather than 'bottle-feeding'. It showed the cultural assumption to view of breastfeeding as a natural event, whereby bottle-feeding as an artificial event.

This raised the question for me that if breastfeeding was a cultural norm, why substantial numbers of women appeared in the category of mixed-feeding. In the next section, I will explore my question about the ambiguous situation of breastfeeding practice in relation to WHO/UNICEF global guidelines of breastfeeding promotion.

2-1-2. The framework of the current health promotion approach in breastfeeding

As indicated in the national survey, Japanese society experienced a huge decline in breastfeeding between the 1960s and 1970s. It was a time when a North American child caring book by Dr. Spock, who introduced the idea of regular feeding, was translated and became a bestseller in Japan (Yamamoto 1983). At the same time, Japanese medical doctors referred 'a bonding theory', by Western psychologists Klaus and Kennel, to advocate the importance of breastfeeding (Yamamoto 1983). The 1960s was the time when Japanese society was experiencing conflicts and confusion between the Western and the traditional Japanese child caring. Yamamoto (1983) argued that breastfeeding was not written about a lot in books, whilst it had been commonly found in Japan. The requirement of expert knowledge means the society has lost it from people's

ordinary life.

The Japanese government has been following the WHO/UNICEF guideline of breastfeeding promotion since 1974 (Takahashi 1996). Following the Baby Friendly Hospital Initiative in 1989, the Japanese Government disseminated the ten steps guideline of breastfeeding for each institution. In the national health proposal, the Japanese government stated the improvement of exclusive breastfeeding rate at the baby's age of 3-4 months, but no clear targeted number was given (Mother's Health and Welfare Association 2004). In the context of dissemination of the guideline, I clarified two problems of the Japanese Government to respond to it:

- The ten steps guideline is considered as the recommendation, not a way to regulate the hospital protocols.
- The interpretation and implementation of the guideline is dependent on each institution, basically the medical doctors' decisions.

It is very common to see the poster of the ten step guideline in waiting rooms; whilst the institutions use bottles in hospital practice and powder milk is given as a discharge package for women. The implementation and the process of decision making are very ambiguous. Therefore it is hard to identify the key players who could make a change in the current hospital breastfeeding. This point will be explored in discussing the hospital practice in chapter 3 and the medical system and medical discourse of breastfeeding in chapter 4.

I will move to my second critique point of the framework of the Baby Friendly Hospital Initiative. In the health promotion context, 'health education', 'evidence-based care', and 'women-centred approach' were used as the key to support and promote breastfeeding. The Baby Friendly Hospital Initiative was based on review of the scientific evidence, which made no doubt about breastfeeding and breast milk being beneficial for both mothers' and children's positive health gains.

I will quote the WHO/UNICEF ten steps guideline to make clear the discussion of my critical points:

WHO/UNICEF 10 steps of Baby Friendly Hospital Initiative (WHO/UNICEF 1990):

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

I will raise three critiques of the approach. Firstly, the guideline was following the assumption thus if the ten steps guideline was correctly implemented, everyone could breastfeed. My question was; if breastfeeding is such a simple event, which could be promoted by teaching how to do it. Secondly, reading the guideline from a non-Western cultural point of view, the terms in the guideline seems to

represent the Western cultural assumptions of 'support': 'a written policy', 'train~', 'inform~', 'show~', 'encourage~', 'demand', 'artificial (teats so on)', and 'support group' represent the Western communication structure. Thinking about my culture, the Japanese people would respond negatively to the idea of having a written policy, since the hidden cultural value has more power to control the situation. When somebody starts to talk about the benefits of breastfeeding, the audiences would react oddly since breastfeeding is considered a cultural norm in Japan. In addition, the English terms of 'inform', 'encourage' and 'demand' have no equivalent terms in Japanese.

Lastly, in Western societies in which breastfeeding disappeared from the ordinary life context, health staff including midwives had to learn about breastfeeding theoretically before teaching women how to do it. In the U.K. setting, breastfeeding promotion was focused on women to choose breastfeeding, which structured by informing the benefits of breastfeeding and breast milk. However, the U.K. national survey showed the limitation of this approach; which the number of women to choose breastfeeding reported in the same, and many of them gave up breastfeeding within the first two weeks (Hamlyn et al 2000). In the North American context, breastfeeding and bottle-feeding came to discuss an equal alternative between the 1950s and 1960s. It was the result of the industrialisation, capitalisation, and the globalisation of medical practice (Van Esterik 1989). After the scientific research proved the benefits of breastfeeding in the 1980s, medical professionals concluded 'breast is best' and ended breast and bottle-feeding dichotomy (ibid.). However, once bottle-feeding became as the equal alternative to breastfeeding or moreover became a main practice of infant feeding, the knowledge and skill of breastfeeding disappeared from the women's everyday life. Therefore the women who want to breastfeed have to look for the skill and knowledge of breastfeeding through their own network. This is the reason why lay support groups became apparent in the North American context of brerastfeeding.

Maher (1992) argued that the current global guidelines adopt a medical model of breastfeeding; learning it from the theoretical approach, which reflects the Western notions of learning. The guideline was considered as the consequence of the medicalisation of childbirth, which happened in capitalised and industrialised societies. The adaptation of the medical model of breastfeeding has the limitation across societies due to the limited resource. Japanese society is considered as an industrialised society and childbirth is undertaken in hospital. However, somehow breastfeeding follows its own cultural value system, not the guideline. I could not say anything is wrong with the guideline and agree with the idea that breastfeeding is best. However, I was questioning that 'teaching', 'encouraging' and 'empowering' are the things which women really want in their breastfeeding.

In the next section, I will look at the cultural and social aspects of breastfeeding in Western research papers.

2-1-3. Women's choice and decision to breastfeed in a Western context

The focused literature review work was undertaken at the onset of my study. It was undertaken to develop a research framework for my study through identifying the features and the limitations of the research approach in the previous breastfeeding research. Breastfeeding is an area studied by various researchers and has a huge numbers of research papers. For example, just doing an electronic search in the data base Medline in 1998 by the key word of 'breastfeeding', 630 hits were gained. In my initial review, I chose the topic of 'women's decision and choice of breastfeeding'. I perceived it as a significant difference in breastfeeding practice between the Western and the Japanese culture, for which I could clarify the cultural features of Western research approaches to breastfeeding.

The literature was searched by the keywords 'antenatal choice' and 'decision of

breastfeeding' using the electronic database Medline (1985-1998). From the 24 papers identified, I selected eight papers; six from a quantitative and two from a qualitative approach; all were primary research papers and clearly investigated the women's decision of breastfeeding. The remaining papers were excluded due to biased sampling, the different focus of the study, and the lack of explanation of theoretical framework. In this review work, I also selected the countries; the U.K., the USA, Australia, and New Zealand, in which English is used as the first language.

The substantial number of women who did not choose breastfeeding appeared as a common phenomenon across the countries. The breastfeeding rate at birth was reported as 77% in the U.K., 53% in the U.S.A. and 77.8% in Australia in the papers. The women's demographic data such as age, marriage, social class and educational background were collected as variables that assumed to influence women's decision to breastfeed (Littman 1994, Scott 1997, Giugliani 1994, Jones 1987).

The relation between those variables and their correlation to the women's choice of breastfeeding is summarised as follows:

- Significant factors: partner's attitudes towards breastfeeding.
- Positive correlations: first birth/ early initiation of breastfeeding/ baby's birth weight/ the experience of talking with female friends or relatives/ attendance at antenatal classes.
- Conflicting outcomes between positive and negative correlations: mother's educational background/ mother's age/ family income.
- No significant influence to women's decision: race/ marital status/ information obtained from professionals.

I looked at the research outcomes from the three aspects; partner's attitudes, women's psychological problem, and midwives role in women's choice to

breastfeed.

Firstly, the partner's attitude towards breastfeeding was identified as a significant factor to influence women not to choose breastfeeding. However, the data were collected by asking the women about their perception to the partner's preference of breastfeeding rather than directly being asked for the partners. The women's answer is likely to be compromised by their own preference of feeding methods. This point was referred to the study by Freed (1993); the women who did not choose breastfeeding were likely to report their partner did not like breastfeeding. The women's attendance at antenatal class was discussed as a possible factor for women to choose breastfeeding in Giugliani (1994) an USA study, and Soo (1988) an Australian study. However, the women's attendance at class could be interpreted in several ways; if it could measure the women's positive attitudes towards pregnancy or high consideration to health education or the effectiveness of antenatal classes or information or none of those.

Secondly, women's attitudes towards breastfeeding were explored through focus on the woman's psychological aspects. Barnes (1997), a U.K. study reported that women who were highly concerned about retaining their body shape were not likely to choose breastfeeding, and those who showed child-centred attitudes to parenting were likely to choose breastfeeding. Soo (1988), an Australian study, reported that women who experienced a psychosomatic problem such as an eating disorder in their teenage were not likely to choose breastfeeding or to stop it in the very early stage. McIntosh (1985), a U.K. qualitative study, explored this aspect studying 60 first time mothers' choice of breastfeeding and their reasons. The women who did not choose breastfeeding reported breastfeeding as 'embarrassing' and 'distasteful', which was termed women's psychological barriers towards breastfeeding.

Lastly, the medical professional's role was reported as having rather a negative or no impact on women's decisions. Giugliani (1994) provided a statistical

summary of the different degree of the people's impact on women's decisions. The women who talked about breastfeeding with fellow-mothers or female friends were three times more likely to choose breastfeeding than the women who did not talk with those people. On the other hand, the experience of talking with medical professionals was put into a category of no influences or women felt negative about the professional advice. McIntosh's (1985) study was able to explore this point that the women preferred to talk about breastfeeding with their own mother or friends rather than medical professionals. In addition, the women perceived that the health professional's advices were biased so that the information was not equally given between breastfeeding and bottle-feeding. Basire (1997), a New Zealand study, argued that the women made their own decision of not to breastfeed before they came to see to medical professionals. This point was supported by Oxby's study (1994), in which the women were likely to decide infant feeding method before pregnancy or in the early stage of pregnancy; once they made their decision, they were not likely to change their mind.

From the result of reviewing the papers, I identified the following points to critique the research approach and research framework:

• The review work suggested the conflicting findings in the statistical correlations. It leads one to question the quantitative research approach; if women's intentions of breastfeeding could be measured and understood by variables.
• Psychological factors seemed to reflect the positivistic approach of studying human behaviour; 'cause and effect' paradigm.
• A qualitative research approach seems to give more possible explanations to understand the women's view and the cultural features of breastfeeding.

Maclean (1989) raised the limitation of the quantitative paradigm in breastfeeding research and called for an alternative research approach that was able to investigate the complex nature of human behaviour, looking at the totality of

people's experiences rather than identifying the isolated patterns of it. The conventional quantitative research approach in breastfeeding, which adapted from the reductionist idea of variables, failed to view breastfeeding as a dynamic event. From the cultural study of breastfeeding, Vincent-Priya (1992) argued breastfeeding was a human behaviour that was learnt through seeing other women breastfeed their babies. The female relatives in the community supported a new mother to learn breastfeeding. Palmer (1993) argued the decline of Western breastfeeding happened due to the society itself making causes for women having to shift into bottle-feeding, which included men's attitudes towards women's breasts or powerful marketing of formula milk. Whilst hospital has become the place for childbirth, the hospital practice and the practitioners' attitudes towards breastfeeding appeared as the negative factor for breastfeeding (McCourt 1996). Beasley (1991) argued the problem of women not feeling they have enough breast milk as 'insufficient milk syndrome', which was a social and cultural phenomenon, rather then it happened by women's biophysical factors alone.

I will add my practitioner's view that breastfeeding is a very individual and personal event, in which each woman and her baby should be considered as a unique couple. In the next section, I will bring my practitioner's view of breastfeeding and conclude in this chapter with the research question and the research approach.

2-1-4. The philosophy of midwifery practice

My philosophical enquiry about midwifery practice began since I came to study in the U.K. Until that time, I had never thought about to talk about my philosophical position, whereby I come from the culture where philosophy is considered to be stored in people's actions, not in language.

I perceive that pregnancy, childbirth and child caring are a part of women's

ordinary life event, and midwives are working for supporting women, a new baby, and other family members to live in a new life setting. I am concerned that midwifery is a creative job, and everyday practices are the resources to reflect my knowledge and skill as a midwife.

I clarify the three key elements to explain my midwifery practice as knowledge, practical experience, and the sensitivity to women's feeling. In addition, midwifery practice is based on the personal ability to integrate those three elements into each woman's individual context.

The following quotes support my ideas:

> *'Through the process of reflection, further observation, and more reflection, midwives are able to make predictions about the type of care which will be most suitable for women under what circumstances'.*
>
> *(Bryar 1995, p3)*

> *'Skilled midwifery care results from the combination of the personal qualities of the midwife with knowledge, theory, reflections and thinking about how theory and knowledge can be best used in care of the individual context'.*
>
> *(Bryar 1995, p6)*

I developed the following points to argue my personal consideration about philosophical position in midwifery practice. Firstly, in English, the meaning of midwife was explained as 'with women', which originated from the old Anglo-Saxon word of 'Mid' meaning 'with' and 'Wife' meaning 'women' (Stevens 2003). In Japanese, 'midwife' was called 'SAN-BA' from the early 16th century; 'SAN' means 'birth' and 'BA' means 'old women' (see more in chapter 3). In the process of modernisation, it was replaced the name 'JYO-SAN-FU'; 'JYO' means 'helping', 'SAN' means 'birth', and 'FU' means 'married women'. In 2003, it was

re-titled by 'JYO-SAN-SHI', in which 'SHI' is used for non-gendered skilled professions such as medical doctors or pharmacists. The Japanese word 'JYO-SAN-SHI' has no meaning such as 'with women' in English. Page (1995) described the relationship between the midwife and the woman as a skilled-companionship, which was also introduced to Japan at ICM conference (International Configurations of Midwives) in Japan, in 1994. However, the meaning of 'JYO-SAN-SHI' has not been developed since then.

I was also concerned about the Japanese hospitalisation and the current position of midwives. Kirkham (1999) discussed the problem of British midwives in the hospital settings. It seems to stem from the conflicts and tensions among the elements such as the high expectation of professionalism, the pressure of implementing the women-centred care within the institution where the midwives could not feel empowered within the system. Eighty per cent of Japanese midwives are working in hospital settings, which took place as a result of institutionalisation of childbirth in the 1960s (see more in chapter 4). The hospital midwives are considered as the assistants of the obstetricians. It suggests the society is questioning the autonomy of midwifery practice, and midwives may loose the position of an independent practitioner and facilitate 'maternity homes'. Japanese midwives are still entitled a female profession, but the discussion of male midwives is ongoing. I do not expand the discussion further in this thesis, since it is not my main focus. However, I suggest the current Japanese discussion reflects the lack of philosophical investigation of midwifery in the current Japanese social context. The meaning of 'with women' should not be an illusion or cliché.

The lack of philosophical explanations of midwifery could be happened due to the lack of careful examination about the nature of midwifery practice and the ways of knowing in midwifery. Much of midwifery research has been undertaken through adaptations of social science approach. However, the social scientists have already criticised its limitation, which their approach were adapted from the

natural sciences disciplines. The idea of generalising all phenomena into theories and understanding human behaviour under the logic and reasoning could not be good enough to understand the complexity of human behaviours (Slife and Williams 1995). In the North American context, the area of midwifery was included in obstetric nursing, which the research framework was followed the biomedical model. The positivist paradigm of objectivity and logic was considered as the best approach and was applied for researching the area of pregnancy, childbirth, and breastfeeding. From my personal experience of both working in a hospital and in a community in Japan, I became to believe that pregnancy, childbirth, and child caring are women's healthy life events. It could be studied more closely using the social sciences disciplines. However, it is not only about the social sciences due to midwifery practice is also about women and children's biophysical events. Midwifery includes multiple disciplined but also has the unique aspects in its practice, thus the midwifery research should be conducted by its own way of knowing.

Since Schön (1983) argued the importance of 'theory-in-actions' in artists, which self-reflections from everyday performances became the source of integrating their theory and practice. The midwifery has been considered as reflective practitioners, in which their knowledge is derived from everyday practices. Following this assumption, the midwifery research will require the approach, in which the researcher's self-reflections are able to bring into the process of research. Therefore the nature of midwifery practice could be illuminated.

With my strong consideration to the way of knowing in midwifery practice, I put forward my study of breastfeeding in the Japanese social context, which I hoped to make some contribution to the philosophical and theoretical aspects of midwifery practice.

2-2. Personal reflections and the research question for the entire research project

The review work suggested that any publication work appeared as the philosophical representation of the authors. The personal philosophical position influenced the focus of the research and the choice of research approach. There were some shifts in the research approach over time, and the researchers became more aware of the role of qualitative research in breastfeeding.

Considering the sensitivity topic, the Japanese survey suggests that mixed-feeding existed as a part of Japanese culture. In my community practice, I recognised that women live in an ambiguous message about infant feeding; breastfeeding is best, but mixed-feeding is not bad. As a practitioner researcher, I have several questions; 'what is the message behind the survey numbers?', 'how Japanese mothers perceive the current situation?' From my practical experience, I assume that breastfeeding is women's very personal event. However, its sensitivity was not identified by empirical research yet. I was required a research approach, through which I could explore the nature and the sensitivity of the topic in the research field.

As a result of the above reviews, I developed a research question:

• What factors hinder or encourage women to breastfeed their babies in the current Japanese context?

My research was aimed to describe obstacles and positive aspects of breastfeeding from women's point of view. Therefore a qualitative research approach was chosen.

The above review work was undertaken whilst I was in the U.K. academic environment. The research question was brought back to the research field.

Firstly it was examined among available Japanese literature, which I will report in chapters 3 and 4.

Chapter 3
The nature of breastfeeding in a Japanese context

In chapters 3 and 4, I will report on the result of my literature review of social and cultural aspects of breastfeeding. This chapter will look at breastfeeding from the historical context, and chapter 4 will focus more on the social aspect of breastfeeding.

In European history, animal's milk was used as an alternative food for breast milk. During the 18-19th century in continental Europe, wet-nurses were used by ordinary women whilst they worked in the urban factories. In the 20th century, it led to the political movement of women who tried to bring back their rights to be able to breastfeed their own baby (Macfarlane 1997). The breastfeeding practice in Europe took the shift from breastfeeding, into any animals or cow's milk, wet-nurses, and then powder milk. In Japan, the shift took place from breastfeeding directly into powder milk, although wet nurses were used by some of the upper class people. The different transition in infant feeding patterns influenced the current controversy between breastfeeding and bottle-feeding. In this chapter, I will review breastfeeding from two aspects: the historical background of breastfeeding and its shift to mixed-feeding, and the role of Japanese midwives in breastfeeding.

3-1. The meaning of breastfeeding in a Japanese historical context

In this section, I will report on the historical context of breastfeeding, which will give the background information to understand the current Japanese breastfeeding practice.

3-1-1. In case, women do not have enough breast milk...

In my literature review, I found conflicting ideas about the usage of cow's milk in

Japanese history. In some areas, cow's or goat's milk was fed to babies (Takahashi 1996). However, it was not common as that found in Europe and also the rest of Asian nomadic cultures. The Japanese people's disfavour of animal's milk was argued in relation to the Buddhism religion that was introduced from China in the 7th century. It may prohibit people to eat and drink animal meat or milk (Sawada 1983). In a paediatric journal published in 1890s, the cow's milk was prohibited to feed infants due to the infant's diarrhoea, which at least showed the evidence; cow's milk was used for infant feeding in a Japanese context (Nishikawa 1992).

Wet-nurses existed as a female profession among the upper social classes. In the 8th century, the imperial court regulated to employ three 'U-BA' ('U' means 'milk', and 'BA' means 'a mother') for a new prince or two 'U-BA' for a princess. The 'U-BA' was selected from the upper social class of women, who were healthy, intelligent, and generous character (Yamamoto 1983). The word 'U-BA' suggested that 'U-BA' was not just a person to breastfeed the baby but also to cultivate a good heart ('KOKORO' in Japanese) in the baby's character. This was practiced until the 1950s and the current Royal Prince and the Princess were the first generations who were breastfed by their own mother (Yamamoto 1983).

For the ordinary people, when women did not have enough breast milk, rice gruel or rice starch was the only way to feed babies. It did not contain enough protein and calories. As a natural course, the babies were likely to die. 'MORAI-JICHI' ('MORAI' means 'to ask', 'JICHI' means 'breast milk') was the way of a community helping women who did not have breast milk, whereby the family asked female relatives for breastfeeding. In reality, it was impossible to ask others to breastfeed for a longer period of time without payment. The family requiring 'MORAI-JICHI' came from a poor social background and could not raise the money for paying their relatives. In Japanese history, breast milk from the baby's own mother was the only way for babies to survive, which was found in common until the Japanese society could have safe powder milk in the 1960s

(Yamamoto 1983).

3-1-2. The wisdom and ritual of having enough breast milk

A Japanese anthropologist argued that each culture had its own wisdom and rituals, which were performed for the women to be able to have enough breast milk (Sawada 1983). In Japan, those rituals were found in each different local area; ensuring women have enough liquid such as soup, rich proteins such as fish, and enough carbohydrates such as rice or noodles. Japanese 'MISO' soup from carp, fish from sea and rivers, 'MOCHI' (steamed sweet rice cakes), 'AMA-ZAKE' (special Japanese SAKE made from rice), 'UDON' (Japanese noodles), 'RENKON' (lotus roots), 'HAKOBE' (chickweed), 'GOBOU' (burdock roots) were descried as those examples (Nishikawa 1992). The description of breast massage appeared in a child caring book in 1703; women's breasts should be massaged everyday or should be suckled by a girl aged between one and four years, which would prevent the strong engorgement of women's breasts (Sawada 1983).

Praying was also commonly found, which was called 'CHICHI-KIGAN' ('CHICHI' means 'breasts', 'KIGAN' means 'praying'). The women and their own mother go to the Shinto temple before birth and prayed for the new mother to be able to have enough breast milk as well as having a healthy baby. The mock breasts, which were made of cloths, and 'E-MA', which was a wooden plate for people write their wishes to have enough breast milk as well as a healthy baby, were offered to the temples. People also prayed to the natural objects such as a tree of 'ICYOU' (a maidenhair tree or ginkgo) or a mountain, as those objects were looked like a woman's breast (Sawada 1983).

Breastfeeding was used as a part of the social rituals, which was called 'CHICHI-TSUKE' ('CHICHI' means 'breasts', 'TSUKE' means 'attaching'). The family having a new baby asked several women to breastfeed their new baby, but this

was not for giving breast milk for the baby's nutrition. The women who breastfed the baby were called 'CHICHI-TSUKE-OYA', ('OYA' means 'a parent'), who looked after the baby as community parents. It was a people's wisdom in which the community as a whole looked after the new parents and their new babies. In the traditional Japanese context, new babies were protected both by their own parents and the community.

3-1-3. Mixed-feeding as an authorised knowledge

In Japan, the first powder milk was produced by a Japanese milk company in 1871, which was through co-operation with a German milk company. However, the first powder milk caused baby's diarrhoea due to the poor manufacturing (Nishikawa 1992). Most powder milk before the Second World War was imported from Western companies, which was expensive for ordinary people to buy. After the World War, Japanese milk companies developed a technology to produce safe powder milk and this was in mass production from the 1960s. It was considered the end of the poor history of 'MORAI-JICHI'. The invention of powder milk was considered as the best solution for women who were not able to have enough breast milk for their babies.

In the Japanese context, the idea of mixed-feeding was introduced by the medical professionals in the 1950s. A group of paediatricians published a guideline on safer breastfeeding in 1950; 7-8% of total feeding should contain other supplements such as glucose water or rice starch (Takahashi 1996). The idea was directly applied in the public health services, which changed exclusive breastfeeding into a form of mixed-feeding, but not mixed with powder milk at the first step. The first national guideline of powder milk was issued in 1951. In the 1960s, as a result of Japanese milk companies starting to produce powder milk in mass production, glucose water or rice starch were replaced with powder milk (Takahashi 1996). The ideas of powder milk and bottle-feeding were welcomed by the young generations, who moved into urban cities, in which the women

started to work outside from home. The image of bottle-feeding was spread out when the television set became a popular electric gadget in 1964, the year of the Tokyo Olympic Games. At the end of the 1980s, some women did not choose breastfeeding, which would never be seen previously in a place such as Japan where breastfeeding was practiced strongly as a cultural norm (Suzuki 1983).

Following the WHO/UNICEF initiative, the Japanese Government started to try making a shift from mixed-feeding into the exclusive breastfeeding since 1979 (Takahashi 1996). However, as the Japanese national survey shows, the exclusive breastfeeding remains at the same prevalence. Once mixed-feeding became a part of child caring culture, it seems not easy to promote breastfeeding as the Japanese society had experienced.

3-2. Hospitalisation of childbirth and its impact on Japanese midwives

In this section, I reviewed the historical background of Japanese midwifery in order to understand the role of midwives in the current breastfeeding practice. I will review it from the three periods of time:

- The origin of Japanese midwife till midwives became a paid work: from the mythological time to Edo period (1603-1868).
- The time of Japanese modern industrialisation: from Meiji (1868-1912) to before the post-war reconstruction
- SANBA' into the current status of 'a nurse-midwife': after the post-war reconstruction.

3-2-1. The history of Japanese midwifery

<u>From the mythological time to Edo(-1868)</u>

In the 8th century, a mythological chronicle called 'KOJIKI' recorded a birth

attendant, who accompanied the woman during birth. After birth, they looked after a new mother and the baby such as bringing food and bathing the baby (Nishikawa 1992). The name of gynaecologists was recorded 'NYOI-HAKASE' ('NYOI' means 'a woman', 'HAKASE' means 'a medical doctor'), who dealt with abnormal births in the imperial court. When the society started to develop a small community to live together, each community owned a 'SAN-YA' (a small hut for childbirth). The women stay there some time before and after birth separating from other family members, whilst the female relatives came to look after them. Each community also had an experienced older woman who attended at many births, which was considered as the beginning of Japanese midwifery (ibid.).

Coming to the early 16th century, in the Edo period (Tokugawa period 1603-1868), the first name of a professional 'midwife' was recorded; where 'a professional job' meant some money was paid for her work and who were called 'SAN-BA' ('SAN' means 'birth' and 'BA' means 'aged women'). They were considered an equal as a family member and invited to the family ceremonies that followed. There was some record that 'SAN-BA' worked for infanticide, where the 'SAN-BA' and the family sent a new baby back to the spiritual world. The background of infanticide was presumed to keep the family size as affordable, which was affected by natural disasters such as drought (Kitou 2002, Namihira 1996).

From Meiji (1868-1912) to before the post-war reconstruction

At the end of Edo period, the movement of formalisation of midwifery knowledge was advocated by an obstetrician, who established a study group for midwives and, the first midwifery journal was published in 1863, which was for other midwives to read the discussion of the study group (Tamogami and Osaki1996). The Meiji (1868-1912) period was the time when the new Government started to modernise the Japanese social system using Western societies as their model. The 'Comprehensive Medical Code' was issued in 1874; which regulated the

whole medical professionals by the legal system. In 1879, the 'Medical Licence Examination Regulation' was issued for doctors who trained under the Western medical training so they could get the license of Japanese medical doctors. In Japanese history, this was the first time when the Western medicine was equally structured with the Japanese traditional medicine.

The 'SAN-BA' (Japanese midwives) were regulated under the Medical Code; 'SAN-BA' were limited to only female over 40 years of their age, and who were able to demonstrate 10 normal and two abnormal births in the presence of obstetricians, and having an autonomy to work as an independent practitioner. The key historical events were summarised from several sources as follows: (Oobayashi 1985, Tamogami and Osaki 1996, Nishikawa 1992):

- 1875: The first rule of 'SAN-BA' registration was issued.
- 1876: The rule of 'SAN-BA' qualification was issued; regulating the birth attendance into the registration system.
- 1876: The first midwifery school was established, which was the beginning of the formal education.
- 1899: The rule of 'SAN-BA' was revised; the age restriction was revised over 20 years female, and added the restriction that midwives only work with the normal births.
- 1901: The number of midwives was recorded 25,485; 600 were practising with the new qualification.
- 1927: The professional union 'the Japanese Midwifery Association' was established, which had enough power to influence politicians.

Towards the Second World War, the midwives were used for nationalism, in which childbirth became incorporated into the political attempts to increase the national population. The midwives were supervised to work under the national policy. For example, the family control was used for women to have more babies, which was against the original professional mission; midwives should help

women to be able to keep a good interval to maintain their reproductive health. Abortions were prohibited even though it was required for protecting women's health. It was called 'the dark era of Japanese midwives' (Oobayashi 1985). Under the Medical Law, nursing was also regulated as the professions who assisted medical doctors. The nursing rule was established in 1912, and the nursing training course required less skill and knowledge than that was required for midwifery education. The social status of nurses was not high comparing the midwives were in the position. This historical background is important to understand the current conflicts between nursing and midwifery.

After the post-war reconstruction: 'SAN-BA' to 'nurse-midwives'

During the post-war reconstruction, all social systems were regulated under supervision of the American General Head Quarters (GHQ). The following medical regulations were issued in the following order:

- 1938: The Ministry of Health and Welfare was launched.
- 1941: Public health nurse registration was established.
- 1943: National health insurance system was regulated.
- 1944: Public Health Centre Law was facilitated.
- 1946: The new Japanese constitution was issued; the new comprehensive medical code was established.
- 1947: Public health nurses', midwives' and nurses' law was established.

The reconstruction of midwives was undertaken by American public health nurses, because the USA had no midwives. As a result of inspecting the Japanese home births, the home environment was considered too dirty and it caused infections. The policy of moving home births into hospitals was developed by GHQ and implemented by the new Japanese Government. Until that time, the hospital had been used only for abnormal childbirth and home birth was the social norm. When the hospitalisation of childbirth was implemented, the society

required hospitals first. Until then the hospitals were only used for the abnormal cases, thus hospitals did not have enough obstetricians to manage such a huge number of normal births. As a result, midwives were moved from their own community into hospitals (Oobayashi 1985). The hospitalisation of childbirth was not completed until the 1980s. The national survey showed that 40% of childbirth took place at home in 1960s, and the 1985 survey reported the 99% of childbirths were taking place in institutions, which the Japanese government stated as the completion of safer childbirth (Matsumoto 1992).

Japanese 'SAN-BA' was re-regulated into 'nurse-midwives' ('JYO-SAN-FU' in Japanese) in 1947, which aimed to bring all care professionals under the title of 'a general nurse'. The idea of nurse-midwives was not welcomed by Japanese midwives. Especially midwives had the right to work as an independent practitioner. Whilst the new law required resetting the educational system, the number of midwives rapidly decreased by 40% (Nishilkawa 1992). Japanese midwives were regulated as a registered nurse, female with a legal status of working as an independent practitioner, and taking the whole responsibility for normal pregnancy, childbirth, and child caring (Oobayashi 1985).

The current professional status of 'nurse-midwives' increases the complexities of the educational system. The nurses are trained through two paths; attending the nursing degree at the university course, or taking a three year course at the female short college or vocational school. Midwifery education is a one year vocational training course following the nursing qualifications. Under the current system, 2,000 midwives were newly qualified each year (Mother's and Children's Health and Welfare Association 2004). However, the Japanese Government initiated to abolish the vocational course, and to integrate it as a part of four years' nursing degree course. Each university is able to train only five or six students due to the lack of midwifery teachers and the problem of replacement, which will lead to the shortage of future midwives. The North American model of clinical specialists or the U.K. and New Zealand model of direct entry training are

being considered. However, still no clear recommendations are made for the future midwifery education.

3-2-2. Hospital protocol of breastfeeding

In this section, I will continue to discuss breastfeeding in relation to midwifery practice. The Japanese hospital protocol was developed in the 1960s using the North American hospital practices as a model, whilst the American hospitals abolished them due to its negative impacts on breastfeeding and mother-baby relationships, and started 'rooming-in' practices (Fukuda 1996).

I could not find any Japanese articles which recorded the hospital breastfeeding practice from women's point of view. A British midwife, who lived in Japan for ten years in the 1980s and worked for overseas mothers' childbirth and breastfeeding, described her curiosity to the Japanese breastfeeding culture as follows:

> *'Until the input from advertising, movies and pornography introducing Western ideals of female sexuality, the Japanese did not view the breast primarily as an object for arousal. It was the nape of the neck, the only part of the woman's body that was exposed when she wore traditional KIMONO that used to be associated with female erotica. With large breasts now being portrayed as desirable, women sometimes give their small breast size as the reason why they have 'insufficient milk'.*
>
> *(Pearse 1990, p310)*

The hospital practice was implemented by the rules; the restricted time and attachment with the baby while the baby was kept in the infants' room, the mothers were only permitted to view their baby through the window, and they were summoned to a feeding room every four hours by music announced from the speaker. Before entering the feeding room, the midwives asked the mothers

to wash their hands and don a gown and paper cap. The baby's weight was checked before handing them to the mothers. The mothers' nipples were wiped by a medicated swab before and after feeding. The babies were latched onto mothers' breast for a limited time. The hospital protocols were based on the belief of preventing sore nipples and protecting babies from infections. Nipple shields were used and it was common that hand expressed breast milk was given by a bottle (Pearse 1990).

The situation was described as:

> *'[Breastfeeding] is found rather undignified, feeding like a cow in the dairy, and rather intimidated by the officious 'dragon like elderly baby nurse'.*
>
> *(Pearse 1990, p311)*

Pearse (1990) considered the traditional Japanese breast massage that was carried out by midwives had shifted to the new trend of 'self-massage'. The shared sleeping arrangement was substituted because of the fashionable 'Western baby bed'. The long duration of breastfeeding was abandoned because of the older women claiming it was self-indulgence.

I explored my question; how much hospital breastfeeding practice has improved since the WHO statement of the Baby Friendly Initiative was introduced into hospitals. Three journal articles reported their success in transforming their hospital practice into more Baby Friendly environment by launching 'rooming-in' systems (Takei 1998, Hachiya 1998, Sueshige et al 1998, Senoo et al 1995). The new protocol was described as follows:

• Breastfeeding starts in the delivery room with a midwife's support after birth.
• After 24 hours of careful observation of a new born baby in the infant room, rooming-in will be set out by locating a baby cot beside the mother's bed. The midwives give instructions to the mother; washing hands, cleaning nipples before

and after feed by wipes, instructing the mothers when and how they need to add formula milk or glucose water after breastfeeding

• At the day 4 or 5: the amount of breast milk is checked by testing baby's weight before and after breastfeeding, and the right infant feeding method is instructed to the mother.

Wakayama et al (1989) reported the positive impact of antenatal education, which focused on antenatal preparation of massaging nipples for women who had a problem such as short or flat or inverted nipples. In the breast care and instruction for mothers in the Baby Friendly Hospital environments, women's breasts were firstly managed by midwives. This is called 'breasts management' (called 'KANRI' in Japanese), in which the instructions are given to new mothers to enable them to engage in self management.

Looking at the contents of the current hospital protocols, the ideas are not so much different from the hospital practice in the 1980s. The idea of task-oriented care was continuously practised; which is called 'manuals' ('TE-JUN' in Japanese, 'TE' means hands and 'JUN' means 'ordering') and 'giving right instructions to women' ('SHI-DOU' in Japanese, 'SHI' means fingers, 'DOU' means leading people). Coming across the word of 'KANRI' (management) in breast care, I feel that the woman's breasts are treated like an object for the medical care, and sounds very mother and baby unfriendly.

3-2-3. Breast massage in a Japanese context

In the Japanese historical context, breast massage was practiced by 'AN-MA-SHI' (Japanese massage therapists) and 'AN-MA-SHI' were asked to come to either home or hospitals for massaging women's breasts, which was commonly seen until the 1930s (Oketani 1983). The breast massage was firstly formally researched by an obstetrician, Ojima, and established as a scientific skill in 1937, and launched in the midwifery education curriculum (ibid.).

A midwife, Oketani, formalised her 300,000 practical experiences of her 40 years' clinical experience of breast massage into the formal midwifery knowledge (Oketani 1983). In the massage session, the following procedures were undertaken:

- The mother was asked to lie on the bed exposing her breasts.
- The midwife sat on the right side of the mother's bed with a big bowl of hot water, applying hot towels to the mother's breast.
- Doing one minute of breast massage, the let-down reflex would take place, which showed as the shape of breast milk flashing from the milk ducts, whilst the midwife was milking the nipple.

In her theory, the breast massage improved the blood circulation, which increased milk flow and improved the quality of breast milk, and removed a blockage if it occurred. 'Oketani Massage' is practised by midwives who attended the private training course. However, the skill and principles are disseminated by publications, through which women could read about it.

The breast massage is not limited by the title of 'Oketani'. A medical doctor Nezu (1992) introduced a new breast care method based on self-care breast massage, which was named 'Nezu method'. He argued that the Oketani method was 'a treatment', dominated by midwives, and his theory was based on the trained midwives to teach women about the skill and knowledge of looking after their breasts by self-care.

Both Oketani and Nezu methods were developed in a way that required midwives to undergo extra training. In hospital settings, follow-up breastfeeding sections are facilitated in the outpatient's unit or postnatal ward, in which the women are able to come back for following -up their breast conditions or have a treatment for mastitis or stopping breast milk when weaning. The cost of the breast massage is

directly paid by the women, around 2,000-4,000 Yen (the equivalent of £10-20).

Japanese midwifery has a reason to be developed as a female occupation, whilst 'breast care' is a significant part of Japanese midwifery. Talking about breast massage to midwives in the Western countries, some of the midwives showed their curiosity or disgust of it. Oketani (1983) argued that the Western obstetric textbooks wrote about breast massage; the massaging of chest muscles, and cooling and warming techniques for enhancing the physical function of producing breast milk. The reason why the massage is not practised in the Western societies seems to be the Western people's perception to women's breasts and the meaning of touching others' bodies.

In this section, I focused on the hospital breastfeeding practice, which led me to a question; whether the Japanese midwifery led-care such as maternity homes could create a positive impact on breastfeeding practice. In order to find the possible answer for this enquiry, I will overview the position of maternity home in the Japanese maternal care system, and then review the breastfeeding practice in a Japanese maternity home context.

3-2-4. The breastfeeding practice in a maternity home

The hospitalisation of childbirth in the Japanese context means that 'moving childbirth from home to institutions where the childbirth is directly supervised by medical professionals'. Until 1950, 95% of childbirth was undertaken at home with the attendance of the local midwives. The number of homebirths decreased from 1955 and down to 60% in 1960, and then only 20% in 1965 (Mother's and Children's Health and Welfare Association 2004).

The medical institutions for childbirth are categorised into three titles, which will be shown giving the number of the institutions in Japan with the percentage of childbirth in 2003 (Mother's and Children's Health and Welfare Association 2004):

• Hospital: the institution that has over 20 beds, 1715 institutions, 52.2% of total births.
• Obstetric Clinic: having under 20 beds, 3940 clinics, 46.6% of total births.
• Maternity home: having the beds for women to stay for and after childbirth, 730 facilities, 1% of total births.

I will review the structure and its relation to the social insurance system in chapter 4; here I briefly describe the features of the Japanese medical system. All medical facilities are governed under the Medical Law and the Health Insurance system. The hospitals and obstetric clinics are facilitated by medical doctors and the maternity homes are facilitated by midwives, but all are regulated under the same medical law named as 'a medical facility'. The maternity home is restricted to only normal pregnancy, childbirth and child caring.

The percentage of childbirth in maternity homes was rated as 8.5% of total birth in the 1960s, 10.6% in the 1970s, and 3.8% in the 1980s (Ooide 2000). The institutions such as hospital and maternity home were required for social reasons. Firstly, the rapid industrialisation made young generations come to live as a small nuclear family, which meant that no other family members were available to support a new mother during and after childbirth. The modern Japanese flat had no space for women to have a home birth. Secondly, still in the 1960s there was a geographical inequality in Japan. Many women lived in remote areas and had difficulties in arriving at hospital after onset of birth; therefore they came and stayed at the maternity home when the onset of labour was near (ibid.). Since the 1990s survey, 1.0 % of total childbirth was undertaken in a maternity home. The number of maternity homes was reported as 730 in Japan in 2003 and 8% of the 20,400 midwives are working as an independent practitioner, who includes to work for the postnatal visits or breast care alone (Mother's and Children's Health and Welfare Association 2004).

The breastfeeding in maternity homes has not been written about well, so the following information was collected through talking with the midwives at a maternity home and the women who gave birth at a maternity home. The young midwives (in Japan, young midwives mean over 40 or even 50 years old), who started to work in the maternity home, perceived that the maternity home was not a safe environment due to the physical distance from the medical facilities. As a result, it seems common to introduce powder milk from the first day, which the midwives considered a way of avoiding the unnecessary risks such as babies' weight loss or jaundice.

From women's point of view, the maternity home is considered as the place to have their own midwife who can look after them through pregnancy, childbirth, and child caring. However, the small obstetric clinics are also the place where women could have an obstetrician as their continuity of carer in their local setting. As I described, whilst the young midwives feel the hospital environment is safer than the maternity home, it seems natural that the women feel hospital environment is safer for them. The women do not like to go to a big general hospital unless having a medical complication, in which they have to wait longer, more chances to have cross-infections, and to be followed-up by the different obstetrician in each antenatal clinic. The small clinics are considered as the good option where personal care and continuity of carer are available at the same expense. In small private clinics, breastfeeding is practiced by the same principles of risk management, in which bottles and powder milk are used routinely.

In my empirical work, I did not consider the place of birth for my sampling criteria, since I could see that the Japanese breastfeeding practice shares the common principles regardless the size of institutions. I will discus this more in relation to the Japanese medical system in chapter 4.

3-3. Summary

In this section, I explored the meaning of breastfeeding in a Japanese historical context; which illuminated the possible reasons why breastfeeding exists as a cultural norm. It appeared with the women's strong wish to make their babies to survive; without their own breast milk, their children were likely to die. In the absence of dairy farming or consumptions, the invention of powder milk gave a light to those women who could not afford the money for asking their relatives to breastfeed instead of them. It is only 40 years ago, this change was took place in the Japanese context. Mixed-feeding was introduced as the authorised knowledge by paediatricians, and then they tried to reverse it to exclusive breastfeeding. It may create the cause for the women to live in the ambiguous cultural assumption; 'mixed-feeding is not too bad'.

When childbirth took place at home, the role of midwives was not publicly apparent. As a consequence of hospitalisation of childbirth, midwives were made to confront their role within the framework of obstetric medicine. The hospital practice is based on a very rigid approach, as the midwives are all responsible for the practices. The discourse about breastfeeding in maternity homes illuminated the risk management of breastfeeding, which further includes the political and economic elements. In the next chapter, I will explore the nature of breastfeeding in relation to the social structure and medical system.

Chapter 4
The social aspect of breastfeeding

In chapter 3, I reviewed the historical aspect of breastfeeding including the historical background of Japanese midwives. In this section, I will review the Japanese medical system and then the maternal care services in Japan. Firstly, I will consider the state of health and illness in the medical care system. I was concerned Scheper-Hughes and Lock's argument (1987); the social structure influenced to people's experience of life, especially the meaning of health and illness. Secondly, I will review the current Japanese maternal care system, which provides the background information to understand the women's experience of breastfeeding that will appear in my empirical work. Lastly, I will bring some Japanese medical discourses of breastfeeding. Yamamoto (1983) argued that Japanese breastfeeding was practised following the self-evident knowledge, in other words, people's common-sense. Lock and Kaufert (1998) argued that 'common-sense' was the form of the unspoken authority of everyday life. I will consider medical discourse as the sources of people's 'common-sense', which creates the social environment for the women to live in and to experience breastfeeding.

4-1. The state of health and illness

Whilst I reviewed the nature of breastfeeding in a Japanese historical context, I developed a feeling that the Western notion of medicalisation seemed not to be able to apply for the Japanese context. Lock (1987) argued that medicalisation meant that the technology determined the social structure and the meaning of power in medicine. In this section, I will look at the meaning of health and illness in the Japanese context.

The features of Japanese maternal care services would be summarised into the following context:

• Women choose the place of birth from hospital, clinic, and maternity home, which is generally made following the advice given by their own mother, relatives or female friends.
• The hospital practice is based on common protocols, but the actual practice is developed according to each institution.
• The expense required for normal pregnancy and childbirth is directly made by the family, whereby it is not covered by the social or national health insurance. However, the medical indications such as vacuum delivery or caesarean sections are covered by the social health insurance.
• The medical practice is different at each institution, and the expense of the medical service is priced by each institution, although some consensus is made among obstetricians.

I will start from looking at the meaning of power and decision making in health services in the 1980s; the Japanese economic success and its invention of a 'miracle' in the Japanese state of health and illness.

4-1-1. The state of health and illness in the modern Japanese context

Steslicke (1987) argued the Japanese success in health state was 'the Japanese miracle', in which the low infant mortality rate and the high life expectancy were achieved in just two decades; between 1960 and 1980. Japanese economic success and the state of health were strongly connected, which supported the World Health Organisation's review; 'countries with a high gross national product (GNP) have a low infant mortality rate and high life expectancy, the opposite being the case for countries with a low GNP (ibid)'.

• The national population is 122.6 million (Mothers and Children's Health Association 2004).
• The life expectancy is 78.36 for males and 85.33 years for females in 2005

(Japan Statistical Association 2005).

- Only 14% of the total population is under the age of 14 years (Japan Statistical association 2005).
- 20% of the total population is over the age of 65 years, of which the actual number is 2,556,000 (Japan Statistical Association 2005).
- The total number of births is 1,123 thousand per year and the infertility rate is 1.29 (Japan Statistical Association 2005).
- Neonatal mortality rate is 1.7 per 1,000 births (Japan Statistical Association 2005)
- The average marriage age: 29.1 for males and 27.4 for females (Mothers' and Children's Health and Welfare Association 2004).

At the end of the 19th century, the average lifespan was recorded at 41.3 for males and 41.0 for females, and the short lifespan was due a high infant mortality rate (Kitou 2002). The average lifespan was reported as 50.06 for males and 53.96 for females in 1943, which is the record during the Second World War. When Japanese society experienced rapid economic growth in the 1950s, the life expectancy increased to 63.60 for males and 67.75 for females in 1955. In 2006, the difference of lifespan between males and females recorded for 6.95 years. The three main causes of male adult mortality reported were cancer, heart disease, and vascular diseases, but middle-aged suicide has shortened male life expectancy (Japan Statistical Association 2005).

After the post-war reconstruction period, whilst the Japanese society experienced rapid economic growth, many of the social policies were developed modelled on the British and German systems (Hayakawa et al 2003). In 1961, the Japanese Government issued a social health insurance system, which proposed all the Japanese citizens should have access to free medical care. It was developed following the British National Health Services (NHS) in principle. Since 2003, citizens were asked to pay 30% of the total medical expenses due to the lack of budget and the high demands of the medical expense due to the high proportion

of aged populations (ibid.). However, maternal care and childbirth did not appear as an issue for developing the insurance service, which seems to be inconsistent if the law and the system was developed using the NHS in Britain as a model.

4-1-2. The principles of medical care system in Japan

Lock (1987) argued that the Japanese had a complex medical system characterised by the predominately private, fee-for-services, and physician's centred system of care with a compulsory health insurance system. In this system, two different values exist. In the basic principle medical practice should be a non-profit service. In the economic principle, the medical service was dominated by fee-for service, in which hospitals could collect the money from the social insurance system according to the implementation of the practice. The hidden assumption was based on the medical practice by the 20th century; the practice was male dominated and the money was paid directly by the patients for the practitioners. As a result, the Japanese medical system has been developed as a competitive and aggressive business market, in which controlled by the doctor's decisions including the pharmaceutical, medical devices, and equipment or resources companies (Lock 1987).

The rapid economic growth in the 1980s put Japanese people into the context of 'health care consumers', who could demand the high technology in medical services. At the same time, the local family practitioners including massage therapists, acupuncturists and the Japanese herbal practitioners remain fully occupied through people's demands, whereby the cost was paid under the same social and national health insurance system (Lock 1987). It led to the conflicts between hospital salaried doctors and the private clinicians, local and rural doctors, and between Western biomedicine and the traditional herbal medicine (Steslicke 1987). Following the tradition of physician centred practice, the professional organisation such as the Japan Medical Association had more power to implement the practice than the Government. It meant that the

Japanese medical system was not characterised by top-down communications (Steslicke 1987). The historical context and the tradition of Japanese medical practice made the Japanese society an exception, in which the Western social theory and the definition of medicalisation did not apply in the same manner as in the West (Lock 1987). The Japanese medical system could not be defined by technology alone (ibid.).

I considered the maternal health care services as a more aggressive market, in which the medical expense of childbirth was not covered by the social or national insurance system. Moreover, the reasons behind this principle have never apparent in public. The practical guidelines of obstetric medicine are issued by the Japan Gynaecologists and Obstetrician Association (JGOA), which includes the recommendation for the expense of the medical service. The actual price varied in each institution according to the facilities, the available medical knowledge and technology. The maternity homes followed the guideline of JGOA, thus maternity homes are involved in the medical competition and marketing business. In the following section, I will overview the maternal care system, in which most women will get their scenario of pregnancy, childbirth and child caring.

4-1-3. The women's life course and the national policy

From the review of the medical system, the current Japanese society is structured according to the combination of Japanese traditional medicine and Western biomedicine. It seems to give multiple messages for the people to live by; especially childbirth and child caring.

I perceived that an increase in numbers of child abuse and maternal depression was one of those phenomena stemmed from the complex life situation (Japan Statistical Association 1998). A Japanese national survey described the younger family's lifestyle and their concern about child caring (ibid). From the sample of

10,703 women, 67.4% had the occupation of a professional housewife; 22.3% of them had been a housewife since the time of their marriage and 45.1% became a housewife from the late pregnancy or after birth. The main reason for stopping outside work was the physical constrains of dealing with both child caring and work. This group of women were older than the mothers who worked outside from home, and the family income was higher than the average. On the other hand, 26.2% continued their work after childbirth, which included 0.2% of women who started working after birth. The grandparents helped with their child caring, if they lived together or close to the young family. The report concluded that the targeted population for maternal health promotions should be housewives, that is, those who stayed at home and looked after their own child or children.

The high frequency of Japanese housewives may make people believe it to be the traditional Japanese way of child caring, but it is not true. Until the 1960s whilst Japanese people lived in a big family, all the family members were the workforce for undertaking rice farming or fishing and child caring was a shared task for the family. The industrialisation moved the younger generations to live in an urban environment and as a nuclear family, which was termed 'KAKU-KAZOKU' ('KAKU' means 'nuclear' and 'KAZOKU' means 'family'). The young mother became an only person who looked after children, which created a new category of 'a professional housewife' (Masataka 1999). The everyday national newspapers reported the incidence of child abuse, postnatal depression, domestic violence, divorce, and smoking and drinking problems among women. The long hours of husbands at work, termed the social phenomenon of 'an absent father', in turn a further social phenomena of 'an isolated housewife' (Lock 1988). In later stages of family life, problems developed amongst the family relationship such as teenager family violence or teenager's refusing to go to school, which are considered as a family crisis (ibid.).

The current Japanese national policy attempts to help the isolated housewives by community support. The high proportion of women who were diagnosed their

infertile was discussed as the cause of small number of children The recommendation was made for covering the medical expense by the health insurance, which could improve the women's access to the medical treatment (Mothers' and Children's Health and Welfare Association 2004). However, the expense of pregnancy and childbirth remained in the same principle, in which made the women and their family need to keep the number of children according to their income, including the amount of money required for children's education.

4-2. The maternal care services

The current maternal care system was developed following two laws; the maternal and children's health and welfare law in 1964 and 1965 (Matsumura 1996). Once women discover their pregnancy, they are followed by two maternal care systems: public health service and the hospital care. The public health care follows the principle of free services, which includes children's vaccinations. The women choose the place of birth from the different type of institutions; the obstetric department in general or obstetric hospitals or obstetric clinics or maternity home. As I reviewed the double principles in the medical services, the women are likely to be cared for with two messages; pregnancy and childbirth is a normal healthy event, but also requires monitoring by medical doctors.

4-2-1. Hospital care system

In the current maternal care system, when women know they are pregnant, they visit the hospital in which they follow pregnancy and childbirth, and also the city council in which the public health nurses give a 'Maternal Child Health Handbook' as well as explaining the public maternal care services.

The women attend the hospital antenatal clinic following the hospital protocol, which is summarised as follows:

• One to six months: once every month.
• Seven to nine months: once every two weeks.
• 10 months: once every week.

The antenatal care is initiated by obstetricians including the following physical assessment:

• To check blood pressure, urinalysis, mother's weight.
• To measure uterus height and abdominal girth.
• To check the baby's growth and heart rate by ultrasonography.
• Vaginal examination: the first antenatal clinic, and then every week after 36week.

A natural birth is the social norm, and the induced birth is only applied for the medical indications such after 42 weeks of the due date. There are no national statistics to know about the percentage of induced labour. However, looking at the survey of the prevalence of childbirth in a week, the childbirth was skewed into weekdays, not weekend or Sunday, which suggests that the planned birth or induces labour is common in the obstetric practice (Mothers and Children's Health Association 2004). The caesarean section rate in Japan approximates between 11-17%, which was only performed due to the medical indications (Mothers and Children's Health and Welfare Association 2004). The women stay in hospital five to six days after childbirth, and learn about breastfeeding and child caring while the medical doctors observe the normal physical recovery. One month after birth, the women and their babies return to the hospital to check up on their health conditions.

'The Maternal Child Health Handbook' was developed by Japanese obstetricians and paediatricians in 1942 in order to improve the maternal morbidity and infant's mortality (Takemura et al 1993). It was revised in 1965 into the current format (ibid.). In the antenatal care, the women bring it with them and the obstetrician or

the midwife write the physical progress of pregnancy. Their childbirth was recorded with the name of the birth attendants. After the childbirth, the handbook was used for recording children's physical development and vaccinations until the children's age of six. The handbook can network the people who work in the maternal health care services; from pregnancy, childbirth, postnatal care, and also their child's health (ibid).

4-2-2. Family mutual support: 'SATO-GAERI' (Going back to the parents' home)

The system of SATO-GAERI' is practiced as a mutual aid within families. The current style of 'SATO-GAERI' appeared in the 1970s, when young people started living in a nuclear family. 'SATO' means 'an old nest' and 'GAERI' means 'returning'. In order to gain some practical help after childbirth, the women who lived in the commune city return to their own parents' home. A Japanese custom 'TOKO-AGE' is practiced, in which the woman stays in her bed for the first two weeks after birth. Especially the housework with water, such as washing, cleaning, and cooking, is prohibited, since it blocks the path of blood that would cause the delay of the women's recovery from the birth and develop a heavy menopause in the later stage of life.

Ten per cent of women were thought to take 'SATO-GAERI' in the 1970s (Kato 1988). 'SATO-GAERI' should be a good support system for a new mother. However, the current 'SATO-GAERI' brought a problem for a new mother to breastfeed her baby. A small local survey reported grandmothers' attitudes towards breastfeeding in 'SATO-GAERI' and its impact on breastfeeding practice (Iwai and Kawayoshi 2001). Among 71 grandmothers, 33 agreed with 'breastfeeding is best' and 38 disagreed with exclusive breastfeeding, with mixed-feeding considered better than exclusive breastfeeding. In the group of grandmothers who did not exclusively breastfeed, their anxiety that the baby was not fed properly by breast milk was higher than the grandmothers who did

exclusive breastfeeding. As a result, they advised their daughter to use formula milk, even though their daughter did not want to use it. This was the generation who gave birth themselves around the 1960s, in the period when mixed-feeding became the norm or was advised by medical professionals.

The percentage of 'SATO-GAERI' is not surveyed in the national statistics. However, in my community, it was commonly found, in which the women described their problem of breastfeeding whilst they were staying in their own parents' home.

4-2-3. Public maternal care

The Japanese public health service was developed in 1958 in order to improve the high infant mortality rates. In the service, the children are followed-up at the baby's three months, 18 months and three years of age, which are based on a mass screening system. Additional follow-up is made by attending paediatric clinics at six and nine months of age and other occasions for vaccinations. The DPT, Polio and Measles vaccination rate is reported 90-95% annually, which is considered to be due to the efficiency of the current maternity service and health education (Mothers' and Children's Health and Welfare Association 2004). After the children get into school, the regular health check is initiated each year by school doctors including physical health growth (checking weight and height), dental hygiene check, eyesight, ear and nose check, and x-ray. Vaccination is also programmed for conditions such as tuberculosis.

Baby follow-up clinics are initiated as a free public health services and by a multi disciplinary team including paediatricians, public health nurses, dentists, dieticians, and midwives and psychologists for counselling. From my personal experience of working in a team, I found that the longer breastfeeding and night breastfeeding were considered negative as it was thought to cause a deformation of children's teeth. The paediatricians and the dentists instructed the women on

the early termination of breastfeeding and early weaning. According to cross-cultural research, Japan was a country to introduce complementary food earlier than the UK or the USA (Tsuneyoshi and Boocock 1997). In fact, the recent Japanese Government guideline indicates that complementary food should be introduced at four months of age, which conflicts with the current WHO/UNICEF recommendation of ideal breastfeeding; babies should be breastfed only by breast milk for the first six months. In the public health services, women are likely to encounter contradictory views and advices to short term of breastfeeding.

4-3. Breastfeeding practice in the medical discourse

I will introduce some medical discourse about breastfeeding, which I considered to create the social environment and factors in which the women's breastfeeding takes place. In this section, I will focus on the medial professional discourses of breastfeeding; the meaning of measurement and numbers in breastfeeding practice. After the Japanese society experienced a huge decline in breastfeeding in 1960s-1970s, a number of breastfeeding books were published. They were the collections of personal experiences, stories of breastfeeding practice that were contributed by paediatricians, midwives, and fellow mothers. The common message in the books was; 'breastfeeding is best, easy, cheap and natural, but you (mothers) should learn how to do it correctly'. In this section, I will look at the nature of breastfeeding in the medical discourse; the guideline used for women to leave hospital and one month baby follow-up clinic, breastfeeding and infant mortality and mobility rate, and the meaning of breastfeeding.

4-3-1. Medical discourse of breastfeeding

The first comprehensive medical textbook of breastfeeding was published in 1983, titled 'BONYUU-HOIKU' ('BONYUU' means 'breast milk', 'HOIKU' means 'nursing') (Kato et al 1983). I identified it was widely used by medical professionals in the 1990s, and seems to become the foundation of

breastfeeding practice. I will illustrate three discourse; the practical guideline used for antenatal education, postnatal hospital care, and one month baby's follow-up clinic.

Firstly, Nanbu (1983), obstetrician, developed the infant feeding guideline that medical doctors could use when the women leave from hospital. In his hospital, the women and their baby stayed five days after childbirth, whilst the baby's weight was tested before and after breastfeeding and noted in the medical record. Comparing the amount of breast milk measured during the hospital stay and the feeding method observed at baby's one month clinic, 100 infant feeding methods were categorised as follows:

Table 3 - The amount of breast milk at 5 days after birth and the indicative feeding methods at 1 month (based on Nanbu 1983, p164)

Group	Amount of breast milk at 5 days after birth (ml/feeding time)	The number of women	Feeding methods at 1 month		
			Breast feeding	Mixed-feeding	Artificial feeding
I	Over 80ml	22	22	0	0
II	60-79ml	23	15	5	3
	50-59ml	12	8	3	1
III	40-49ml	14	6	7	1
	30-39ml	9	7	1	1
IV	0-29ml	20	3	13	4
Total number		100	61	29	10

From the study, he concluded that the following advice could be given to the women according to the amount of breast milk that the baby got at the day of leaving the hospital:

• Group I : This group of women could be 100% sure and the medical doctors could advise to breastfeed only.

• Group II : This group could be advised that they could breastfeed their baby.

• GroupIII: This group divided into some variations of feeding methods. Therefore the medical doctors should monitor the baby's weight at one month and give the appropriate further advice.

• GroupIV: In very few cases, the women are able to feed their babies by breast

milk only.

During the hospital stay, those women were instructed with detailed information about having enough breast milk such as: trying to breastfeed as their baby cries, the women need to take liquid such as water, tea or soup, 600ml at least each day, and if the interval of breastfeeding fell within one hour, the women need to use the formula milk. The reason for women's shift from breastfeeding was reported; women's feeling of tiredness, baby's frequent crying, previous experience of formula milk feeding, the feeling of softness in their breasts, and baby's refusing to latch onto the breasts. The women in the group shifting from breastfeeding considered the small breast size or the shape of nipples were inadequate for breastfeeding, and also their own mother could not exclusively breastfeed (Nanbu 1983). The women in group Ⅳ, three out of 20 women achieved to breastfeed only at one month regardless the small amount of breast milk being measured at the time of leaving hospital. This study suggests that breastfeeding is not a simple biophysical event, but is also influenced by the women's attitudes towards breastfeeding.

Secondly, the individual biophysical difference in the process of producing breast milk was discussed in the study by Miyazaki (1983), a paediatrician and a researcher working on maternal guidelines. Miyazaki's study developed a critique of the hospital practice, which tends to be based on Koyama's formulation:

- Total amount of intake for a day=65-70ml x (the number of day after birth – 1).
- The amount of each feeding = (the number of day after birth – 1) x 10ml.

As a result of this formulation, the hospital practice was always to add the same amount of formula milk according to the day after birth. Miyazaki argued the danger of practising infant feeding by mathematical formulation and studied the amount of breast milk which the baby took each day. He reported the difference in each individual baby, as presented in Table 4:

Table 4 - The daily intake of breast milk among term infants (based on Miyazaki 1983)

Day from the Birth	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14 days
Average amount	0	8	52	150	251	332	379	478	483	499	482	518	515	526	540ml /day
Minimum amount	0	0	0	0	10	170	120	175	160	245	250	320	360	350	425ml /day
Maximum amount	0	115	210	430	575	760	845	800	810	790	735	785	660	730	690ml /day
Frequency of feeding	0	2.9	5.9	6.7	6.9	7	7	7	7	7	7	7	7	7	7 times /day
Sample	300	300	298	297	283	286	246	172	122	73	48	31	21	14	8

Miyazaki (1983) argued that the intake of breast milk was different for each mother and each baby, and individualised care should be the recommendation.

Lastly, Suzuki (1983) discussed; how to identify the insufficient breastfeeding at baby's one month follow-up clinic. From his practical observation and analysing the medical records of baby's one month clinic, he identified that 5-20% of breastfed babies were not gaining their weight at 30g per day, which he clarified as inefficiently breastfed babies. He argued 5-20% should be considered as a big number, thus the paediatricians should positively advise the mothers to add formula milk.

I found the above medical discourse could illuminate certain values of breastfeeding. Firstly, the infant feeding was initiated by measurement and numbers, which seemed as though it was a scientific approach. However, from the women's point of view, those numbers increased their anxiety of breastfeeding rather than increasing their confidence of having enough breast milk. Secondly, the medical discourses were developed supporting mixed-feeding as a safer method, which put women in a position of needing to engage in acrobatic thought between the traditional value and the modern value of breastfeeding. In the process of establishing the medical discourses, the paediatricians themselves also worked out ambiguous messages, in other words between the practical norm and the statistical norm. Their analysis seems to adopt some scientific notion. However, the interpretation of the research was largely subjective, since the implications of the practice were illuminated from

their personal opinion. The meaning of research in the Japanese context seems to be different from the Western context, which I will explore more in the chapter 5 in relation to the Japanese way of knowing and the features of Japanese communication.

4-3-2. Infant mortality and morbidity rate and breastfeeding

In Japan, when infant mortality was high, the infant feeding methods were actively discussed as an issue to protect infants from severe infections. In the 1900s, perinatal mortality rate was reported as 156/1000 births. In the 1950s, while the infant mortality rate was reported as 60.1/1000 births, paediatricians analysed the risk of infant mortality rate between three infant methods; breastfeeding, mixed-feeding, and formula milk feeding. It was reported that formula milk fed infants were three times more likely to die than breastfed infants, when they had an infection during the first month (Takahashi 1996). The infants who were suffered from severe infections during the first month tended to come from mixed-fed or formula milk fed backgrounds (Yamamoto 1983).

A national health study in 1977 followed-up mortality rates at the infant's age of one, three, and five months and compared those infants who were breastfed, mixed-fed and formula milk fed (Hirayama 1983). It reported no significant differences in terms of the mortality rate at one month, but at the three and at five months, breastfed infants were less frequently visiting medical doctors than formula milk fed infants. A significant difference was found in the medical expenses (Hatakeyama 1983). This survey particularly followed-up breastfed infants coming from two different breastfeeding methods; one from no formula milk at all, and one from having just one or two bottles of formula milk for the first 12 months. As a result, the former group required only one third of medical expenses than the later group. Comparing between breastfed infants and formula milk fed infants, formula milk fed infants spent double the amount of medical expenses, especially for respiratory infections, bowel problems, and five times

more for skin disease.

The infant's physical growth was compared between breastfed babies and bottle-fed babies from the following variables; physical size such as baby's weight and length, physical development such as turning over, twisting, crawling, and sitting, and social behaviour development such as smiling and making a response to other's talk and touch. In the 1950s survey, the formula milk fed babies were bigger than the breastfed babies in their length and weight. In the 1970s, no difference was found which was attributed to the re-regulation of the ingredients and calories of formula milk in the 1960s (Takaishi 1983). In the statistical analysis, no significant difference was found. However, Takaishi(1983) concluded; breastfed babies showed more positive responses in social behaviours than the bottle-fed babies, and skin-to-skin contacts in breastfeeding could make positive impacts to develop the relationship to others. His conclusion follows his personal observations in his medical practices, not a statistical analysis, which I will discuss further in chapter 5; the meaning of knowledge in a Japanese context.

The medical discourse on breastfeeding illuminated the ambiguous message; breastfeeding is best, but powder milk should be instructed for the babies who are not enough breastfed. The message should be ambiguous since the numbers of mixed-feeding women have been substantial since the 1960s. In Japanese communication, people avoid emphasising the benefits of breastfeeding and are generous for the women who have not enough breast milk. The people have common-sense to understand them; not all of the women could breastfeed, even though they wanted to do so.

4-3-3. The nature of breastfeeding discussion

I started to look at the possible reasons for mixed-feeding in a Japanese context. Paediatricians seemed to be the people who could argue the importance of

breastfeeding, but also were the cause of the confusion in breastfeeding.

My question about the current mixed-feeding culture was also questioned by a paediatrician Yamamoto as follows:

> *'During the post-war modernisation and the rapid industrialisation, Japanese people forgot the real essence of breastfeeding; breastfeeding is not only food for growing babies but also nursing babies, through which the baby could gain physical and emotional attachment with the mother. It enhances their total health. The wrong recognition of formula milk emerged within medical professionals when they started to believe that formula milk was perfect and superior to breast milk. Some of them seem to believe that babies can grow up without breastfeeding. It is very obvious that people's attitudes changed since Japanese society has recorded the low infant mortality rate. During 1950s-1980s, medical professionals experienced the decreasing numbers of infants who died in hospital. At the same time, in hospital settings, formula milk has been used and exclusively breastfeeding was replaced by mixed-feeding. There is no direct relation between the low infant mortality rate and the usage of formula milk. However, people created some myth to believe formula milk saved baby's life. I have to say now is the time people have to rethink about the real meaning of breastfeeding: its humanity and the unique role of nursing babies'.*
>
> *(Yamamoto 1983 p2, translated by author)*

When I started research around breastfeeding issues, I had difficulty in translating the English word 'breastfeeding' into Japanese. Dr. Yamamoto explained those concept differences as follows:

> *'Until formula milk and bottle-feeding were introduced into the modern human life, the word 'breastfeeding' did not exist in English. Originally*

'nursing' is the word that means babies are fed, of course by mother's breasts. No bottles existed, no need to say about 'mother's breasts'. However, since bottles were introduced and a word of 'bottle-feeding' has become more familiar, people required a word that can be used comparatively to bottle-feeding. For me, an English word 'feeding' gives an artificial feeling, which food was just thrown into the mouth, no sense of caring to the person. The word of breastfeeding still sounds very artificial and the real essence of mother's role in breastfeeding has been missed out. The English word 'breastfeeding' cannot be translated into Japanese. In reality, 'BO-NYUU-EIYOU' ('mother'-'milk'- 'diet') is commonly used by medical professionals in Japan. However, 'BO-NYUU-EIYOU' is more about the nutrition. It missed the important connection between babies and their mothers. It would be more appropriate to use word 'BO-NYUU-HOIKU' ('mother'- 'milk'- 'nursing'). It is really important to identify that breast-milk is universal food for babies, but it is more important to identify the meaning of the mother's role, which babies are nursed and cared by'.

(Yamamoto 1983, p84, translated by author)

Yamamoto, in his writing, emphasised the humanity and nursing in breastfeeding. His argument represented the holistic idea of health, which was explained in Japanese; 'a good health is cultivated in a good 'KARADA' (means 'a body') and 'KOKORO' (means 'inner self').

4-4. The points for further discussion

In chapters 3 and 4, I explored the meaning of breastfeeding in the Japanese historical and social context. As a result of my review, I found a lack of empirical work which described breastfeeding from women's point of view. It also means that the existing Japanese literature could not clarify the sensitivity of the topic from the women's point of view.

When I overviewed the Japanese maternal care system, I compared it with the Western discussion undertaken over women's bodies. In the current modern context, the pregnancy is diagnosed by a home testing kit just after the women knew the slight delay of the regular menstruation. In the clinic, the baby in their womb is introduced by the ultrasonography, in which the monitor illuminates the image of the baby. It is a way of objectifying the things happening inside one's own body. The objectification and the way of attaching to their own baby influenced the women's decision making process about abortion (Sandelowski 1993). In the study, women perceived her baby as an object living outside from their body rather than one living inside their body.

In a Japanese context, the women's experience of pregnancy and childbirth has not been researched. However, when I visited the women for postnatal visits, they showed me the five or six series of the baby's image photos. I could not help but think that the experience of pregnancy surely influenced their attitude to the baby and breastfeeding. Before the ultrasonography became as a part of maternity services, the women should rely on their senses to feel the shifts in their own body. From my personal communication with a Japanese independent midwife who worked in a maternity home, the women visit the maternity home earlier due to the self-diagnosed kit. The early diagnosis made women's morning sickness heavier and the women required more medical treatments. In the Western research, the technological innovation in obstetrics made the female body as an object of treatment, which was called 'medical model of childbirth' (Oakley 1984), or women's bodies was argued as a machine of reproduction (Martin 1987). The women's feeling or emotions were separated from the process of pregnancy and childbirth. A lot of discussion is occurring about technological innovation and its impact on pregnancy and childbirth. However, breastfeeding has been missing from those discussions. Maybe it was because the medicalisation of breastfeeding could be stemmed from multiple elements such as personal value and belief and also social and cultural knowledge and expectations, rather than technology alone.

Yamamoto (1983) argued that breastfeeding is a part of women's childbirth and life cycle. As a midwife, I view breastfeeding as a continuous process from pregnancy and childbirth. My concern is with how women's experience of their own body during pregnancy and childbirth would or would not influence breastfeeding. Yamamoto (1983) emphasised breastfeeding as a social phenomenon ('SHYAKAI-TEKI-GEN-SHOU', 'SHYAKAI' means 'a society', 'TEKI' is a word to make a noun into an adjective form, 'GEN-SHOU' means 'phenomena') rather than a biophysical event, since breastfeeding is experienced as a part of social and cultural changes. Breastfeeding could not exist separately from social context, which supported my intuitive idea that breastfeeding should be researched in relation to women's context.

My literature review addressed some of the features of Japanese communications. In the next chapter, I will discuss the meaning of 'ZEN-JIN-TEKI'; the Japanese way of knowing, seeing and believing.

Chapter 5

The meaning of a holistic approach: the Japanese way of knowing, seeing and believing

This chapter was developed in order to clarify my viewing position as a qualitative researcher. It followed my personal reflection from talking with other qualitative researchers: 'research in general, but qualitative research particularly, should be considered as a product from the researcher's viewing position; how she/he can see its own world and believe it as a truth'. In addition, my personal background, coming from a non-Western culture, made me conscious about research being based on Western ways of knowing and seeing, which I could not simply take for granted. The Japanese research publications were translated from North American or British ones, in which I feel that the Western philosophical assumptions underpinning research methodology seems to be diminished in the process of translation. It may have happened that the translators did not have enough experience to consider the philosophical differences in the ways of knowing, which I experienced as difficult to understand in this study.

In this study, I used 'ZEN-JIN-TEKI' as my theoretical framework for studying breastfeeding in my cultural context. As a result of reviewing Japanese research books, I could not come across any discussions that reflected Japanese philosophy of 'ZEN-JIN-TEKI', ('ZEN' means 'inclusive or whole', 'JIN' means 'a human', and 'TEKI' is a word to make a noun into an adjective). In my personal definition, 'ZEN-JIN-TE-KI' is a way of understanding an each individual as a whole. I expanded my area of indicative reading into Japanese cultural study, philosophy, and Japanese language. However, 'ZEN-JIN-TEKI' was not discussed as such in a particular thought, from which I had to assume that it was too embedded in Japanese culture to be discussed in this way. In Japanese cultural studies, it was not illuminated by people coming from other cultures, which again suggests 'ZEN-JIN-TEKI' could not be explicitly understood by only living and observing Japanese culture.

I decided to develop this chapter as a form of self-reflective writing, in which my arguments were developed by reflecting my personal thoughts and experience living in my Japanese culture. Roth (2003) argued that reading of cultural materials would be an intervened action between the author and the reader's personal biography. In his argument, personal biography could be considered as dialectically related to one's own history and culture. I could use my biography as a dialectical material that emerged from the constant interactions between myself and Japanese culture. The critique of the Western dualistic approach was used for illuminating the features of Japanese ways of knowing. Hendry (1999), as a social anthropologist, argued that people's explanations of their own world were reflected through their view of 'time and space', which was called cosmology. Coming to the end of my research, I could see that this chapter played an important role to make a bridge for the audience to be able to understand the women's narratives within the women's ways of seeing.

In this chapter, I will discuss the concept of 'ZEN-JIN-TEKI' in relation to Japanese view of 'time and space'. It is termed 'multidimensional cycles', which is based on the elements of body/mind, and nature/human in oneness. The key to understand the multidimensional cycles is 'inter-connections', as it views all human beings as interconnected each other, and similarly humans and nature. The first part of this chapter will report on my detailed examination of the idea of 'ZEN-JIN-TEKI'; a holistic approach to understand other, and then review Japanese people's views of time and space. As I chose a qualitative research approach, the interview method was considered as my main data resource. The language was considered as the cultural representation of people's views of time and space. The last part of this chapter will review the nature of Japanese communication; the meaning of silence and 'KOKORO', and the meaning of people's emotions and narrative approach in a Japanese historical context.

5-1. The meaning of 'ZEN-JIN-TEKI' approach

In chapter one, I described my research aim as using the following two phrases; 'a holistic picture of breastfeeding' and 'describing it from women's point of view'. This section represents the result of careful examination of my personal assumption; which is about; how 'I' understand others.

5-1-1. 'ZEN-JIN-TEKI': my personal reflection

I tried to recall when and how I came to understand others by 'ZEN-JIN-TEKI' manner. My memory started from my grandparents, who lived through the earthquake in Tokyo in the 1920s and experienced two World Wars. They told me that 'humans are made to live by nature. The people who could work for other people will have the most precious life'. I could also remember my reading of a Japanese archive of 'KO-JI-KI', which was written about the origin of Japanese people and Japanese land. It tells, at the beginning 'KAMI' (Japanese Shinto Gods), human and language emerged from the earth. The concept of 'ZEN-JIN-TEKI' means any life, human or creatures or natural objects, exist as the part of nature. Each individual life is different due to the nature which contains the different characters: each tree grows differently, whereby each tree has different flowers to bloom at the different year and in different seasons. This encourages people to live their own life uniquely.

Reflecting my early school days, the teachers encouraged the students to understand everything in a holistic manner. The school curriculum was based on a multidisciplinary approach, whereby children could study the range of subjects. It was believed to cultivate the broader view and to take various angles for understanding others. The first and the second year of university education were designed so that students could study broader subjects. The idea of holistic approach is applied for researching phenomena, which is described as catching 'ZEN-TAI-ZOU' ('ZEN' means 'inclusive', 'TAI' means 'a shape or a form', 'ZOU'

means 'a reflection'). When people want to understand the phenomenon; try to approach it in a way of understanding the whole picture, and then look at each part, and to make sense of the phenomena as a whole.

In a Japanese context, midwives are considered as a philosophical profession, as well as school teachers, medical doctors, lawyers, in which each profession requires a philosophy to work for others and society. 'ZEN-JIN-TEKI' approach or trying to understand the things from 'ZEN-TAI-ZOU' are considered as the essential philosophy for those professionals. From my experience of working as a midwife, the personal philosophy is a core of midwifery practice. I recognised that childbirth is a time when an ordinary woman becomes a philosopher; to think about the meaning of its own life; where and why we were born? When the women have a sick baby, their question becomes more crucial. They do not expect to have only medical explanations such as its cause or cure. The woman, as the baby's mother, wants to know the philosophical answer; 'why it happened to me or to my baby?'

This PhD study became a chance to expand my philosophical enquiry about midwifery into an explicit discussion. I was engaging in the comparative discussion through the entire research project. When I lived within my own culture, I did not recognise 'ZEN-JIN-TEKI' as a Japanese cultural idea, which is based on the elements of wholeness, togetherness, involvement and attachment with others and their environment. My comparative discussion around 'ZEN-JIN-TEKI' may give the trigger to discuss the value and the limitations of a Western dualistic approach, which tries to understand human behaviours under the format of body/mind, culture/nature, men/women, and emotions/reasons in separation.

5-1-2. Knowing my culture and representing it to others

The difficulty of articulating one's own philosophical framework was argued by using a metaphor of 'wearing lenses'. Slife and Williams (1995) suggested that

researchers were often unaware what sort of philosophical positions they took. When the researcher wore the rose-coloured glasses, they became to believe the world were all coloured by rose. In addition, the view of time and space took the role of 'mental lens', which became the place where the person combined the prior experiences with the ongoing world's events (ibid.). The above discussion gave me a trigger to examine the philosophical framework using the concept of time and space.

When I started to look at the original meaning of philosophy in ancient Greek, the philosophical quest was focused on; what is God? Why do humans exist? All those questions were carried out to seek the connection between the human's existence and the God (Erikson and Nielsen 2001). On the other hand, Japanese philosophy was focused on practical aspects of life; how to live with others in harmony, rather than asking the meaning of human existence. The different philosophical component influences the view of time and space. The Western model of time is called a 'linear model', whilst the Japanese one is 'multidimensional cycles', which influences peoples' attitudes towards their own life as well as others'.

From my experience of travelling in other cultures, I perceived that philosophy is an individual matter, rather than being defined as a single belief system within a culture. In other word, personal philosophy would not have a cultural boundary. In the study of human management, Taybe (2001) argued that culture should not be a single disciplinary system, as locating the polar opposites such as between collectivism and individualism. Each culture has been characterised as a mixture of multiple elements. The culture could be rather seen in a personal belief system, thus age, gender, education, and personal experience were the elements through which to construct its meaning (ibid.). His discussion provides me with a means to think about the possibility of discussing 'ZEN-JIN-TEKI' cross culturally, and suggests a personal dialogue would be the way to talk about the meaning of research and knowledge across cultures.

In the next section, I will explore the elements of Japanese cosmology; the meaning of time and space in a Japanese context.

5-2. People's attitude towards time and environment

In this section, I will describe Japanese people's attitudes towards time reflecting multidimensional cycles model, which considers 'time and space' are interacting in multiple ways, and its existence as external and universal.

5-2-1. The meaning of life: human's life as a cycle

I will look for the significance of viewing everyday life as a cycle in the annual calendar. Since 1873, Japanese society uses the solar calendar and the time is defined by the Greenwich Time Line. However, the Japanese national holidays follow the Japanese traditional 'KOYOMI'; the Japanese lunar calendar (It is different from Chinese lunar calendar), which divided four seasons into 26 sub-units of seasonal time. Practically it was/is used for people to operate fishing or farming; when people can go and should not go to sea or rice farming, from the preparation of rice paddies in spring to cultivating in autumn.

The four seasons with 26 sub-units reflects people's view of working each year as a cycle; which is considered 'spring-summer-autumn-winter' as one cycle. In the current Japanese social system, the new school year commences from April and finishes in March. For Japanese people, it sounds very awkward that the new school year starts from September and ends in July, in which are found North America or European countries.

The idea of a four seasonal cycle is used for describing the each stage of life:

- Spring: A time of birth, the life is very unstable, and requires somebody to look

after.

• Summer: A time of growth, the time of adulthood, it is the time that people are expected to grow and to learn the meaning of life from the real life experiences.

• Autumn: A time of cultivation, from the middle age such as 50s or 60s, when the whole life experiences are integrated into the happiness and wisdom.

• Winter: A time of going back to the earth, the life is going to rest and preparing for the birth.

I could not say that all of Japanese people believe in reincarnation. However, I perceive it is common to hear this seasonal metaphor when Japanese people talk about their lives.

Hendry (2003) described the modern Japanese people's life as living in 'a ritual harmony', where certain rituals were practiced from time to time through the year. Those Japanese rituals were explained using the concept of 'KE-GARE' ('KE' means 'natural energy or energy for life force', 'GARE' means 'to be weakened', the word implies a tree was going to die), which was the condition where people's energy fell into disharmony (Kitou 2002). The physical strains such people engaged in the task of seeding in rice paddies was considered as the condition of 'KE-GARE'. Therefore people with families and community together take break and have a dinner together.

The women's reproductive health such as menstruation, pregnancy and childbirth are considered as a state of 'KE-GARE', when the family need extra care for the women as well as their newborn babies. The following rituals are carried out after birth to the baby's first birthday:

• 'UBU-YU': The ritual of baby's first bathing after birth.

• 'OSHICHI-YA': Seventh day after birth, to give a name and have a family dinner.

• 'OMIYA-MAIRI': One month after birth, the baby, the mother, and the grandparents go to the Shinto temple to pray for the healthy growth of the baby.

• 'KUI-ZOME': 100 days after birth, which is the first day the baby starts to eat the ordinary food, and prayed that the child will have no problems to get food for the whole life.

The children's three, five and seven year's birthdays are the age of 'YAKU-DOSHI', in which children are getting into an imbalanced condition and the parents give special attention and extra care to maintain children's physical and emotional condition. The family also go to the Shinto temple and to pray for their healthy growth. In adulthood, 'YAKU-DOSHI' ('YAKU' means 'a bad cause or an evil function', 'DOSHI' means 'age') appears at the male age of 25, 42 and 60 years, and the female age of 19, 33 and 60 years. When some family members are in 'YAKU-DOSHI', they join in the special praying ceremony on New Year Day.

After the age of 60 years, the ritual shifts into a form of a family celebration.

• The age of 60 years: 'KAN-REKI' means life is expanding from the age of 60.
• The age of 77 years: 'KI-JYU' means the age of filling with joy to live.
• The age of 88 years: 'BEI-JYU' means the age of full of cultivating rice.
• The age of 100 years: 'HAKU-JYU' means to go back to the purified stage, in which the person is re-born.

In this life cycle, 'ageing' is concerned a positive value as their lives are full of lived experience, which turns full of joy and wisdom. The older generations are respected by others, as they are able to help young generations using their wisdom. It will promise the family good fortune in future.

Viewing life as a cycle, the meaning of each life event such as marriage or parenthood or aging or death could be existed as a shared cultural value from generations to generations. For example, parenthood is explained as the time when people learn about the meaning of life and the gratitude towards their own parents. The family rituals are the time when young generations are able to learn

the meaning of life and their own body. In this context, the individual body is considered as family possession, which was gifted by ancestors as well as their own parents.

5-2-2. The meaning of time and environment in oneness

Bloch (1989) argued that the Western psychology assumed that human cognition developed by receiving ready-made information from the previous generations. In this context, environment exists outside or separate from the human, therefore the human became in a passive position to receive the information from the environment. Japanese cosmology views human and environment as interacting from time to time, which is described as the relationship between 'a mirror and its reflection'. Here, I will discuss its meaning in relation to Japanese people's attitudes towards health and illness.

The traditional Japanese medical books described the human body as the manifestation from four natural energies: fire, water, earth, and wind (Nishikawa 1992). The condition of illness was described as the imbalanced energy among the four elements (ibid.). Any illness was induced by the environmental factors; inability to adapt to changes in the external environment such as weather, and poor diet and sleep, and worries or anxieties. The medical doctors paid their attention to look at the environment. People kept their own environment clean so that they could avoid inducing any cause of illness. People's emotions such as anger, jealousy or greed were considered to make a bad influence on their own environment; therefore people are expected to control their emotions.

The interaction between human and environment is also described as a cause and effect on human life. The idea is not as simple as explained by a one-to-one relationship. Therefore Japanese people behave to others with the most generous and polite manner. This cultural assumption makes people to be responsible for their own environment, whereby everyday life settings would

influence the present life and the future life condition. In the hidden cultural assumption, the people are expected to respect the other people's time and space as well as their own.

5-2-3. Japanese people's attitudes towards time

Comparing people's attitudes to time to those of Western people, Japanese people were loose to time (Tsunoyama 1984). It seems awkward considering the punctualities in the modern Japanese social system. The notion of 'time is money' was introduced in the 1980s, but still Japanese people consider time as a public possession or a shared value (Tsunoyama 1984). The idea could be referred to the usage of time in the Edo periods in the 18th century (ibid.). The Japanese time followed the irregular time, in which the length of the day and the night was shifted each day, as the length of the day and the night was not equal each day through a year. In summer, the day time was longer than the night. The day time was divided into six units as well as the night time. As a result, the one unit of time was different in the day and the night, and the spring, summer, autumn, and winter. This made Japanese people's attitudes to time flexible and loose. The time was announced to the public by ringing the bell of the Buddhist temples. As the result, each community was governed by the community time as the time existed as a shared value.

As I have mentioned before, the seasonal cycle was important to operate the rice farming in Japan, which required the mutual aid among people in the community (Kenmochi 1978). Especially the big seasonal tasks such as seeding, preparing the rice pad, planting, and the cultivation were operated by mutual aid, which should be completed within the certain time. Otherwise, the seasonal events such as annual visiting of typhoons in autumn would affect the rice harvest. The management of water was regulated across the communities by time (Tsunoyama 1984). If somebody broke the rule, the family was excluded from the mutual aid work, which put the family in danger. In the area of manufactures or

craft workers, they also worked as a team. The time was considered as a shared possession within the community members.

Coming to the 1960s, the number of the population who engaged in agriculture declined and the Japanese people's life shifted into a Western style. The Western idea of individualism was translated (and misused) as 'individualistic idea', in which the idea of Western privacy is used by people who wanted to live in 'self-centred life style' or 'egoistic life' (Kiriyama 2004). However, as Tsunoyama (1984) argued, among the majority of people, the time was valued as a shared possession, which was used for people to live in harmony.

As a result of reviewing the concept of 'time and space', I found two concepts could clarify the philosophical condition; how to live in their own life and how to relate to others. Japanese cosmology viewed language as a part of the environment, in which the language is used following the cultural rules; people live in harmony.

5-3. The role of language in the Japanese way of knowing

In this section, I will review the key features of Japanese communication and the hidden principles of Japanese conversations; how the multidimensional cycles of time and space influences the Japanese people's way of communicating with others. I will review three areas; the role of silence and the concept of 'KOKORO' in Japanese communication, the features of Japanese language including the grammatical rules.

5-3-1. The meaning of silence in Japanese communication

Living in a British culture, I recognised that 'silence' has a different meaning in each culture. In Japanese communication, people work with the assumption that deep grief or emotional pains are never expressed by words. When people

perceive that somebody is in a profound emotional state, they just leave the person and keep the space and time for that person to be able to reflect her/himself. The silence appears as the emotional support, which delivers more meaning than saying. In a Japanese context, a wise person generally does not to talk a lot, which was symbolised by the Taoist idea:

> *'He who does not know talks,*
> *He who knows does not talk'.*
>
> *(Chia 2003)*

In the Western scientific paradigm, 'to know' was not enough to describe 'what' about the phenomena, which was more about to answer the question of 'why?' The Western scientific knowledge meant to give the reasoning behind the phenomena (Chia 2003). On the other hand, in the Japanese way of knowing, 'to know' is neither about describing 'what' nor answering 'why'. As I quoted, the person who really knows about the phenomena is able to give the meaning of the phenomena through the personal reflection and to bring their experience and personal knowledge together into a form of practical wisdom. People who are full of wisdom are considered attaining the high state of 'KOKORO' and are highly respected from the members in the community.

The space of 'KOKORO' is perceived within the silence in communication (unspoken part of communication), which provides the time and space for the speaker and the listeners to engage in the process of self-reflection. Seale (2005) argued in his medical discourse analysis in the U.K. setting, when the silence lasted over seven seconds, the participants showed their discomfort to be there and made some comments or noise in the setting. I perceive that it is common that silence lasts more than seven seconds in Japanese communication. Moreover, seven seconds could be considered too short to reflect its own thought.

The Japanese language and communication are highly dependent on context,

which means people change the manner of talk and what they talk or do not talk about according to their time and space. As a consequence, it is common to see that the same person shows the different opinions in the different time and in the different place, with and for the different people. It has been described that Japanese people have two faces; 'OMOTE' (front or the veil shown to others) and 'URA' (the honest part of one's own opinion or the value which could only be shown within the group of people such as real close friends or family) (Doi 1971). The silence is used to moderate between people's 'OMOTE' and 'URA', which is the place the people's real feeling exists.

5-3-2. Japanese way of knowing: the concept of 'KOKORO'

In 'ZEN Buddhism', the meditation was described as the only method to attain the highest state of 'KOKORO', which was described as 'selflessness' (Cohen 1994). It was the state of mind that people have no boundaries between self and others (ibid.). In Japanese communication, people understand each other through the existence of 'KOKORO'. I will give the following examples to describe the meaning of 'KOKORO'.

The Japanese traditional performance, which were called '-DOU', were performed for this aim (Kenmochi 1978). 'KA-DOU' (Japanese flower ceremony), 'SA-DOU' (Japanese tea ceremony), 'SHYO-DOU' (a Japanese calligraphy), 'JYUU-DOU', 'KEN-DOU', 'AIKI-DOU', 'KYUU-DOU' (Japanese archery) were performed in order to attain the highest state of 'KOKORO'. In the process of learning, the teacher did not tell anything of the theoretical knowledge. Firstly, the beginners need to sit silently, and keep watching the teacher's performance. Secondly, the learners immediately engaged in the action by following the exact form as the teacher showed it. Through repeating it 100 or 1,000 times or their life time, the person could develop the highest state of 'KOKORO'. It is the condition to know the universal rhythm in life. It is important to emphasise the process of learning includes three elements:

• The capability of keeping concentration ('SHYUU-CHYYU-RYOKU'; 'SHYUU means 'concentration', 'CHYUU' means 'the centre', 'RYOKU' means 'ability').
• The sensitive and sensible eyes to catch the important elements of the performance ('KAN-SATSU-RYOKU'; 'KAN' means 'careful observations as well as looking at the thing as a whole', 'SATSU' means sensing).
• The ability of reflecting 'self' and other's thoughts through one's own 'KOKORO' ('JIKO-DOUSATSU-RYOKU', 'JIKO' means 'self, 'DOUSATSU' means 'to develop the profound understanding through in-depth self-reflection').

After spending some time for practice, the teachers might give some ideas to think about the meaning, but nonetheless the given advice is a just a reflective thought, not the answer or a theory or reasoning. (However, this does not always happen). The idea of engaging in the direct performance is very different from the parrot fashion or copying it without self-reflection. The role of 'a teacher' means to be their mentor, through which the learners could come to know the meaning of 'KOKORO'. The learners are almost to engage in the task of reading their own teacher's 'KOKORO'; in turn the teacher reads the learner's state of 'KOKORO'. A performance without 'KOKORO' is restricted by unspoken manners and also a good performance is just observed by unspoken manner, in which the learners establish the communication with their own teacher by spending a long time being with them. The language is not used between them, but a teacher with a high state of 'KOKORO' could tell the things in a non-spoken manner. The relationship between the teacher and the learners are established through the time and space, and the existence of 'KOKORO'.

Reflective learning with the above three elements; concentration, sensitive and sensible eyes, and self-reflection through 'KOKORO', are used in any Japanese education setting as nursery or elementary class teaching, which I consider a strong part of the Japanese way of knowing. In general, people are encouraged to engage in actions before making any value judgments about 'self'; how good

or not good at them they will be. As the time and space exists as the universal concept, 'KOKORO' could be a limitless space. This type of learning, which starts from immediate engagement with the tasks, is commonly practiced by the specialised professionals such as Japanese carpenters or gardeners. I think that Japanese midwifery follows this type of learning. The younger or student midwives are trained seeing the senior midwives' state of 'KOKORO'; how they are being with women and their babies.

In a Japanese philosophical context, the concept of 'KOKORO' made it possible to understand other's experience as they experienced it (Kenmochi 1978). In my research approach, the existence of 'KOKORO' is reflected in my idea of understanding breastfeeding from women's point of view, which I will discuss further in relation to Japanese communication.

5-3-3. The features of Japanese communication and language

Hendry (2003) described her curiosity as to why Japanese people seemed to be comfortable to describe how they were different from others; it could even be seen among the ordinary housewives. As I described, 'self' is about the state of 'KOKORO' in a Japanese context, which should be different from the identity that was understood in a Western context. In order to live with others in harmony, 'to know self' is the first rule children need to learn from their own parents, which includes to listen to others at the end, to watch the things that others do in silence, to reflect one's own self from seeing or listening to others, and to think about other's feelings before saying or doing something to others. For example, when the children are with adults, they should not join in the adult's talk. When people are in a group, the youngest should not talk even they are questioned. In the process of learning languages, children are expected to learn two sides of language; how to talk and how to not to talk.

The cultivating of a good state of 'KOKORO' in the children is the parents'

responsibilities, especially for the mothers. An example can be found watching small children playing with other children. When a friend asks him/her to borrow the toy and is refused it, the mother tells her child; 'if you are told 'No' by your friend, how do you feel?' The mother's message is; 'you must feel sad, so you should be generous to others' and also 'if you do not behave kindly, this will affect you. You should understand how others feel'. The control of one's own emotions is told as the important manner not to invite any conflicts with others. Children's behaviours are also influences on mothers to live with other people.

Hendry (1993) argued Japanese communication as a form of 'exchanging gifts', which the message was exchanged through 'indirect communications'. It suggests the meaning of 'a gift' was found in the unspoken part of communication. Doi (1971), a Japanese psychiatrist characterised Japanese society as having high dependency to others ('AMAE' in Japanese), in which the degree of unspoken language was dependent on the relationship amongst the people. When the relationship becomes closer, less language is used. For example, the older couple almost instantly know what each other think. Doi (1971) also argued that Japanese communication took the form of 'disagreement avoidance', in which people tried to avoid inviting any conflicts while they were talking. People were expected to sense the other people's emotions from the message flowing in the atmosphere. The meaning of Japanese communication is defined by the context. It means that any people's presence, while either being engaged or not engaged with the conversation, influences any communications.

I will summarise the features of Japanese language in order to give a view of how Japanese language is different from English. It will become a key to inform my methodology in the later chapters.

• In the very basic grammatical rule, the verb form comes at the end of the sentence including the meaning of 'does' or 'does not'. Unless knowing the very last word of the sentence, the listeners could not know whether the speaker is

ending with positive or negative ideas.

• Japanese spoken communication takes three forms called 'TEINEI-GO' (a formal language), 'SONKEI-GO' (respectful form of language), and 'KENJYOU-GO' (a modest talk, in which the speaker puts the self down). The choice of three forms of language is made according to the time and place, in relation to the people in the communication settings. Over usage of 'KENJYOU-GO' or 'SONKEI-GO' is considered as indicating an ill-mannered person. In the translation work, it would not be possible to demonstrate the clear distinction between three usages.

• Eighty per cent of Japanese sentences have no definite subjective such as 'I' and 'you' (Bryson 1991). The sentence starting with 'I' is considered ill-mannered or self-centred. Instead of using the definite subject, the conversation takes no subject or an indefinite subject such as 'we' or 'they'. The listeners need to engage in some guesswork as to whose perspective the speaker is talking about or what it means by 'we' or 'they' from the context.

• The Japanese discourses took the form of 'turn-taking' (Furo 2001). While others are talking, the other people do not interrupt the talk. Each sentence ends with the ambiguous end or with the silence, which is the time for people to see other people's or each other's responses and seek for the direction of the conversation, which is the technique to use for disagreement avoidance.

• The Japanese language is written with the combination of three phonetics. 'KAN-JI' is the character adopted from Chinese. 'HIRA-GANA' was invented as a simplified form from 'KAN-JI in the 8th century. 'KATA-KANA' was the phonetics adapted from 'HIRA-GANA', which was used for describing the overseas languages.

• Japanese language has many homophone terms, which are pronounced the

same, but have the different meaning. The meaning is inferred from the context.

• Each 'KAN-JI' has its own meaning and the Japanese term is written with the combination of two or more words. For example, breast milk in English is written the combination of two characters as 'BO-NYUU'; 'BO' is a character of 'a mother' and 'NYUU' is 'milk'.

These aspects informed Japanese communication as a form of 'negotiation'. The purpose of the conversation is to try to find how others feel and how each person locates her/himself in the process of synthesising each other's emotions. I revised Hendry's (1993) idea of Japanese language as 'wrapping'. In my perception, Japanese people are wrapping their 'KOKORO' as a message.

5-4. The meaning of philosophy and the role of explicit knowledge in a Japanese historical context

In the current Japanese research context, the narrative method is introduced as a new approach from the Western cultures. I personally felt it could not be new. As a result of historical review, I re-clarified that Japanese research has the area of fieldwork and the narrative approach, which was established in the 1920s and named Japanese empiricism (Watanabe 1976). In the final section, I will look at the meaning of knowledge creation and the location of narratives in the academic context.

5-4-1. Japanese way of knowing: before the Second World War

Chia (2003) argued that most Asian countries were based on the direct engagement with actions in their learning, rather reading or relying on the written theoretical knowledge. Japan was considered as one of those cultures due to the usage of non Anglo-Saxon language (ibid.). However, I rather viewed Japanese culture as relying heavily on written materials as well as learning from the

engagement with actions. In this section, I report on my review of clarifying the feature of Japanese people's attitudes to knowledge.

Firstly, Japanese society was based on high literacy culture since the first civil law established in 789. The first civil law resulted from the study of philosophical thought such as Buddhism, Confucianism, and Taoism, introduced from China and India. In each historical era, Japanese scholars studied the other cultural philosophies and integrated them into a Japanese law, which could achieve the aim that people lived in harmony. In each era of history, books and journals were published and widely read by the ordinary people. In the 18-19th centuries, a number of travel records or diaries were published, which introduced the different ways of life in the different local areas. The practical knowledge such as farming or fishing was written in the form of a year diary, which the younger family could live with the nature in harmony. In the 1880s, the literacy rate was reported as 70-80% of the whole population. The high literacy rate was considered as the reason for the rapid modernisation and industrialisation of Japan in the Meiji restoration in the 20th century (Watanabe 1976). In this context, the ordinary people played a key role to create and circulate the knowledge.

Looking at the modern history in the Meiji restoration, European philosophies, especially German and British philosophies, were thoroughly studied by Japanese university scholars between the 1930s and 1950s. Heidegger's phenomenology, Heuristic or Hermeneutic approach, social theories such as Marxist or Max Weber were all analysed, and the strength of those theories were integrating into the previous Japanese thought. The positivist approach was analysed, and the Cartesian thought, which was considered following the Anglo-Saxons ideas of God, did not accord with the Japanese nationalist policy of Shinto. As a result, the Cartesian philosophy was cut off from the process of adaptation, which meant Japanese positivism was just a method, not a methodology (Watanabe 1976).

Whilst the centralisation of knowledge was undertaken in university based approach, the Japanese way of knowing was established by the people who came from the ordinal background. The most well-known fieldwork was published by a Japanese folklorist, Yanagida (1875-1962). The study was based on ethnographic approach; to live in the field and to collect people's narratives about its local rituals, habits, and dialects. The analytical framework was focused on people's emotions, in which he used his empathy ('KYOU-KAN' in Japanese, 'KYOU' means 'together', 'KAN' means 'to feel') and represented it as narratives. The approach inspired people's imagination and empathy, and was read and supported by the ordinary people. It was called Japanese empiricism in order to distinguish it from the subjectivity and objectivity in European empiricism (Watanabe 1976). The Japanese empiricism was based on fieldwork in which the researchers use themselves, including their emotions and feelings, as a medium to understand other people's experience.

5-4-2. The meaning of self: after the Second World War

Japanese people are very conscious about their culture comparing with other societies, which was developed in two particular periods of time, during the period of Japanese colonisation in 1920 and during the post-war reconstruction (Yamashita 2006). The first period of time was based on the study of other Asian countries such as South Korea, China, some parts of Russia, Indonesia, and Micronesia, and Japanese scholars applied a Western anthropologists' approach to study other cultures and to answer the question; 'where Japanese people came from' (ibid.).

During the Second World War period, the North Americans studied the Japanese people and culture. Those studies were used for the operation of the post-war reconstruction, and then used by the Japanese scholars to re-examine the Japanese people's identity (Yamashita 2006). As a result, 'NIHONJIN-RON' ('NIHONJIN' means 'Japanese', 'RON' means 'discussion') became was a well-

established area by the 1980s. After the Second World War, the North American approach of rationalisation of knowledge became a major part of Japanese knowledge. At the same time, Foucault's social theory was studied with strong support as well as strong critiques by Japanese philosophers in the 1960s (Sato 2000). The modern Japanese philosophy took the form of mixture of the traditional Japanese philosophies, Western philosophies, and North American notions.

Looking at the Japanese historical context, the ordinary people are always to take the key role to create and to use the knowledge. In the current academic context, the scholars choose to publish their research in the ordinary journals, rather than the academic journals. As a result, the ordinary people are in the front line to access the most up-dated knowledge. Aoki (1989) termed this social phenomena as 'TAI-SHYUU-SHYOUHI-BUNKA' ('TAI-SHYUU' means 'ordinary people', 'SHYOUHI' means 'consuming', 'BUNKA' means 'culture'). The term of 'consuming' symbolises the speed and high-tech culture of circulating knowledge, which leads to the further critique; the Japanese culture lost its own philosophy to live with people in harmony and 'KOKORO' to respect other's time and space (Kiriyama 2004).

5-4-3. Japanese empiricism: the position of people's emotions

I had a good example to understand the significance of Japanese people's way of understanding others in the medical discourse of breastfeeding (see chapter 4). The paediatricians advocated that breastfeeding provided some advantages for babies' growth and emotional development, even though the advantage could not be obtained statistically. They were talking about breastfeeding on behalf of babies; how babies could feel whilst they were breastfed. The ordinary people or mothers read their ideas by synthesising their own emotions and personal experience. It reflects the features of Japanese communication; people could put a high value on personal experience ('KEIKEN-CHI', 'KEIKEN' means

'experience', 'CHI' means 'wisdom') and personal knowledge ('JITSU-SEN-CHI', 'JITSU-SEN' means 'practical', 'CHI' means 'wisdom'). The Japanese word 'CHI' has various meanings, and I defined 'CHI' in this context as 'wisdom', in which people's emotions are the driving force to transform a theoretical knowledge into practical wisdom. As a result of my review, I concluded that Japanese culture operated through high engagement of personal experience, reflections, emotions, and tacit knowledge.

I became aware that my approach for developing the research methodology was influenced by the Japanese way of knowing. Aida (1972) argued that the way that Japanese scholars integrated multidisciplinary ideas and recreated them into a new value system was 'AWASE-BUNKA' ('AWASE' means 'going together', 'BUNKA' means 'culture'). The process began with reviewing all the possible ideas and making a negotiation between those different systems and ideas. My approach could be explained by 'AWASE' culture, in which I developed my research methodology as the result of negotiation between the Japanese way of knowing; the emotions and the personal experience as the core of knowledge, and the Western way of knowing; objectification, reasoning and logic as the core of knowledge creation. It is also important to understand that my interview and narrative was based on the Japanese empiricism; which represents the process of synthesising each other's emotions.

5-5. My personal reflections

In this section, I tried to describe how my personal theory 'ZEN-JIN-TEKI' is related to the Japanese cultural value system. In the introduction, I stated my philosophical position; I step back from the things that I know about breastfeeding. The meaning of 'step back' would not imply the meaning that was used by Western empiricism; being detached from the things of the world (Slife and Williams 1995). As I described, I am coming from a culture where the attachment and involvement is the cultural value of living with others. The meaning of 'step

back' is not a separation from the participants. It is about how to reflect myself, my own thoughts and emotions. It is the only way possible to belief the existence of 'KOKORO'.

I will summarise the main points for developing my methodology as follows:

• The meaning of a holistic picture of breastfeeding could be developed in relation to women's environment, whereby the study of women's experience means to understand their experience within their individual life context.

• The Japanese concept of 'KOKORO' gives the assumption that could be possible for researchers to understand other people's experience as they experienced.

• The nature of Japanese communication is based on the negotiation process and synthesising emotions or exchanging each state of 'KOKORO'. It suggests that my position in the empirical work could be defined by each woman's attribution to others.

• The translation work between Japanese and English will appear more than a technical matter.

• The analytical framework should be developed as a way of making sense of women's ideas and feeling from what the women did not talk as well as what they talk in the interview.

In the next chapter, I will report on the process of integrating these ideas in the research methodology.

Chapter 6
Research methodology

This chapter reports on the process of designing the research methodology; how I brought my research questions and background information into a qualitative research context. As I described in chapter 5, I perceive my way of knowing is based on Japanese empiricism, in which the personal reflections and emotions exist as a part of knowledge creation. The idea of Japanese empiricism was not formally theorised in a way of research methodology. Therefore I designed research methods adapting from one in the Western social science, which I was able to maintain the rigour and logic in my study.

I chose naturalistic inquiry as a research paradigm to investigate my research question; 'what hinders and encourages women to breastfeed their babies in the current Japanese social context?' The paradigm provided the framework for investigating the phenomena in a natural setting; therefore it was consistent with my philosophical framework of viewing breastfeeding as a part of women's everyday life context. I designed my research using a step-by-step approach with two main phases. The aim of phase one was to explore the research question in the empirical field using a case study approach and to develop a data analytical framework that would be workable for making sense of qualitative data collected in Japanese. Phase two aimed to study breastfeeding through focusing on women's time and space. The research was designed having a longitudinal component of women's experience of breastfeeding. The detailed research design will be presented at the beginning of reporting each phase (Chapter 7 and Chapter 9). In this chapter, I will provide an overview of my research design.

6-1. Designing naturalistic inquiry

Naturalistic inquiry followed the theoretical framework of 'a discovery oriented approach' and 'inductive data analysis' (Patton 1990), which made it possible for

researchers to keep the flexibility of designing the research method according to the outcomes that were obtained from each research stage. The inductive nature of the framework was important due to the lack of empirical research that looked at breastfeeding practice in a Japanese context, especially from the women's point of view. The first task of my empirical work was undertaken to explore the research context.

> *'Naturalist designs are typically selected when little is known about a phenomenon or when the need arises, because of perceived biases or omissions concerning what is known, to return to the phenomenon in its natural, naive, or a theoretical state'.*
>
> *(Sandelowski et al 1989, p78)*

In my research, I stepped back from the things that I believe I have known, and look for the gaps between the things that are known and not known. I believe that it should be possible by using the state of 'KOKORO' or self-reflections.

In my research, I investigated Japanese women's experience in a Japanese setting. It is very obvious the research process involved working with the Japanese language and culture. Whilst the research was undertaken as a form of cross-cultural discussion, both sociological and anthropological approaches to understand 'culture' were considered whilst the inductive research process.

6-1-1. Designing breastfeeding research in a Japanese context

My initial research question was, what hinders and encourages women to breastfeed their babies in the current Japanese social context? Through the literature review, I identified the problems with breastfeeding.

• Theory-practice gap: the idea of 'breast is best' and women's struggle to do it in real settings.

• 'Emic' (women's perception) – 'Etic' (researcher's perception) gap: the gap between research and breastfeeding practice. The previous research approach was not able to illuminate 'emic' perspective of breastfeeding.

My research aimed to identify the reason behind the gap, which required two different types of research activities. Firstly, I clarified the gap from women's point of view, and then to look for the possibilities of understanding and filling those gaps both in practice and at a theoretical level. I developed my initial thoughts into a practical plan using a naturalistic inquiry, which has three features; qualitative data collection, emergent design, and inductive thoughts. I designed my breastfeeding research as a step-by-step approach with the possibility of conducting more inductive inquiry and the ability to explore further the gaps.

Phase one: The exploratory phase

The initial empirical work, the exploratory phase, required the interviewing of a small number of women about their experience of breastfeeding in my community in Japan. The entire aim of phase one was to explore the research ideas in the field and to seek the gaps or missing points in the previous theoretical discussions of breastfeeding. The following sub-aims were set for developing the detailed research design:

1). To explore the topic in the actual field and to identify the related areas for breastfeeding practice.
2). To examine the sensitivity of the topic of breastfeeding and to identify the language that women use to describe breastfeeding.
3). To experiment with my interview approach and data analytical framework through the process of interviewing, transcribing interview data and analysing them using the strategy of my data analytical framework, and representation in English.
4). To identify how the researcher's personal biography such as personal bias

and prejudice and personal framework influence the research process.
5). To identify the positive and negative aspects of doing research in one's own culture.
6). To clarify the areas and themes for the next phase of empirical work.

Phase two: More focused explanation of breastfeeding

Phase two was initially designed to bring the research question that emerged from the phase one empirical work into a profound study of breastfeeding, which could address the research question; 'what is the real essence of breastfeeding?'. The detailed design was developed in order to study women's experience of breastfeeding with a focus on women's biophysical and emotional shift, and environmental change. The concept of women's time and space was identified as the key to the design of phase two. As a result, a follow-up case study with an ethnographic approach was chosen with the following aims:

1). To look at breastfeeding focusing on women's account of time and space.
2). To identify the real essence of breastfeeding, which has been omitted from the previous breastfeeding discussions.
3). To identify the elements that encourage or hinder breastfeeding practice.
4). To identify the researcher's role in a long engagement with the women and its impact on women's experience and the findings.

The empirical work was designed to follow-up women's experience of breastfeeding, in monthly interviews, from the early postnatal period to the baby's first birthday. The analytical framework was based on 'a case-oriented approach', which was developed through the exploratory work.

6-2. Theoretical consideration of naturalistic inquiry

In this section, I consolidate the idea of naturalistic inquiry and discuss the

theoretical aspects of research method.

6-2-1. The character of naturalistic inquiry

The features of naturalistic inquiry were characterised by the following five axioms, which I summarised from Lincoln and Guba (1985: p37-38):

- The nature of reality (ontology): there are multiple constructed realities, which can be studied only holistically.
- The relationship between the knower and the known (epistemology): the knower and the known are interactive and inseparable.
- The possibility of generalisation: the findings are time and context bound.
- The possibility of causal linkages: it is not possible to make a clear distinction between causes and effects.
- The role of value: the research is bounded by inquirer's value, which stems from the inquirer's personal belief, the choice of paradigm, the choice of substantive theory, the values flowing in the context, and the conflicts or resonance among those four values.

The five axioms were used in designing the breastfeeding research:

1). The research is undertaken in natural settings, which is based on the assumption that the realities cannot be understood without the context.
2). The researcher uses herself as 'a human instrument'. The researcher's biography and reflections, tacit knowledge, and propositional knowledge are all considered as a part of research. The questions the researcher asked in the field, the analysis brought from the data, and the final presentation from the interpretation are considered as a product from the researcher's viewing position.
3). Breastfeeding is an aspect of human behaviour, and its meaning is constructed by the data obtained qualitative data collections techniques.
4). The data analysis is based on 'inductive data analysis', which enables to

represent the multiple realities, and provides the possibility of transferability of the findings into other contexts.

5). The naturalistic inquiry is an emergent design. No fixed preordination is given. It is based on the idea that the interaction between the researcher and the researched phenomenon emerges through the research process.

6). The credibility of data is established through the interactions between the investigator and the respondents.

7). The research findings are reported in a mode of a case study; reporting each case as one unit.

8). The conventional idea of internal and external validities is not appropriate to validate the data. Instead trustworthiness is established by spending a certain amount of time in the field, by the richness of the data or 'thick descriptions', and by using multiple data resources.

In the following sections, I report on the key theoretical considerations.

6-2-2. The mode of a case study

In naturalistic inquiry, Lincoln and Guba (1985) emphasised the importance of studying each data as one set of data, and encouraged researchers to illuminate the significance of the phenomena by reporting 'a case study'. Stake (1998) argued that 'a case study' was about studying an object for the aim of investigation, in which 'a case' could be a person, an event, an organisation or a cultural group. In this section, I will discuss in detail the qualitative interview method, data analysis, and representation of the data.

Research method: a qualitative interview

Leininger (1985) overviewed a qualitative method as follows:

> *'The qualitative type of research refers to the methods and techniques of*

observing, documenting, analysing, and interpreting attributes, patterns, characters, and meaning of specific, contextual or gestaltic features of phenomena under study'.

(Leininger 1985, p5)

Leininger (1985) argued that a number of methods were available under the name of a qualitative method. In looking at the two most commonly used methods; observation and interviews, the difference between the two could be described as follows:

'Whereas observation is an act of taking notice of something, interviewing is an act of communication'.

(Janesick 1998, p29)

In the main principles of naturalistic inquiry, interviewing was defined as 'a conversation with a purpose' (Lincoln and Guba 1985).

'Interviewing is a meeting of two people to exchange information and ideas through questions and responses, resulting in communication and joint construction of meaning about a particular topic'.

(Janesick 1998, p30)

The key component of interviews is that two people are talking, they need to communicate with each other, and the meaning of the topic is constructed through the conversation. In this setting, the interaction between an interviewer and interviewee is the key to making sense of the topic. In my study, I was interested in women's experience of breastfeeding in their everyday life settings. I chose the women's home for interviewing, in which I can observe their environment.

Concerning the actual research interview, Lincoln and Guba (1985) described the

distinction between structured and unstructured interviews as follows:

> *'..., the structured interview is the mode of choice when the interviewer knows what he or she does not know and can therefore form appropriate questions to find it out. ...The unstructured interview is the mode of choice, when the interviewer does not know what he or she does not know and both questions and answers are provided by the respondents'.*
>
> *(Lincoln and Guba 198, p268)*

As a result of indicative reading, I defined interviewing in my research from three perspectives; using an open approach, developing a dialogue with women, and using the interview as opportunities to learn from women. Interview skills and techniques could not be learnt by reading research textbooks. A qualitative researcher needs to train themselves by taking account of their own viewing point and the nature of the field including language issues, which Janesick (1998) called a 'stretching exercise' for a qualitative researcher.

Open approach and narrative account in interviews

Reflecting on my previous research experience of interviewing with Japanese women, I learnt that the opening question was the most difficult part of the interview process. In the research textbooks, the opening question is exemplified as 'please tell me about your experience or view of (the research topic)'. In my case, it would be; 'please tell me about your experience of breastfeeding'. However, I questioned whether this approach would be effective to reveal women's true feeling on breastfeeding. I set my opening question about women's general feeling of child caring.

My open approach might be considered too ambiguous, which could not measure what the research proposes to measure (Kvale 1996). However, still I was concerned that the open approach should be my interview approach. My idea

was supported by the idea of narrative approach, which was a way of exploring the topic using the interviewee's order and the information being structured by the participant's own interest (Sandelowski 1999). In the narrative interviews, the researcher's role during interviews was defined as to encourage the interviewee to tell their stories in a spontaneous manner and to put the questions which helped the participant to tell the story (Kvale 1996). I also chose this open approach considering the nature of Japanese communication, which I used interview as a negotiation process with the participant. If I stated from 'please tell me about your experience of breastfeeding', it is possible that the women would not feel free to talk about their honest feeling, which would hinder getting to know the real picture of breastfeeding.

Data analysis and representation : a case-oriented approach

Kvale (1996) argued that qualitative researchers were required to create their own system, which constructs the reliability of the data within their own framework. The qualitative data presents numerous possibilities to read the data and analyse them. In my research, I tried to read my data in a holistic way, so I considered it inappropriate to use a grounded theory approach or the coding and categorising in a conventional content analysis. Those approaches are used for identifying the pattern or variables of its cause and effect. I developed my data analysis system drawing on 'a case-oriented approach' (Sandelowski 1996), in which the interview data are read as a whole to gain an holistic understanding of the women's experience both reading what was told and was not told by the woman. It was also used to obtain the pattern of discourse, the form of language, and the meaning of silence, which is particularly important to read in the Japanese interview data.

I considered each interview as one case unit, through which I could develop my understanding of the phenomena within each woman's context. The idea of holistic reading could be explained by the following quote:

'The case-oriented approach is especially useful for showing how the same set of factors, varying in the same way, can interact differently and have different consequences in different cases, or how different sets of varying factors in different cases can interact to produce common outcomes in these cases'.

(Sandelowski 1996, p526)

A case study could be initiated by studying one case, in other words one interview. However, having multiple numbers of cases and comparing across the cases, the researcher could illuminate the significance of each individual context.

I developed my analytical framework of qualitative data as follows:

- I treated each interview as one unit of a case and studied the meaning of the case within the context.
- The totality of the story is the priority, which I named 'a message from the woman'. This total message is obtained while interviewing and transcribing the data.
- Reading written transcriptions as a whole and identifying the women's attribution to the experience as a woman's message.
- Following the women's message, more detailed analysis is conducted, which includes the process of reading the data line-by-line and identifying a key sentence or a phrase.
- After analysing each case independently, the themes and the meaning of the cases are compared across cases, which functions to illuminate the significance of each case.
- The credibility of the data is given by the different approach according to each research aim. In exploratory work, the interview data are explored by indicative reading, and formal and informal discussions with midwives or academic scholars. In the follow-up study, the final interview is set out to obtain the feedback from the

women, and to discuss my findings.

The framework of presentation of each case was undertaken in the form of a case report. As I focused on describing breastfeeding from the women's point of view, the interview data was represented as a form of women's narratives. During the data analysis, my role was a 'narrative finder', who could reveal the women's account of the phenomena. In the process of representation, my role was shifted into a 'narrative creator' who edited the many different aspects of the phenomena into a coherent story (Kvale 1996).

I chose the different narrative format to present my data, which I will discuss more in detail in chapters 7 and 9.

The ideographic generalisation and the sample size

Lincoln and Guba (1985) argued that naturalistic inquiry followed the idea of ideographic generalisation rather than nomothetic generalisation. The 'nomothetic' in positivist tradition meant following 'a law', which naturalistic inquiry did not follow. The ideographic generalisation meant understanding the phenomena based on the particular individual. As a result, the ideographic generalisation allowed for illuminating the exception from the law (ibid.). In my research, ideographic generalisation means that each woman's experience of breastfeeding would be treated as a unique individual case, and the researcher is drawing the features of phenomena through comparing the uniqueness in the context.

The idea of ideographic generalisation influenced the process of my decision about sampling and the sample size. As I applied the idea of a case study and proposed to study each individual case for developing the profound understanding of the phenomena, I presumed that my study would be initiated by a small sample size. I also planned following the inductive aspects of naturalistic

inquiry, that the sample size would be defined according to the actual research process and the results of data analysis. It would be decided according to the variation of the phenomena; how homogeneous and heterogeneous the cases were. The process of sampling and the decision on the size of the study will be described in more detail in the chapters to follow.

The researcher's role: the meaning of a practitioner researcher

The researcher's role in the field was described 'as a human instrument' in the naturalistic inquiry principle, in which the researcher's personal biography and reflections, and tacit knowledge and prepositional knowledge were all considered as the part of research (Lincoln and Guba 1985). As I considered myself as a practitioner researcher, I was more questioning about what is the difference between a theoretical researcher and a practitioner researcher in doing breastfeeding research. My question was not answered by reading research papers or research textbooks. Therefore I expanded my question through having a dialogue with other qualitative researchers.

The problem of a practitioner researcher such as medical clinicians or nurses doing research was described as familiarity to the field or the phenomenon. It was very difficult to look at the familiar practice with a fresh gaze (Atkinson 1999, personal communication). In addition, the practitioner researchers had the tendency to look at the phenomena with 'a problem solving mind' (ibid.). Even in ethnographic study, they tried to understand the phenomena under the framework of a cause and effect, which was considered as the positivistic tradition of medical practice. In his advice, we should start to describe 'what is happening' in the field and to use questions so that informants could describe 'what and how he/she was doing'. I perceived that 'why' types of questions are important to stimulate the researcher's reflexivity and to raise researcher's curiosity in the field. However, his advice made me think about the potential bias

of 'a problem solving mind', which may influence my research process to be less open or less discovery-oriented.

Concerning interviewing approaches, nursing researchers are very good at interviewing people, but not good at data analysis (Sandelowoski 1999, personal communication). This is often due to the lack of consideration of theoretical framework before initiating data collection. In addition, in qualitative research, the term of 'emerging' is often used in such sentences as 'the key themes emerged'. However, the term 'emerge' gave the wrong idea to qualitative researchers as if the key themes naturally emerged as the data were collected. Whilst I designed my study as an emergent design, I was very conscious about the role of the analytical framework, which I developed according to each research aim and also my role in the research setting.

The actual meaning and the role of a practitioner researcher was expanded through each empirical phase; as a result of interacting with the women and their babies. In the exploratory work, I carefully examined my role from women's point of view, and the researcher's bias and reliability and validity of the data will be reported in chapter 8. In the more focused explanation, whilst I used an ethnographic approach, my role was developed as a fieldwork researcher, which will be discussed in relation to the researcher's reflexivity and its impact on my midwifery practice during in the field in chapter 9. As a result of a long engagement with women's time and space, my role as a midwifery researcher appeared as 'an embodiment of a midwife', which I will discuss in relation to the key them of 'a craft work' in chapter 11, and the implications and limitations of my study in chapter 12.

About the research field

Here I present an overview of my research field, which I used for my empirical work.

Mitaka-city is an urban town in Tokyo. Its convenient location to travel to the city central, young generations came to live for temporally arrangements since 1960s urbanisation. The population is approximately 167,000, and the average number of childbirths was reported 1,000 - 1,400 per year. The social policy of Mitaka council has focused on launching the facilities for the social welfare and health services. As a result, the five community centres (a place for community groups to run the social activities, and also having a public library), three centres for children ('JIDOU-KAN' in Japanese, a space for children to play after school), and two sports centres were opened in the 1970s. In 1998, the Japanese Government introduced the agenda of establishing a child caring support system in each community, and two childcare support centres were launched, which were called 'SUKU-SUKU-HIROBA' ('SUKU-SUKU' is a Japanese metaphor for growing the children healthy, 'HIROBA' means open space) for children from one to five years of age, and 'NOBI-NOBI-HIROBA' (NOBI-NOBI is a Japanese metaphor for children stretching out their body and hands freely) for zero month to three years of age. The centres were opened in order to support professional housewives, who look after their children by themselves. The centres offers a day-care nursery service (the expense is paid by the women, equivalent to six pounds per one hour), and free counselling services by social workers.

Since 1963 the Mitaka midwifery association are involved in the public maternal health services. In 2004, nine community midwives, from 36 to 70 years of age, are the members of the association who work for postnatal visits under the co-operation of the city council. The national postnatal visit rate was reported as 30%, which was due to the shortage of human resources (Mother's and Children's Health and Welfare Association 2004). In Mitaka-city, the total number of postnatal visits has been recorded at about 80 per year. The service in Mitaka-city covers the second or the third time mothers and the women can request it within 60 days after childbirth, whilst other cities take the policy; offering it only for the first time mothers and within 28 days after birth.

The postnatal visits are made on women's request by a postcard. The reasons why women did not request the postnatal visits have not been known formally. An informal survey was initiated by the community midwives in 2003, which reported the reasons as the longer stay at their parents' home after childbirth longer or simply forgetting to send back the postcard. Even though the women send back the postcard, when the midwives contacted them to make an appointment, some of them said not to want to have the visit, because they were too busy or have no problems with child caring. Some husbands do not like to have visitors whilst they are at work. Ninety-five per cent of mothers attended 3-4 months' baby clinic at the city health service. The public found that the women who did not have a postnatal visit were more likely to develop a problem with child caring. This may have happened because those women were not aware of their problem or too isolated from the community that made them not able to ask for other people's help.

Using my community as a research field

I decided to use my community as a research field. I knew that I had the option to choose other communities for my fieldwork, but I did not. My choice was based on theoretical but also practical, and ethical reasoning.

Firstly, breastfeeding is a sensitive topic. Although I am a midwife, I could not say how much it was sensitive for women to talk about and also gate keepers. It seems practically difficult to find an alternative place for which I used for the aim of research. Still the research is not familiar, and also Japanese people, especially in public sectors, are very nervous about the usage of personal information that obtained through their services. Secondly, I am concerned that the new location and its impact on my self-reflection. From my practical experience of working in the next community, I found the different areas have different local values. It seems not possible to become to know it within limited

time for the research. This point was described by another community midwife as follows:

> *'It took ten years until I really feel I am a community midwife. The meaning of being a community midwife is... not just a midwife. I could talk with the mothers... which park is good to play, when mothers are coming to the park, and which café welcomes mothers and babies...which shop is good to buy fresh vegetables... Going by bicycle, I know who are living here and there... as you know, somebody shouts my name and I need to stop and chat. The mothers also talk about me. Now I know I became popular among mothers in my area...'*
>
> *(Personal communication with a community midwife)*

Lastly, my research was approved by Thames Valley University research committee in 1999. However, doing data collection in Japan, all the responsibilities of the research should be taken by a researcher's accountability. In addition, I was concerned the everyday Japanese newspaper reported the increase of maternal depression and the incidence of child abuse. I felt safer to do my research in my community, in which I could always ask for practical support from other midwives and also available resources. It was important to protect myself and also the women whilst I am doing research.

6-3. Summary

In this chapter, I reported on the methodological issues of designing qualitative breastfeeding research in a Japanese setting. Naturalistic inquiry was based on the idea of emerging design, whereby the theoretical aspects of research were addressed and the content of the research was carefully examined in each single research activity. The following chapters report on the process of developing a holistic picture of breastfeeding in a Japanese social context, which was the process of re-creating research method.

Part Two: Exploratory Work

Chapter 7

Reporting on phase one: exploratory work

In chapter 6, I described the overview of the theoretical considerations of the research methodology. The following chapters are devoted to report the process of bringing those ideas into the research context. Part two is presented in the two chapters; chapter 7 and 8, which reports on the exploratory work. In chapter 7, I describe the process of the exploratory work from three aspects; how the research design was put into the empirical context, how a case-oriented approach was developed through the actual research process, and how the role of a practitioner researcher was identified from the women's point of view. In chapter 8, I present the interview data according to chronological time. The women's narratives are arranged in the order in which they occurred, and then I discuss the meaning of 'women's context' in relation to my research approach and Japanese language.

The exploratory phase was designed to explore the meaning of theory-practice gap in breastfeeding in the field. The detailed research design was developed in order to reveal women's views of breastfeeding. Three women were interviewed at 3-4 months after childbirth, the data was analysed using a holistic reading, and the findings were represented in a format of narratives that enables to illuminate the following features of my research approach. Firstly, the narrative form helps to demonstrate how my open interview approach influences the women to talk about breastfeeding. Secondly, it demonstrates the idea of 'a holistic reading'. Lastly, it gives some ideas to understand the features of Japanese conversations, even after the interview transcriptions were translated from Japanese into English.

7-1. Research design for phase one: exploratory interviews

In this section, I report on the detailed research design and the process of implementing the exploratory interviews in my community.

7-1-1. The focus of exploratory interviews

The first empirical phase was named exploratory interviews, whereby it was undertaken in order to explore the nature of the topic, the nature of the research field, and the nature of the Japanese communications. I set my position as standing back from the things that I believed I knew about breastfeeding and trying to understand breastfeeding from the women's point of view. The detailed research procedures were developed taking into account the theoretical and practical considerations. The following sections report on the timing and the place of interviews, the sampling, and the detailed design for a case-oriented approach.

7-1-2. Interview setting and sampling

I firstly looked at several examples of breastfeeding research in order to identify the appropriate timing of interviewing women about breastfeeding. A study of women's experience of childbirth discussed the accuracy of women's memory of childbirth after one year (Penny-Simkin 1992). Looking back at my previous research experience when I interviewed women at 12 -15 months after childbirth, women were able to describe their experience from pregnancy, childbirth, and breastfeeding. However, I found their talk was based on the memory of something either very significant or problematic for them. It did not fit with my research aim; describing breastfeeding with a more detailed context.

In my exploratory work, I decided to interview women at 3-4 months after childbirth visiting them at home. It was made considering the practical aspect of women's lives and the nature of topic. Firstly, from my practical experience in my community, I considered that the timing of 3-4 months after childbirth would be close enough for women to talk about it in detail, but not too close to reflect their feeling or emotions towards breastfeeding. I perceived whilst people were too close to the event, they could not talk about their experience to other people. Secondly, I was concerned that the interview required energy to talk. From my practical experience, women began to settle in their new lives around 3-4 months, so that they could give a bit of time for me to interview them. Thirdly, I chose the women's home as a place for interviews, which women did not need to worry about going out with their baby, and I was able to know about the women by looking at their environment.

The next step was to think about the way of recruiting women for the interview. The sampling strategy was developed taking account of my personal bias as a midwife. At this stage, I had returned to my community midwifery work and had my own cases of postnatal visits. However, I decided not to use my cases for the exploratory work. I recruited the women from the other community midwives' cases of postnatal visits, in which the women could see me as an interviewer in the first place and possibly it could make the women being relaxed to talk about breastfeeding.

I asked one of the community midwives if I could use her cases for my research. The midwife was 58 years of age and I had worked with her for eight years, which is enough to know her personal biases as well as her strengths in the practice. She had some experience of doing research and brought her experience of research to review the cases of postnatal visits.

I set one inclusion criteria for my exploratory work; women and their babies who were healthy at the postnatal visit. Feeding method was not considered

as the inclusion criteria, as I tried to explore the meaning of breastfeeding from the different patterns of infant feeding. The midwife and I reviewed her cases, from which I could make an arrangement of interview at the targeted time of 3-4 months after birth. Firstly, I read the 17 cases of that particular month, which comprised a sheet on the women and their baby's condition. Secondly, I asked the midwife to tell her impression and the women's response to her visit. At this stage, 10 possible cases were selected including first, second and third time mothers. The rest of the cases were excluded due to the baby's or mother's health problems. During the review, the midwife also considered the aspect whether the women could have 'healthy conversations'. That is considered that some of the young generations just answer; 'yes', 'no', or 'I don't know' manners. The midwife advised me not to include those women for my research.

From the review work of the cases with the midwife, I noticed that the second and the third time mothers were more concerned about the eldest children, which seemed less appropriate for the exploratory work. I added the further criteria of focusing on first time mothers, and five cases remained. The cases were ordered by the date of the baby's birthday from earliest to the latest. I asked the midwife to make the initial contact with the woman whose baby was the earliest birthday and to obtain the woman's permission for me to contact her.

7-1-3. Doing research by a case-oriented approach

Qualitative interviews are often initiated by recruiting multiple numbers of cases at the same time, doing the data collection within an intensive time frame, and pooling the data before doing the analysis. In contrast, a case-oriented approach requires a different process; each case was studied thoroughly before going to the next data collection, the result of the case can be used for the criteria of the next sampling, with which the first case

considered to establish the ground of selecting the further cases (Sandelowski 1996). In my research, I considered the onset of the study was from the initial contact made by the phone with the women. I developed the following procedures to study each case as a whole:

1). Any contacts or information gained in the setting is included as a part of interview data, which is used for eliciting the woman's message as a whole.
2). The second analysis is undertaken whilst making written transcriptions from the tape-recorded data. While listening and writing, further messages were identified.
3). Reading the written transcription. Possibly at this stage, line-by-line reading is required for understanding the message.
4). Comparing the findings from detailed reading and the message obtained during the interview, the significances of the woman's story are re-clarified.
5). Using the key messages, a woman's narrative is developed with which could illuminate the features of breastfeeding within each woman's context.

The five stages above were planned to be conducted firstly in Japanese transcriptions, and then the stages three to five were repeated after the data were translated into English. The sample size could be defined taking account of the time required for analysing each case. I anticipated approximately five cases would be a reasonable number to explore my research ideas in the field.

7-1-4. The intake and the actual interview schedule

After the review work with the midwife and having the woman's permission for make a contact from myself, I phoned the woman and sent an invitation letter. The letter described the aim of my research, permission for tape recording, and the protection of her privacy and confidentiality. One week later, I phoned again if the woman agreed to take part in my study.

The first participant was 22 years of age and a housewife. She started breastfeeding during her hospital stay and was bottle-feeding at the time of interview. Completing the data analysis for the first case, which took for three weeks, I recruited the next woman, who was 28 years of age, and was breastfeeding at the interview. I finished my data analysis and recruited the third woman, who was 26 years of age and was mixed-feeding at the interview. The different infant feeding methods provided the different context to study breastfeeding. I also realised that my content of interview started to get into a certain pattern whilst repeating the three interviews. I perceived it made to narrow down my ideas, even though I was using the open interview approach. I reconsidered the aim of exploratory work and stopped my interview at the third case, after which I could focus on a more detailed study of the meaning of women's context, expand my reflections and explore the nature of topic, and identify the further themes and questions that could lead the next step of my empirical work.

7-2. Findings part one: women's narratives

The first case was considered to establish the background for my exploratory work, whereby I report the first interview as a process; starting from the descriptions of entering the setting, the process of the interview, and my reflections from the interview. This format illuminates the woman's response to my opening question and the woman's reflection to talk about her experience of breastfeeding. The second and the third case are represented into the following format; a summary of the case, the woman's narrative, and my reflections from the case. Three interviews lasted 90 minutes and it is not possible to include every single word out in this section. Some parts of interview are summarised in a way of representing the storyline and the women's narrative account, which will be indicated by the following signs:

Direct quotes of women's comments: Plain with double quotation mark "...."
Summary of women's comments: Plain with bracket mark (....)
The questions and comments from the interviewer: - followed by Italic
Either hesitation or the sentence has no clear ending: the sentence begins or ends with the three full stops '...'
To add some explanation about the word: Plain with square bracket [...]

7-2-1. Case 1: Mrs D

The interview setting

It was one o'clock in the afternoon. I arrived at the front door and rang the doorbell. There was no answer and no voice to reply. I waited for another few minutes, and then rang the doorbell again. There was still no answer. When I took one or two steps away, I heard the door chain move and the voice was coming, '... Sorry, sorry. I kept you waiting. Please, please come in...' I was invited to go into the living room and saw her baby was lying on the baby's bed whilst the nappy was open. Mrs D explained that her baby was constipated, and every two or three days she used a cotton swab for stimulating the baby to push out stool. She came back to the bed and tried it again, but nothing happened. I asked if she would like me to help. It took a bit of time before the baby started pushing. She gave us massive. On the living room table, a feeding bottle was left with 100ml formula milk inside it. I held the baby's buttocks and helped Mrs D to change the nappy. After the baby was dressed properly, Mrs D went into the kitchen, washed her hands, and came back with a tea tray. The baby was awake, but not crying. She sat opposite me cuddling her baby on her lap. She apologised again for keeping me waiting and then offered some tea.

- *Before making a start, do you have any questions?* (She shook her head, and said...)

"Not at this moment... We talked about your research on the phone..."

- So... can I make a start?... (She nodded)... firstly... how old is your baby, now?

"Now... she is... two and a half months..."

- ...and how do you feel.... about like....your life... I mean your life since having your baby...

"Um...It is a real difficult question, isn't it?... Um...How I could say... I ... maybe... enjoy everyday my life... maybe... but I worked before (having a baby) and... So I feel I miss something... Of course (I feel) my girl is very sweet and I love her very much... but I feel something... I miss something... You may know... It is often said... for example in TV programmes... child caring is told like... it occupies the whole life and it feels as lasting forever, no time for myself... I often think it is so true... No, no, I am not serious, but ... No, it would not be the thing you want to hear for your research. I am sorry... I am not able to answer your question...Maybe I would be useless for your research..."

- No, No... Of course, you are absolutely OK. Let's carry on. Umm..., So, maybe... Let's try to think like ... what is the most difficult thing in child caring?

".... Um.... difficult thing?... Let me think... Nothing particular... Nothing makes me to feel difficult... she is healthy... everyday is just busy ... Probably the problem is... my concern is all about my baby... It may not be a good thing. For example, I would like to understand more about her...like... why she is crying. Sometimes I feel her cry means something wrong happens to

her, but I could not understand her... and I sometimes become really anxious about her crying... Any other things (talking to herself)... I cannot say exactly, sorry... but... maybe because of my previous job...my work is about looking after children... When I left my work, my boss said to me like, until the age of three is the real important period for children. Of course, emotional side ... Actually having my baby, I become really cautious about each bit I am doing for her... when she is crying, but I cannot cuddle her immediately, it might affect her... (Thinking like this) it scared me... Thinking about my work, I knew my attitudes influence children's development. ... So for my baby... concerning her emotional side, my attitude will influence her character, isn't it???... She might have a very good nature, but because of me, she might be wrongly developing. This may be the most difficult thing..."

- ... so, could you explain a bit more about your work?

(She was working at the children's nursing home for two years, where children from the age of three to eighteen years old are cared for, who have family problems like abuse, parents' divorce, or health reasons. Her husband works at the same children's nursing home. She explained her feelings about the children who are cared for in the nursing home as follows).

"...The children at the nursing home, they were lonely, isolated, stressed and having emotional problems..."

- I don't know it is good to say 'serious', but when you knew you were pregnant, did you think about your child caring in a very serious way?

"I was not and am not very serious, but I sometimes feel like... Maybe I am a bit... nervous? Maybe... Basically I believe... babies are all born pure nature, and parents and other family member's attitudes influence the baby. In my

case, it is me, always staying close to her... I feel happy being with my baby... but sometimes I feel child caring is a lonely task..."

- So what things make you feel happy?

"Well... her smiling. Is that alright to say this kind of small thing? *(I say, yes)* ...When I see her smiling, it reminds me the feeling of... she was in my womb ten months... that time makes my baby so special to me. Everyday I get this special feeling to her. When I was at work and with many children, I felt a bit annoyed by children... But... for my baby, I am very different. I have never been bothered by her. I can do anything or everything for her. Of course, it is parents' responsibilities and it may not particular thing to say... Anything else? (Talking to herself)... I also feel the relationship with my husband has changed... Living as a couple, we were very good, but always talked about our work... Now ...she has become our central concern... always talking about her, this gives us (she and her husband) a kind of contentment..."

(She did not think a lot about child caring before childbirth such as how to change nappies or to feed babies. She was only concerned about what the childbirth is like).

- ... so, let's talk a bit about your childbirth... you gave birth at...

"....Yes, M hospital..."

- ...How was that?

"... um.... it was good... maybe..." (a long pause)

- ... so... how was the hospital stay?

"In hospital... Um..." (a long pause)

- (I am trying to think about the meaning of a long pause; if she may have no idea to talk or it might indicate she is reflecting or hesitating or reliving a bad experience. I bring out a further question)... maybe... if I can say... how about your childbirth?... was it....

"...about my childbirth? Um... (a long pause, and at the end she started talking). The hospital staffs were very kind, but... it is not a problem of the hospital... It was... me... because... I had a sleeping problem... since 10 months (of the pregnancy)... My womb was very heavy... maybe because of that, I could not sleep... I might have been a bit nervous, maybe... I stayed awake through the night... sleeping... like ... from 8am to 5pm... I know ... it was not healthy, but it was the only way I could get sleep... After birth, my feeling of something inside was still there... I could not sleep... also at the different environment like staying in hospital... made me difficult to sleep... I feel... breastfeeding was a real pain... Somehow I don't know, but I believed breast milk was naturally coming after birth... Yes, my breast milk was coming, but... my breasts were so sore... I need to ask you...Should every mothers' breasts become like that?... It was more than what I thought. The hospital midwives or nurses?... anyway... The staff expressed my breasts and it was painful. I did not like it... But, I could not say no, because I had to face it. I know it was for my baby... It was very hard time. I really wanted to go back to my home and hide from them... I went back to my parent's home and spent one week with my parents... I was told to breastfeed... It was really hard to listen... Coming back to my home, I was still told like... 'Try breastfeeding'... In addition, I found... cooking was a hard task... when my husband is on night shift, I eat alone. It was not so nice...My life became... no proper eating, once a day eat something very simple... no proper sleeping... I noticed my breast milk was less and less... My mother told me... 'Better to continue breastfeeding'... I was so tired and I did not want to eat. Eventually

my breast milk stopped, and I started (formula) milk feeding... it was...at the end of one month..."

- ... sorry for asking more about... but... when you left the hospital, you did breastfeeding and bottle-feeding...

"... yes... I firstly breastfed and then... added some milk..."

- ... Do you remember how much milk you used...?

"... How much...? I could not remember... it was a bit odd... maybe 50 - 60ml?... probably... I don't know now... I spent 40 minutes... for breastfeeding... the hospital staff said one hour was too long, do 10 minutes for each side and repeat it several times... I did so... but my breast milk became less and less... I squeezed my breasts, tried not to waste any drop of breast milk...but... the things did not work and I changed to formula milk only.... But... somebody always asked me about breastfeeding..."

- ... what do you mean somebody ask about... ?

"... My mother, for example. She still says to me... breast milk is better than formula milk".

- ... and do you know the reason?

"No, I don't know. Maybe she breastfed me... I don't know... Probably... she believes breast is best... I don't know... my mother seems to have a very strong sense of it... during my college course, I should have studied about breastfeeding, but I could not remember... The other people..., like... meeting my friends... They all asked me like... 'Are you breastfeeding?'... I feel sad.... How can I tell them I can't breastfeed?..."

- ... is that because... you feel that you would have liked to breastfeed longer?...

"... yes, probably... If I could make a little bit more effort... more eating and sleeping, I could have more breast milk... feel so sorry for her (her baby)... and maybe it is the reason for her constipation... How do you think? ... And also how do you feel the idea of 'SKIN-SHIP'. When babies are not breastfed, do you think it is true they have a problem of 'SKIN-SHIP' [This is a Japanese-English word, which means skin to skin contact between a mother and her baby]. So... do you think she is not having enough 'SKIN-SHIP'? ..."

- ... um... It is very difficult to answer... I cannot say yes or no... I can see you did your best. I can see you are healthy and your baby is healthy. It is the most important thing, isn't it? ... Sorry, I may not answer your question (she answered she feels alright)... So, could I ask a bit more about hospital practice? I am aware you are talking about the different advice from the midwife and the nurses in the hospital. Do you have any ideas about better support now? If they supported you differently, would it make a difference?

"Um..." (a long pause)

- ... so maybe... try to ask like... could you explain their approach?

"...um... In postnatal ward, the midwife who supported my birth came to see me when she was on the shift. She said... When my baby was not suckling properly, better to leave her from the breast and try to latch on again. We (with her midwife) agreed to practice it until my baby got a right way. But at the night shift, other nurses came to me and said that the different positions were better... supporting baby's neck in this way or that way... try to keep the eye contact... I know the point... But... it was just too much..."

- ... it sounds too much... really....

"... and... at the end we (she and her baby) got the way the midwife told me. It did not take long until we could do it...but..." (a long pause)

- ... so, after leaving hospital... who supported your breastfeeding?... Is that... your mother?

"... No... she was... not... She said... I should breastfeed. She warmed up my breasts by hot towels... or said to eat rice cakes. Of course, when I was at my parents' home, she cooked for me... onions, potatoes and vegetables, and miso soup for each meal... All would help to produce breast milk..." (a long pause)

- ... so... any other people say something?...

"... No, but when I met someone, they asked me like... Are you breastfeeding?..."

- ...maybe... was it your friend?

"Of course, my friends all did. When I visited my previous work place for 'OHI-ROME' [a Japanese ritual; after having a baby, the parents bring their baby to show other relatives or people], I was asked 'are you breastfeeding?' I know they did not mean it. It is a kind of greeting, maybe. I could not say no... So I just said like 'Well...', and then 'yes, I did... but, gradually it did not come out' and they fell silent. I wonder, is this a question [Are you breastfeeding?] that everyone would like to ask a new mother?... Maybe... yes (she talked to herself), I might ask the same question if I met somebody having a new baby. But... even my male friends... they asked about breastfeeding... Only one,

my best friend... she said 'It is alright not to breastfeed. The formula milk is as good as breast milk. Do not think too much about it'. In fact, many children grow up healthy by formula milk, as you know...Until now [talking in the interview], I did not realise ... I was asked so many times about breastfeeding... it seems a bit mad..."

- ... and... did your husband say anything about that?

"... No ... He did not... He wants me to stay with the thing that I really feel comfortable with... so, I feel like that... he seems alright about formula milk..." (a long pause)

- So... maybe about your husband... um... did he say anything about your birth? He was there (yes, he was)... and was it planned?...

"... When we (she and her husband) visited the hospital, we heard about husband's attendance at birth. We did not have any special reason... just we got an interest..."

(They read the maternity journals together. They just bought a new video camera and it seemed a good chance to try it. On the day of birth, her husband was working shift, but his colleague covered his shift).

- ...Did your birth start naturally?

"No... My birth was induced. What is the name of the medicine?... I could not remember... "

- When was that?

"...it was two weeks before the due date. In my case... my baby was staying very low since eight months... the doctor told me like... to stay in bed... Every week I went to hospital... I had a kind of uncomfortable movement inside my womb, and the doctor found, '4cm open'. It was not birth pain...it was like a gas pain... I was a bit worried... I don't like the idea... if my birth started when my husband would be at night shift, I must be alone... My husband wanted to stay with me. The doctor advised a planned birth and I said yes..."

- So, how did you feel about your birth?

"I really worried about natural onset. Of course, when the day of birth was fixed, I was worrying. But the doctor explained the process of birth... coming to hospital at 8am, the inducing starts from 9am, and the medicine would be increased according to my pain... I had time to prepare myself. It is much better than not knowing when my birth would start..."

- So how was the actual pain?...

"... um.... It was not too bad. The magazines said, 'childbirth is 100 times more painful than period pain'. I could not imagine how painful it was. But I could cope with it... My birth was quite easy and short... I suppose..." (a long pause)

- So starting at 9am and... your baby was born...

"It was... 4.30pm... I had no pain until 7cm, and from 8cm I felt a period pain, and from 9cm, I was in a very strong pain... and then, a half an hour later she was born..."

- ... you said... your birth was a short one?

"Yes. I talked with other mothers in the hospital. Their experiences sound worse and longer... hard time for pushing... Compared to them, my birth sounds so easy..."

- ... and ... what did your husband say?...

"He said it was great!"

- What does it mean great?

"Because I could not see my baby coming, but he did. In addition, just before the baby came, my pain became so strong and I needed to push so hard. It was an incredible experience, he said. In fact, I saw he was in tears. He felt just more attached with the baby...

- More attached?

"He felt more love? Maybe love is the word? ... probably... he got a real sense of becoming a father???.... I don't know... He did not say anything more than that... When I met my husband's friends, they said my husband became a campaigner, saying like...childbirth was such a respectable job. We did not choose the hospital because husband could attend at birth. However, I felt we made a right decision..."

(Her husband attended the class at the hospital. Mothers' classes at the hospital focused on childbirth, not child caring or infant feeding. She attended mothers' classes at the town hall, but she did not remember what she was told).

(Her parent's home was one hour drive from her home, and she often went back to her parents' home and spent a long weekend there. Her father did not

say anything about child caring, but she felt a kind of warm feeling to her and granddaughter. Husband's parents were divorced and no contact before pregnancy. But having a baby, the mother-in-law has started to visit her home, and she was not comfortable enough to cope with the change).

- ...On the other day, I heard you asked about public nursery? Are you thinking to go back to work?

(She did not decide to go back to her work, but she would like to go back to work sometime and continue her career in the welfare field. However, she could not see the good timing to decide to return to her work, because she felt a bit 'KAWAISOU' [a Japanese word; feeling of sympathy to her baby] to take her baby to a nursery at a very early age. She was concerned the balance between 'HOU-NIN' [not being too spoiled by parents and let the child be independent] and 'KA-HOGO' [a Japanese word; too spoiled by parents and the child becomes dependent on parents]. She talked a lot about this with her husband).

- ... By the way, when did your community midwife visit you?

"It was at the beginning of two months."

- How was that?

"It was good, but not very good, I should be honest... It was a good chance to have information about maternity services in the community and nice to ask about small matters such as... constipation..."

- Do you think if the midwife could visit you earlier, would you have any changes such as... breastfeeding?

... No, I don't think so... Sorry to say like that... "

- It is quite alright to hear your feedback... Now... for example... if you have any questions or look for some advice for child caring... your mother is the person to ask or...?

"Um... I do not ask my mother... because she says she forgot everything...Only once, when I phoned the hospital about constipation, but... their answer was not practical... and... something like about baby's emotional development... I read the textbooks from my college study. I can understand it... Do you think... I am in a kind of 'HIKI-KOMORI' [a Japanese word; it is considered as Japanese social phenomena, which described the problem of a person was not able to contact or talk with others]..."

- No, ... I don't think so. It is a very individual matter. I think... you know what you want. Sometimes mothers collect too much information and just feel confused. I think... you can phone or talk when you need, do you? (She nodded). You can try your idea first and then understand the things. I think... you are doing really well and you do not need to worry about 'HIKI-KOMORI'...

"Stopping my work and staying at home, I came to understand the feeling of isolated mothers and the reason for child abuse. In my case, my husband supports me. But if he could not support, I would have the same problem, like... difficulties in child caring... "

-... your husband...is he helping like... ?

"Bathing, feeding, changing nappy, and 'SOINE' [a Japanese word: sleeping with the baby]. When I become tired, he takes her from me... I know... it is not a good idea to compare other husbands... but I think he is really good..."

- Do you have any other things to say?

"no, but... I am really sorry...I did not answer your question. Is it alright for you?"

- Yes, of course... so maybe one more question...How do you spend your time, when your husband is off from work?

(Her husband prefers to stay home and spends the time at home. Only once, she used a baby's nursery room whilst they went to see a film. However, she felt so unhappy when they returned to the nursery and saw her baby was left in the baby bed crying. She decided not to use the nursery again).

I left her home around 3.30pm. Before leaving her home, I told her if she had any further issues she wanted to talk about, she could phone either her community midwife or myself. She also added that her husband was interested in my research.

What is her main message?

The first interview was a process to find the direction for her to talk in the interview setting, which I felt to make a journey with her. At the beginning of the interview, I was concerned how the woman felt comfortable to talk in the interview setting.

When I entered the living room, I saw a tea tray was set on the kitchen table, which assured me that she was prepared for my visit. Seeing the half emptied bottle on the table, I was ready for listening to her story of bottle-feeding. In the interview setting, she hesitated a lot, even though she agreed with joining in the interview. I was concerned that the opening conversation was important

to know her. We spent some time to talk about her job, during which I perceived that she was a very sensitive person and very capable of describing her experience from an objective sense. When I asked her feeling of living with a new baby, Mrs D described that she enjoyed child caring, which I felt was her honest feeling, but still I felt she was a bit nervous to talk to me. After spending some time on her feeling of child caring and pregnancy, she seemed more relaxed and was able to talk freely.

Reading the interview as a whole story several times, I identified 'her feeling of isolation' as the main message from her narrative. Her narrative illuminated how the biophysical change influenced her environmental shift. I clarified three elements to feature her experience of breastfeeding:

- Her feeling of apprehension to child caring, and feeling sorry for her baby.
- Her strong concern to baby's emotional development.
- Her physical conditions: the problem of sleeping and eating.

Her story also illuminated that the nature of the field carried the strong expectation of breastfeeding, which was symbolised by her phrase; 'I can't tell others that I cannot breastfeed'.

Reading her story focusing on her emotional shift, she seems uncomfortable with her physical change whilst pregnant. The feeling that her tummy was too heavy and some wobbling movement around the womb stimulated her progress of labour, which made Mrs D feel uncertain about what was going on during her pregnancy. Her problem with sleeping was described as meaning she could not become a healthy mother. I found that she did not talk about her feelings of apprehension in her pregnancy with other people, even with her husband. The breastfeeding seemed to add to uncomfortable feelings within her physical change. The story of conflicting advice between hospital staff can be considered as a common story. However, it is important to notice that she

did not tell anybody about her feelings of discomfort with her sore breasts and the experience of her breasts being hand expressed by the hospital midwives. She tried not to show her negative feelings about pregnancy and breastfeeding, which might be considered as she was not ready to become a good mother.

In her story, Mrs D's mother was described as giving support such as cooking or warming up her breasts, but Mrs D did not feel she was supported. It suggests a gap that exists in the current social setting; the gap between the woman's expectation and the other people's perceptions to support breastfeeding. Looking at the relationship with her husband, they are and were in a good partnership. However, her feelings of ambivalence or uncertainty about pregnancy and breastfeeding were not shared with her husband. The contacts with her friends were described as increasing her pressure to breastfeed. She had a large friends and family network. However, other people's expectations of breastfeeding changed her relationship with those people, who were not perceived as supportive.

Her story also illuminated how her biophysical condition such as sleeping and eating influenced her energy to continue breastfeeding. As a midwife, I could imagine she was not physically well to continue breastfeeding. It implies that breastfeeding is a biophysical event, in which the woman's general health condition should be the primary concern for people in the immediate environment.

My empirical work began with studying a woman's context of shifting from breastfeeding into bottle-feeding at one month. The second case illuminates the story of a woman, who breastfed her baby exclusively.

7-2-2. Case 2: Mrs T

Summary of the case

The second interviewee was a woman 26 years old, the baby was three months, and her husband was 36 years old. She presents herself as a housewife, but she worked before having the baby. Firstly, she was followed by an obstetric clinic near her home. In late pregnancy, she was suspected of pre-term onset of birth and sent to a red-cross hospital. She gave birth there, stayed for a week, and then went back to her parents' home for two weeks. She was breastfeeding her baby at my visit.

Interview setting

It was one o'clock. I rang the doorbell, and the door was opened immediately. She invited me to come to the dining table. The house was very quiet. I asked her where her baby was. She said her baby was sleeping, just after she fed him, and we could talk until three o'clock. She served coffee, and then opening the 'FUSUMA' (a Japanese sliding door). She showed me that her baby was sleeping in the baby 'FUTON'. She sat down opposite me and said, 'what should I talk about? I am really pleased to talk to you. I do not have a good person to talk with about my child caring. My husband is not the kind of person to talk a lot'.

- Do you have any questions about my interviewing? (She said NO)... So, how old is your baby now?

"Three months old".

- ...how do you feel about your life since having a baby?

"What do you mean by how I feel?"

- Anything you like…. Like something you feel happy or difficult… or…

"Oh, I understand… Yes… The life has become organised … I have to say my life became healthier".

- … healthier, so beforehand…

"Last four years, I mean… since we got married, we spent our time as we wanted…"

- Did you work?

"Yes, I did. The office was not so far. I did not need to commute. So, I had late night. But now, I am breastfeeding and need to eat properly. It is very healthy. Beforehand, like… at the weekend, I was lazy, got up late, had a big lunch and ate very late at night. Now, I need to eat three times properly. I don't know what time I need to get up for breastfeeding at night. So, I go to bed earlier. But now, my child does not get up at night. So my life becomes a bit loose… I go to bed at 1am…"

- Is that for breastfeeding?

"No, no… The last breastfeeding is around 12am… I spent a bit of time after breastfeeding with him, and then do washing, have a bit of time chilling myself, and go to sleep. I can sleep until 7am… "

- … at the baby's age of this month, I cannot imagine… your baby sleep until 7am?

"Yes, I think I am lucky... For the first four weeks, I breastfed 2am and 4 or 5am. I could sleep six hours in total, but feeling is a bit different. I felt very tired. I started dreaming about breastfeeding, when I had to get up. I sometimes confused like 'Did I change the nappy?... (After leaving hospital), I was two weeks at my parents' home and my mother looked after my baby. When my baby started to cry, she brought him and I was asked to breastfeed immediately whilst I was eating. For my mother, my baby was the most important thing".

(She gave birth at a red-cross hospital near her home and her mother picked her up from hospital to her home, which took two hours drive from the hospital. She did not have planned to go back to her parents' home before childbirth. After childbirth, she talked to her mother and husband again, and decided to spend sometime at her parents' home).

- *What do you mean by you made a right decision?*

"I feel my body could not have recovered like now...I feel really well now. The amount of washing was huge for cloth nappies, I mean... Now I use them during only daytime. My mother kept cloth nappies that she used for us (her and her sister). She did not chuck them out when she moved into a new home, to my surprise. I just think... it would be nice to use them, no more reason. When I was at my parents' home...I can spend my time in bed, no washing and no cooking. It was good for my body, but at the end of the two weeks, I felt a bit... like... bored. I am a bit selfish. It is a petty thing to say ... I could not watch TV programmes that I wanted. Coming back to my home, it is hard to do all the housework by myself, but I am feeling better..."

- *... how was your birth?*

(In the late pregnancy, she visited the small clinic and found her cervix started to open. The doctor sent her to the red-cross hospital, and she stayed there for two weeks and came back home at 36 weeks. Her birth started naturally).

"I went to the hospital at 4am and he was born at 11am. My husband went to work and got a phone call from the hospital, 'your baby has been born'. It was not good... I would like him to stay with me. In the hospital, nobody came and checked me. Firstly I was sent to a room in the postnatal ward, but I got so much water and could not stay in bed... and I was asked to stay in a small waiting room near to the labour ward. That night so many babies were born. I called a nurse, but nobody came... At the end I got a feeling... like... something was coming out. I called and called...I could not wait anymore, and somebody came and saw my baby was near... They rushed... he was born just as I climbed into the bed... "

- How did you feel about that?

"Before birth, I felt a bit nervous...like... I may not find the difference between the real pain or gas pains? ... After birth, I felt like... nothing happened to me. I felt so easy. Of course, it was really painful. My husband did not know what my pain was like. I was a bit disappointed he could not understand me. There was no time to phone him...I feel like...If we only have one child, it would be the first and the last chance for him to see childbirth..."

- How about the hospital stay?

"... It was very hard. I did not have enough breast milk. Of course, it sounds normal for the first time mothers. But other mothers had enough breast milk. The nurses said to me like... 'You will be alright. Most mothers will have enough after leaving hospital'. But nurses checked my baby's weight everyday. I was told that he lost his weight. And then they said.... 'We should

add some dextrose water'. I had to think...'It means I am not alright'. As you know, 'maternity blue'... I felt like...very blue. I did not know why I feel so depressed... it is impossible to feel so blue just because of breastfeeding... (The hospital does rooming-in system from the second day of birth). When my baby started to cry, I went to the feeding room cuddling him. The second or third time mothers breastfed their baby in their own room... But I had to go to the feeding room, changing the nappy and then breastfeeding..."

(Every three hours she went to the feeding room with her baby, spent one hour for breastfeeding and returned to her room).

"(My baby) did not cry much. One night he didn't cry and I slept the whole night. (On the next day) the nurse said, 'you should get up even though the baby was sleeping'. So I tried to wake him".

- Did it work?

"No, of course not. He was just sleeping. I doubted why I should wake him up. There is no point really... The hospital were very strict about breastfeeding...Every single thing was checked and I had to follow their orders...The baby's mouth needs to be shaped like 'Donald Duck' and latched the mouth wide and deep. Keeping a Japanese cushion on my lap, making my baby the right height. In addition, my breast milk was not coming. I was told to try to breastfeed harder. I felt like... sick..."

- How about other mothers?

"At least they looked better than me. When I saw them breastfeeding their baby, I could see the difference. Their baby made sounds of swallowing breast milk. However, two other mothers, who gave birth on the same day,

had other problems. One had some problem with baby's ears and another one had a forceps birth. So we all had different problems".

(She spent two weeks in the hospital during pregnancy, but she did not see any familiar faces in the postnatal ward. The advice given about breastfeeding on the day of her leaving hospital was simple).

"I thought... I had to use formula milk and asked a midwife about that. She said... the baby had started to gain weight... and alright to breastfeed, no additional formula milk. I felt it was too simple... In fact, I felt my breast milk was coming after leaving hospital. The nurse was concerned about the baby's jaundice on that day. They said that I could not take him home and I started to worry. In the end, we came back together..."

(When she was at her parents' home, her father cooked lunch while her mother was working. Her sister lives there and she felt it was really good to have somebody around her. Otherwise she would have more problems, especially feeling blue. Her mother-in-law sometimes visited her).

"My mother-in-law was a bit difficult... As soon as coming into the house, she said like, 'This room is too hot!' and opened the window...or maybe, she does not like that my mother helped me. I don't know. Anyway I had to clean up everything before she came. However, around that time, I breastfed at night and had to sleep during the day. When she came, I couldn't. So I felt a bit annoyed.., I know... I shouldn't say that... But I said this to my husband, and he managed to talk to her...My husband's sister has already got three children. So, it is not a new life event for my husband's parents, but it may be different because he is a 'UCHI-MAGO' ('UCHI' means 'inside', 'MAGO' means 'a grandchild', grandchildren who could inherit the family name)..."

- Do you feel any differences in your life?

"It is very different... Going out with him, I have more opportunities to talk with other people, even strangers ask me like 'how old is your baby?' ...when I go shopping, of course it is daytime, I talk with neighbours. The younger children, they like small babies, don't they? They rushed and asked me like... 'what is the name?' It may sound very exaggerated, but I feel a bit like... start to live in a new world..."

(She had a friend who had a baby one month earlier and they e-mail everyday, but do not talk on the phone. Before having a child, she did not talk about children. She feels like, 'it is coming again').

- *...It is coming, sounds odd to me. What do you mean?*

"I was stressed a bit about...talking about a baby... because we have been in fourth year from our marriage. No sign of falling pregnant. I could not decide whether I should go to the hospital (for infertility treatment). When my friends phoned me to tell their pregnancy, I felt like.... why I could not ... Probably now I don't like to talk about my baby to others because of my experience...I talk about my baby only with people who have children..."

(She met with two other mothers who all spent time together in the hospital. However, she did not enjoy talking with them).

"...We compared... The child caring book said, 'Don't compare your own baby to others'. But we did... like compared baby's weight as 'a status'. I am wondering... why baby's weight is so important... maybe because, my baby gains average. I did not care about it as much as they did".

(In the hospital, those two mothers had enough breast milk, but one mother would like to go back to work, and started bottle-feeding. They breastfed

seven minutes and then added formula milk. She still followed the hospital instructions; breastfeed each side five minutes and repeat it twice. The reason not to change her approach was described).

"Because I believe it is 'right'... When I feed each side for five minutes and he still sucks after five minutes, I just let him go until he stops".

(She felt better to have a first baby at the general hospital rather than a small clinic, as she had more chance to talk to other mothers. In the hospital, she stayed in a room with four other mothers. It was very hard to hear the other babies' crying. She listened to the radio and was not too much concerned about other baby's crying).

(At the six months of her pregnancy, she asked the obstetrician about baby's gender).

"... I thought... my life would become all about child caring, but it is not so bad. When I knew my baby was a boy, I expected it would be very hard. 'A boy' means more difficult than having a girl... it is a very general idea, isn't it?"

- How about your husband? Any concern about child caring?

"He is a kind of person who does not like to talk about the things. He is always very quiet. When I worked, he did housework. I did not have morning sickness. There was no difference for him... and now everyday he bathes the baby. It is a new job for him. Only once he could not come back early from work and my baby was particularly fussy on that night, and I felt it was difficult by myself... (my husband) is useless at changing nappies. It requires a bit of skill..."

(At the weekend, her husband wants to spend time with the baby at home. He said they could not relax if they went out with their baby. I felt she seemed to finish her talk and asked if she has any further issues. She answered 'no' and I asked my question).

- I would like to ask a bit about your breastfeeding. Is it alright? (She answered 'yes'). Did you read any books?

"Yes. I felt everyone concerned with the same things... should not drink alcohol during breastfeeding".

- What did you think about infant feeding during pregnancy?

"I did not have any concern about it during pregnancy. I hoped I could breastfeed. That's all. I don't like the idea of powder milk... it requires more work like...washing bottles or.... I really wanted to breastfeed, but it is a normal feeling, isn't it?"

- What did your mother say about breastfeeding?

"Nothing. She sometimes said... it is better to eat rice and vegetables rather than oily food... My mother shifted to formula feeding earlier, so she was not so fussy about that".

- Didn't you talk a lot about breastfeeding with her?

"No... but, when I got mastitis, and had a high fever, she worried about me".

-What did you do?

"I phoned my hospital. They said if I had fever over 38 degrees, I should not breastfeed. It was at 7pm and I had reached 38 degrees. My mother went to buy formula milk, and fed it to my baby. I could not even move from the bed, and had no idea about mastitis. It started suddenly... And the next day, the fever was gone. I felt a bit dizzy, but I started to breastfeed again...It happened after one week from leaving the hospital. My breasts became very sore, and then I started shivering. I stopped breastfeeding and expressed breast milk by hand. But a small amount of breast milk came. I believe that babies could suckle more than hand expressing?"

- After that, is everything alright?

"No, one month later, this happened again. It was worse... I phoned the community midwife during the day, but she was not at home. I tried to rest, started shivering and my breasts were getting sore and sore. That evening, I got her help. She made a potato compress for my breasts. She said it was alright to continue breastfeeding, but not to eat too much. I lost appetite, so it was not a problem. Since then, I became more careful with my eating, trying not to eat too much sweet or oily food".

- I understand it was really hard, but you did not feel like... would you like to quit from breastfeeding?

"No, not at all... I know... breast milk contains some immune factors, which are good for my baby.... I don't know more than that. I just feel like ... I would like to continue breastfeeding as long as possible".

- ... Do you have any other thoughts about breastfeeding?

"...no... but... maybe the first time I got mastitis and my mother tried to give him a bottle, he did not take. We did not know why. He does not like a teat

or.... When I saw it... I felt really sorry for him. Probably breast milk tastes better than powder milk. When I breastfed him again, he suckled so strong. Seeing that, my mother said 'He loves breastfeeding'. When I heard that, I just felt like... 'Yes, it is true'... When I was not breastfeeding, my breasts filled up with breast milk. I found that my baby's suckling is the only way of making my breasts easing from that feeling...I think... we are working as a team... "

- How do you feel about the postnatal visit?

"It was good. Around that time, I did not have a chance to talk to other mothers. The midwife said to me like... 'Everything is alright'. It makes me feel 100% alright. She did breast massage. At the second visit, she said if I had any problems, I could phone her. When I phoned the hospital before, the nurses just gave some instructions. It is nicer to have someone to come and to talk to me".

She and I agreed to finish the interview. We had a coffee together and she talked about her hobby and her plan to go back to work sometime in future. I said if she had any comments, she could contact either myself or her community midwife.

What is her main message?

When I contacted her on the phone to make an appointment for the visit, she clearly asked me to come at 1pm. When I visited her, I saw her baby was comfortably sleeping in the bed. She was settled and relaxed with her baby, which made her atmosphere relaxed. The interview flowed really well and the woman seemed to really enjoy talking to me, and I felt relaxed to talk with her. Instead of the positive feeling in the interview setting, I did not feel I could elicit her real message during the interview. I needed to allow time for reflecting back to the message from the whole interview.

This interview was a real chance to create the system of a case-oriented approach, which entails reading the data as a whole and understanding the woman's message from the whole context. After transcribing the data, reading the transcription several times, and checking the memos that I took during the interview, I realised her main message was clearly in the interview; she simply wanted somebody to talk with about her experience of child caring. Having this point as her main message and reading the interview again, I can make the sense much more about her interview. The interview was based on the descriptions about how the events were experienced. The reason why I felt the conversation flowed in a spontaneous manner was because she did not put her talk in a problematic way. However, her emotions were there in her story. She experienced the social expectation of having a baby as a married couple, the contradictory view between the traditional family value and the modern lifestyle, and the existing tension amongst the fellow-mothers' relationship.

Mrs T described her biophysical change as a positive shift, which made her lifestyle healthier. She left her work in late pregnancy. After childbirth, she described her experience of talking with neighbours and children as living in a new world. It sounds a positive reflection. However, it may reflect that she was not much involved in the community whilst she was working and not being around her home during the day. This may an example of understanding urban communities in which young mothers live.

Her message of 'difficulties in having someone to talk with her' was explained several times. Firstly, when she met with another two mothers who gave birth in the same hospital, she felt some tension with them and the babies' weights were talked about as a status. In this context, the measurement (baby's weight) was used to judge whether their child caring was successful or not. However, she was not concerned the baby's weight is such an important,

neither her child car is successful or not. Secondly, she mentioned the problem of talking about her baby with her friends whom she knew from the school, but no children or not got married. This also represents the Japanese social norm; women in certain age should have got married, and then have children.

In this interview, the story of breastfeeding appeared as a part of her experience of hospital staying. From the interview, I got an impression that she is a practical person to handle the things in the most effective ways. However, she described that the experience of hospital stay was something to make her feel blue. 'Feeling not having enough milk', 'everyday baby's weight checking', 'being advised to add dextrose water after breastfeeding', 'being asked to feed every three hours', 'being taught and then corrected her breastfeeding technique and position by midwives', all these increased the level of her anxiety. Even though the hospital practice may be the reason for Mrs T to feel blue, but she said, 'it was not bad enough alone to make her such a depressed feeling'. Her comment suggests that breastfeeding is a biophysical shift, which brings some effect on her emotions. Their experience of it was influenced by the interactions with people in the environment, which made women's feeling better, but also worse.

When she concluded her talk, I decided to ask about her view of breastfeeding, whereby I perceived that she might be comfortable enough to talk about breastfeeding more. Breastfeeding was not her main concern during pregnancy, her mother gave practical help, but no pressure to breastfeed, and then her story of mastitis was raised. At this point, I considered it was very important to take narrative account to listen to her experience of breastfeeding. Firstly, it has become clear when breastfeeding was experienced as a part of her ordinary life, she did not talk about it. Unless she experienced the mastitis, the meaning of breastfeeding would not have been described. Secondly, mastitis was described as a sign of having enough

breast milk. From my practical experience as a midwife, medical professionals perceived that 'mastitis' was a cause for women to give up breastfeeding. However, her story illustrated the women's perceptions to mastitis was positive one. Thirdly, the final part of interview informed my position as a friend, not a midwife. It was useful to know how my position was defined in the interview setting. It supports her main message of having somebody to talk with about child caring. Lastly, her response informed the point that her reason for continuing breastfeeding was based on her baby's response to being breastfed after the mastitis. She knew the advantage of breast milk, but it was not perceived as the main reason to motivate her to continue breastfeeding. Her story suggests that the women's reasons for breastfeeding may be based on their own practical understanding.

Her story represents the transition of her life to become a new mother. Her story gave rise to three points:

- The social environment such as cultural expectations influenced her experience of pregnancy, child caring, and breastfeeding.
- The structure of interview is dependent on woman's expectation to the interview, and my role in the interview is defined by the woman's perception towards others.
- Once breastfeeding became a part of woman's everyday life, it is not likely to be discussed by the woman as a special concern.

For me, the second interview was a pleasant experience of talking with the woman about her child caring. The third case gave me a different experience of talking about breastfeeding.

7-2-3. Case 3: Mrs S

Summary of the case

The third woman was 30 years old, the baby was four months, and her husband was 32 years old. Before pregnancy she worked. One morning she was bleeding, and went to a private obstetric clinic. The ultrasound could not diagnose it at that time. After her pregnancy was diagnosed, she got strong morning sickness, which continued until eight months. She spent most of the time in bed either at home or at the clinic or her parents' home. She gave birth at the private clinic, stayed for six days, return to her parent's home for two weeks and to her parents-in-law for one week, and came back to her own home.

When I invited Mrs S to the interview, she could not decide to take it and her husband encouraged her to join in the interview. She asked me the reason about tape-recording. As soon as I started to interview her, I realised that she used a lot of medical jargon or technical terms, which I had not heard in the previous two cases.

Interview setting

It was 10am. I rang the doorbell and waited for a while. She invited me into the living room. Her baby was lying on the sofa. I did not see a baby bed in that area. 'He had just vomited and I had to change all his clothes. My husband may be back to pick up some stuff, so I will stop talking to you, is it alright?' She brought some tea and sat opposite me, whilst her baby was lying on the sofa. She explained that she could not decide to buy a baby bed. During the daytime, she did not like to leave her baby in the bedroom, but found it difficult to bring the 'FUTON' [a Japanese word; a Japanese sleeping mattress] into the living room. This was why her baby was on the sofa, but it

made her worry about her baby falling from there. I explained the reason for tape-recording again. I felt that she was not relaxed and the atmosphere was for some reason tense. She sat with her back straight as if she was waiting for my questions. I explained the interview was the time for her to talk freely.

- So, I will make a start... firstly, could you tell me about...how do you feel about your life?

"Since he was born... now he is strong enough, I mean... his neck is stable. I don't need to worry about his neck. I go shopping with him and enjoy my life... Somebody come to me and ask... 'How old is he?' Just a few days ago, I went to a department store and used the feeding room. It is nice to talk with other mothers. I really enjoyed that".

(She started to talk a bit about her previous job. She worked in customer service in a children's clothes company. She likes to talk with people. After birth, the company asked her to come back to work, even part-time, but she would like to stay with her baby).

- Could you tell me about... about your pregnancy and also childbirth?

"At first, I had bleeding and then a diagnosis of pregnancy, but the ultrasonography could not scan the embryo. The obstetrician thought I might have an ectopic pregnancy. He could only say, 'Stay in bed'. Two weeks later I went back to the clinic and got into a stable condition. And then, I got my morning sickness. I could not get up. I stayed at the clinic for one week, when I was so ill... One day after my due date, I got rupture of membranes. I went to hospital at 9am. My baby was born on the next day. It took 26 hours 26 minutes".

- Did the obstetrician use any medicine during the birth?

"Yes. I got weak pain. The obstetrician said I should give birth by the next day, otherwise my baby would get some infection. I was given some medicine, and my pain suddenly became very strong. When I feel I could not stand it, I was taken into the labour room. The doctor said my cervix opened 9cm, but the baby's head was too big. In the end, I got a vacuum delivery. The suture was painful, but the obstetrician was good and told me I would make a good recovery".

(She had no idea how she chose the hospital. She went to a university hospital, where she had to wait a long time, and worried about cross infection. She checked the yellow pages and found the small obstetric clinic. When she met the obstetrician, she felt good about the doctor and the care in the clinic).

- What did your husband say about pregnancy?

"He really, really would like to have a child. The first two years of our marriage, we planned to enjoy our life as a couple, and then started to think about our child. After three years we could not fall pregnant, I started to worry something was wrong. Eventually I fell pregnant. My husband was happy. However, I suffered morning sickness and spent some time at my parents' home".

(She spent one week in the clinic due to severe morning sickness. The clinic had no antenatal classes, but some informal talk about childbirth was given personally. She did not think about her husband's attendance at the birth, but her husband stayed with her at birth).

- What did your husband say about your birth?

"He was busy looking after me. He could not bear to see I was in agony with the pain. At the end, the midwife pushed my tummy. He really wanted to stop her. I was alright on the next day. I felt I could have another birth... I forgot everything... it is a bit strange. I only remember... it was enjoyable..."

- You mean childbirth itself?

"Yes. During pregnancy, I was very anxious like... 'Can I really have a healthy baby?' When I first saw him, he looked like a small monkey. But I really felt he was really sweet... I enjoyed my birth. During pregnancy, I was always telling myself 'It should be O.K. All mothers have healthy babies, so I should be the same'. I cannot imagine... how I would feel when the baby is coming. In fact, the pain really hurt me... I could not take anymore pain, and then my baby was coming... When I talked to the mothers who had a caesarean section, I really felt sorry for them. They were in pain after having a baby. They could not walk to the toilet and also could not even see their babies. They need to take at least two years to fall pregnant again. It seems to me... their bodies require more time to recover and the operation gave them such stress".

(She stayed at the clinic six days after birth. On the first day, the baby was in the nursery room. From the second day, her baby was brought into her room).

- How about that?

"My baby did not wake up at night. The baby next to my bed was always crying. My baby was easy... Of course, I fed him every three hours. He fell asleep after the feeding. I was happy I could stay with him..."

- How did you feed your baby in the clinic?

"It was mixed-feeding. On the next day after the birth, the midwife came to my room with my baby and tried to latch him on my breasts and then fed [formula] milk. On the next day, she massaged my breasts. I did not have enough [breast milk] and added some [formula] milk".

(She watched a video about breastfeeding in the clinic before birth. She planned to go back to her parent's home for three weeks, but her mother had a relative's funeral. She needed to go to her parents-in-law's home instead).

"... Mother-in-law said like... 'You just stay in bed. I can do everything for you'. But... at least I wanted to do my washing...She stopped me doing that. I could not relax at all... In addition, my baby got into 'YO-NAKI' [a Japanese word: crying at night]. It was really hard to soothe him. Maybe my baby picked up something from my feelings..."

(After coming back to her home, she phoned her mother-in-law to talk about a problem, since her mother is working).

"My baby suddenly refused to take a bottle, and does not take any (formula) milk. It was around two months. I tried some fruit juice, and he refused it. He only took my breast, but my breast milk was not enough. He could not sleep, and cried and cried, which lasted a half day. I cuddled him and tried to comfort him. I phoned my mother-in-law, and she had experienced the same kind of thing, but no ideas what we could do for two months' baby. It was not possible to give weaning food. Luckily I got a bit of breast milk and he survived for a while. At the end, he started to take [formula] milk. When I saw he slapped the bottle, I understood he did not like it. He was just crying and crying. There was no way to settle him. I felt so sorry for him..." (a very long pause, which made me wonder whether she wanted to talk about it more or not talk it about more. After long time silence, I perceived that she did not want to talk about the topic of baby's crying. I changed the topic).

- What do you talk about with your husband now?

"It is not a real conversation. I just tell him what happens during the day, and he nods and says, 'you did really well'. My husband changes a nappy and also feeds milk. My baby also likes his father.... My husband seems so crazy about the baby. Now I can see how much he wanted to have a child".

(She used cloth nappies, which her friend gave to her. She had no idea at first how to use them. She felt it was convenient and no need to worry about the cost. And she believes it was good for baby's development of sensing uncomfortable feeling from the wet nappies. But at night this made him wake often, and she decided to use disposable nappies during the night. Now he slept six or seven hours at night).

-So, it was very hard for you not to have proper sleep at night?

"Yes, 'YO-NAKI' was the most difficult thing. Of course, it is a bit early to say 'YO-NAKI' in the first month. [Notes: 'YO-NAKI' is a problem with 5-6 months' old babies]. Now he sleeps through the night... like six hours. Coming back to my home, we (she, her baby and her husband) slept in the same room. I got up every three hours for feeding and tried not to make any noise whilst my husband was sleeping. But I could not work for looking after two people. In the end, I asked my husband to sleep in another room. He was pleased. The lack of sleep made us dizzy... It is very recent when I can sleep at night. I got energy to go shopping and chatting with my friends... "

(She bought baby goods and clothes at the eight months of her pregnancy. She has a friend who had a baby last year, and got some advice from her. She got an impression a boy and a girl were different).

"...I have a question for you. I am still using cotton wipes for cleaning my nipples before breastfeeding. Do I need to use them? (I answered she did not need to use it)... (She came back to the topic of a girl and a boy)...The most different thing is... girls are easier and sleep a lot, and boys are more fussy and difficult in sleeping. When he does not like the milk, he slaps the bottle. I have never heard girls doing like that... The other thing is... like... I cannot do the things as I planned. When I am ready to go, he makes a fuss and again I change the nappy or all his clothes again. I always find I am late. I would like to do the things as I planned... "

- Have you got any troubles about breastfeeding?... like... cracked nipples...

"No. The only thing is I did not have enough breast milk. That's all. No problems".

(Her voice sounds so definite to say; she does not want to talk about breastfeeding anymore, so I changed the subject).

- ... so.... How... was the postnatal visit?

"It was good. She checked his weight and I knew he was alright. Around that time (40 days after birth), I felt my life became easier, but I felt a bit anxious and had several questions. The midwife gave me breast massage, explained about weaning food, and other public health services in the community".

- I think... I asked everything that I want to know... So... would you like to ask me something?

She said no and I finished the interview. After I switched off the tape recorder, she started talking the following issues:

• Her baby has started turning over, and so she wants to re-arrange the room, but how she could do it.
• She and her husband quite often visited each parents' home, and she found her father-in-law was so glad to have a boy.
• She breastfed six times a day and each time added 160ml formula milk.
• She tried not to cuddle her baby, because she did not know when and how much she can cuddle or touch her baby.

The following points were questioned:

• During the summer, how many clothes the baby needs to wear, and how about socks.
• How often she needs to go out with her baby each day? How to clean his ears?
• How to talk with babies and is it better to use any special language such as what is called as baby's language?
• How and when will she start weaning food?

I answered her questions and talked about child caring issues. It was around 12pm when I left her home. I also said to her if she had any questions she could talk with her community midwife or myself.

What is her main message?

Besides using a lot of medical jargon, she used very formal language in the interview. She tried to describe the things exactly as it happened. Even when the interview came to an end, I felt that she kept a distance from me. After I switched off the tape recorder and then she started to ask me the questions, I realised she took my interview as a visit by a medical professional. I guessed her perception to the interview was based on her previous experience of relating to the medical professionals. As she described, her pregnancy started

from bleeding, and her feeling of anxiety was the main message from her story. The questions she asked me after the interview were very detailed and she needed very exact answers that she can follow. I was not certain that she was ready to talk about breastfeeding. When I asked about her feeling of breastfeeding, nothing particular could be read from her answers. However, I felt I should not talk or ask her about breastfeeding. The atmosphere stopped me from talking about it anymore. Reading the interview transcriptions and trying to understand her emotions, I clarified she did not want to have any pressure to her breastfeeding.

In her story, breastfeeding was described as 'she had no problems', which gives me a chance to think about the timing of interviewing women about their breastfeeding. I learnt breastfeeding would be a sensitive topic for three reasons:

- My position as a researcher or a practitioner would not be perceived to be appropriate for the woman to talk freely about breastfeeding.
- The timing of 3-4 months after birth would not be the most appropriate for women to be able to talk about breastfeeding.
- The woman's feeling of uncertainty would hinder her to talk about her own experience of breastfeeding.

7-3. Summary and points for the further data analysis

In this section, I demonstrated my research approach and the role of context in each individual story. Each interview was analysed separately, and I noticed that the different feeding method characterised the women's feeling of uncertainty. It seems true to think the reverse effect that the women's emotions influenced their breastfeeding; their stress or anxiety would influence their physical conditions.

The three women's interviews illuminated the nature of breastfeeding as follows:

- Breastfeeding is talked about in a problematic way in the story of the woman who shifted into bottle-feeding at the early stage.
- Breastfeeding is likely to be mentioned once it became a part of woman's life.
- Breastfeeding is not allowed to be subjected to ask whilst the woman is very uncertain about her child caring.

In the next chapter, I will represent the women's narratives into chronological time and explore the above points further.

Chapter 8
Reporting on phase one: further data analysis and discussion

In my exploratory work, I had three women's stories of breastfeeding, through which I could study breastfeeding from the different perspectives. As a result of a holistic reading and studying women's experience from a narrative account, women's uncertainty emerged as a main theme for understanding their experience. This chapter reports on the results of the second part of data analysis allocating the women's narratives in a chronological order, which could illuminate the sequence of events; how each event relates and interacts with each other.

In the discussion, the following questions will be explored; what the women said and did not say about breastfeeding? How they presented themselves in the interview setting? What type of discourse they chose? The first part of this chapter illuminates the meaning of 'the same set of elements' in understanding breastfeeding stories. The discussion is undertaken for clarifying the nature of the topic, the nature of the field, and the nature of Japanese interviews. The second part reports on the discussion that looked at the theoretical issues that arose from studying breastfeeding across cases. The idea of 'a longitudinal study' and 'an ethnographic approach' was examined by indicative reading, and then further discussed taking account of the finings that obtained from prior-ethnographic work, which will be reported in the last part of this chapter.

8-1. Findings part two: allocating women's narratives in chronological time

As a result of studying women's narratives, three messages were identified; the feeling of isolation, the woman's wish to have somebody to talk about her experience of pregnancy, childbirth and child caring, and the feeling of uncertainty. Reading the interview transcriptions several times, my analytical mode worked towards arranging the women's events according to chronological

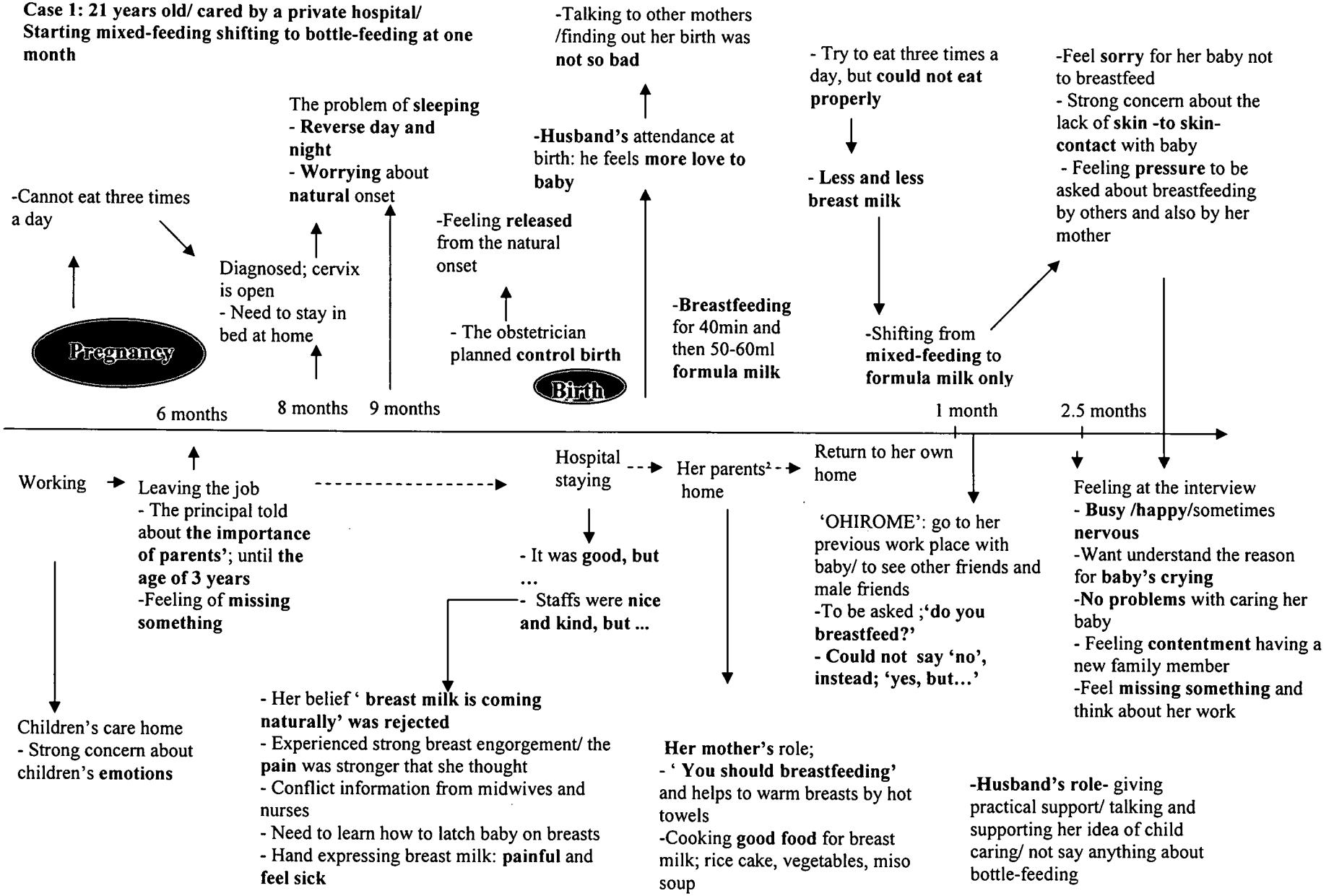
time, which represents the events as they took place in the biophysical change; before and during pregnancy, childbirth and after birth up to the time of the interview. In the following section, I clarify the meaning of 'the same set of factors' and discuss how those factors were interacting in the same way or leading to the differences in women's stories of breastfeeding.

8-1-1. Allocating women's events in chronological time

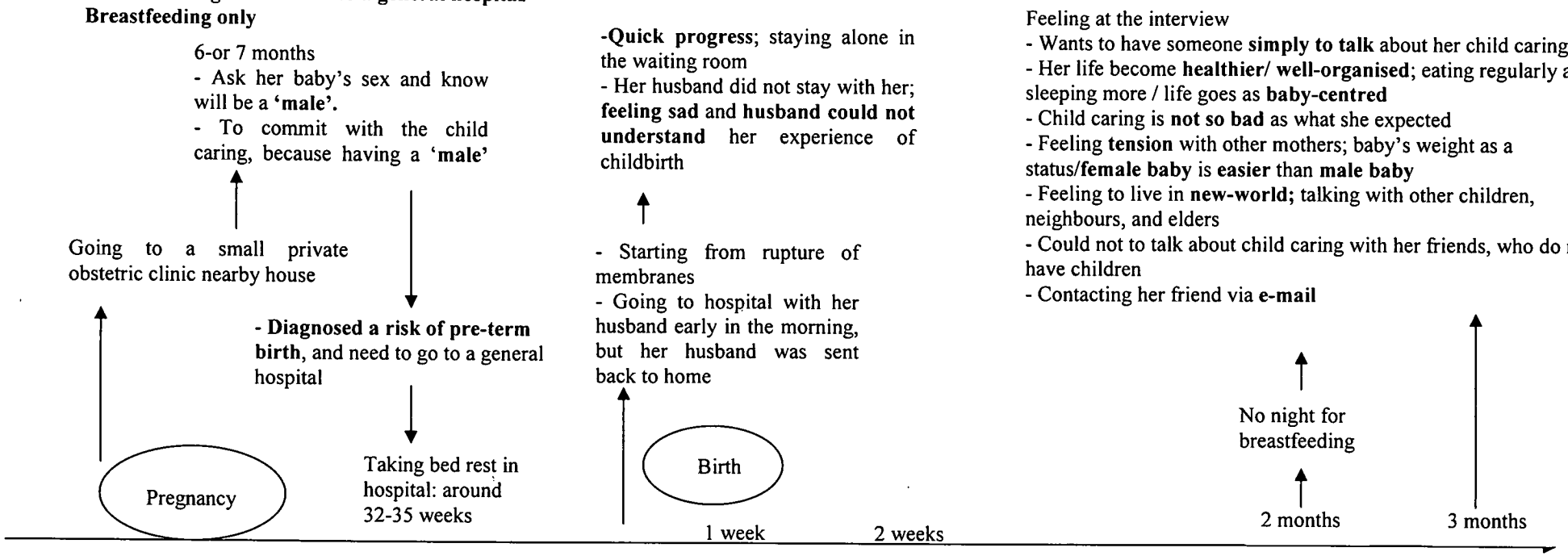
From reading three women's narratives, the women's context was consolidated by the key theme of 'biophysical change' and 'its impact on women's environment', which I could list as follows:

- Her basic lifestyle; before pregnancy.
- Her life during pregnancy.
- The experience of childbirth and hospital stay after birth.
- The experience of 'SATO-GAERI' (Going back to her parents' home).
- The life after coming back to her own home.

The further data analysis was undertaken for illuminating the relationship between these elements. I developed a format which I could consolidate the women's narratives in the chronological time [See diagrams: Case 1; 2, 3]).


Case 1: 21 years old/ cared by a private hospital/ Starting mixed-feeding shifting to bottle-feeding at one month
-Talking to other mothers /finding out her birth was not so bad
- Try to eat three times a day, but could not eat properly
-Feel sorry for her baby not to breastfeed
- Strong concern about the lack of skin -to skin-contact with baby
- Feeling pressure to be asked about breastfeeding by others and also by her mother
The problem of sleeping
- Reverse day and night
- Worrying about natural onset
-Husband's attendance at birth: he feels more love to baby
-Cannot eat three times a day
- Less and less breast milk
-Feeling released from the natural onset
-Breastfeeding for 40min and then 50-60ml formula milk
Diagnosed; cervix is open
- Need to stay in bed at home
- The obstetrician planned control birth
-Shifting from mixed-feeding to formula milk only
Pregnancy
Birth
6 months
8 months
9 months
1 month
2.5 months
Working
Leaving the job
- The principal told about the importance of parents'; until the age of 3 years
-Feeling of missing something
Hospital staying
Her parents' home
Return to her own home
Feeling at the interview
- Busy /happy/sometimes nervous
-Want understand the reason for baby's crying
-No problems with caring her baby
- Feeling contentment having a new family member
-Feel missing something and think about her work
- It was good, but ...
- Staffs were nice and kind, but ...
'OHIROME': go to her previous work place with baby/ to see other friends and male friends
-To be asked ;'do you breastfeed?'
- Could not say 'no', instead; 'yes, but...'
Children's care home
- Strong concern about children's emotions
- Her belief ' breast milk is coming naturally' was rejected
- Experienced strong breast engorgement/ the pain was stronger that she thought
- Conflict information from midwives and nurses
- Need to learn how to latch baby on breasts
- Hand expressing breast milk: painful and feel sick
Her mother's role;
- ' You should breastfeeding' and helps to warm breasts by hot towels
-Cooking good food for breast milk; rice cake, vegetables, miso soup
-Husband's role- giving practical support/ talking and supporting her idea of child caring/ not say anything about bottle-feeding

Case 2: 34years/ cared by a small private clinic and then being transferred to a general hospital/ Breastfeeding only



Working at a office nearby home → **Housewife** → **Hospital staying** → **Her parents' home** → **Coming back to own home**

After marriage
- Wanted to have a child, but unable to get pregnant
- Ater four years, **feeling pressure** and **stress** to talk about having a baby with friends

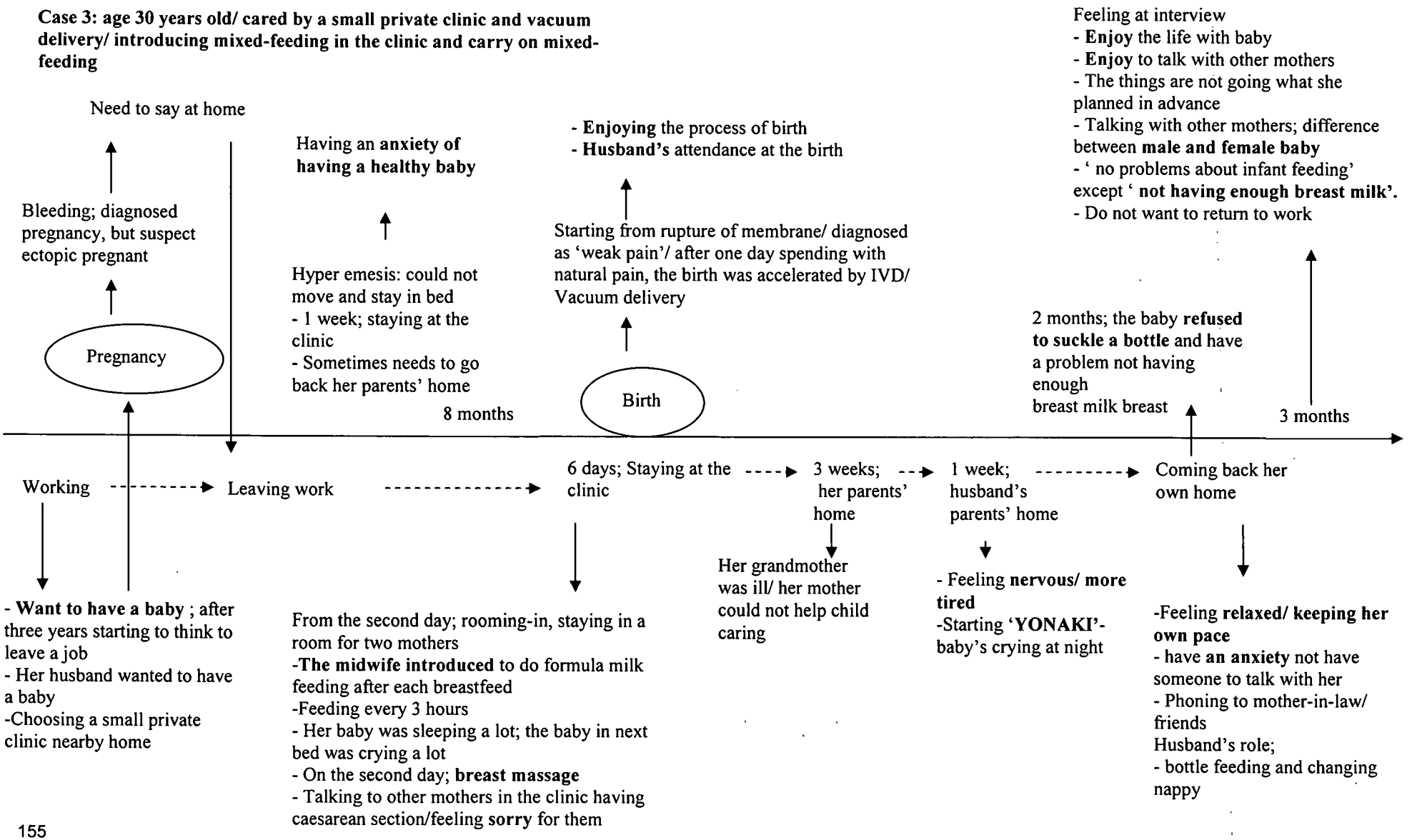
Not so enjoyable/ feeling pressure /'maternity blue'
- **Not having enough breast milk**; by seeing other mother's breastfeeding/ baby's daily weight check
- Conflict messages ;'Not to have enough breast milk during hospital stay is normal' vs 'Let's add dextrose water'
- Regular feeding; **every 3 hours /no time to take rest** between the feeding
- Rooming-in; 2 day: Go to the feeding room at each feeding/**very precise way of breastfeeding**; how to cuddle or how to latch
- Staying with four other mothers; problem of sleeping/**sorry** for seeing other mother's baby's crying

Her mother **did not say** anything about breastfeeding/ prepare for cooking/washing cloth nappies
Experiencing mastitis; 1 week
- High body temperature
- Phone to the hospital; 'not to breastfeed'
-Her mother went to buy formula milk/ the baby did not suckle the bottle/ return to breastfeeding next day
-Her mother: **'breast milk is more delicious than formula milk'.**

-Feeling **relaxed**/ keeping her pace
Her husband role
- Coming back at 6 o'clock
- **Helping** bathing a baby
- At the weekend: he **wants to spend the time with baby at home**
- Mother-in-law's visiting; feeling uncomfortable

The experience of the second mastitis: 2 months
- Phoning to the community midwife/ 'potato compress' /continue breastfeeding
- Try not to eat sweets and high calorie food

Case 3: age 30 years old/ cared by a small private clinic and vacuum delivery/ introducing mixed-feeding in the clinic and carry on mixed-feeding



I compared the three diagrams and looked at how the elements were interacting with each other. The commonality and the difference in women's experience could be summarised as follows:

- The experience of pregnancy: each woman had an experience of staying in hospital due to medical reasons.
- The childbirth was described as 'it is not too bad'.
- Breastfeeding in hospital: conflicting advice was found commonly, a strict approach for teaching and learning, and introducing bottles besides breastfeeding.
- The family support system of 'SATO-GAERI': It works in either a positive or a negative way, and the woman's feeling of either being supported or being isolated.

In my approach, the following demographic data are used for understanding women's emotions:

- Her age and work experience.
- Marriage status.
- Educational background.
- The relationship with her husband.
- The relationship with her family and her friends.

I identified the three women's social backgrounds were comparable. My concern was not generalising their experiences by treating each factor as a variable. I used those elements to illuminate the significance of women's context, which I could formulate into the following explanations; If three women were cared for by a similar type of maternity care system and family support, why could some women breastfeed, and others did shift into the other feeding methods? In the following two sections, I will look at these elements in relation to women's uncertainty in child caring.

8-1-2. The women's emotions on their biophysical shift

The diagrams of chronological time made it possible for me to look at women's narratives within the women's continuous time frame. At the beginning of interview, I asked the women's feeling of their child caring, thus they all answered the life with a new baby was enjoyable and they were happy. I considered their feeling was true, but the remainder of the interviews described women's ambiguity and uncertainty in their child caring. I firstly look at how I clarified the meaning of ambiguity and uncertainty from the things that the women said in the interview.

The pregnancy was described under the common theme; the women and her family have a strong expectation of having a child. The story of their anxiety about not falling pregnant was described as they might have something wrong in their body. They felt constant pressure from their family or their social environment, which made the women unhappy in their life. The experience of pregnancy seems the time the women came to know about the individual differences in their bodies. The women's experience of pregnancy also illuminated the obstetricians focused on investigating abnormal in pregnancy. As a result, three women were asked to stay in bed either at her home or in hospital. The women perceived pregnancy as a medical event. Their physical shift in pregnancy was perceived not pleasant experience as it was termed as 'normal'. However, the idea of 'normal' creates the pressure for the women not to be able to show their discomfort with their physical shift to other people.

In contrast, the experience of childbirth was described in a positive way, 'not too bad' and 'not too painful', or even 'enjoyable', whilst the hospitals did not provide any medical aid for reducing the pain such as epidural or anaesthetics during the childbirth. They were not particularly well looked after by the people in the hospital. When the women described their feeling about childbirth, they were very focused on their own feelings and emotions. The hospital breastfeeding; the

regular feeding, introducing bottles, and the conflicting advice among hospital staff, were illuminated by the three women's stories, which made them discomfort to practice breastfeeding.

In the first interview, I was very concerned about the lack of sleep, feeling of tiredness, and its impact on her breastfeeding. By following her story, I cannot help to think how her tiredness influenced her breastfeeding. The experience of sore breasts and pain by hand expressing increased her feeling of uncertainty about her body. In the case of the third woman, her experience of pregnancy made her anxious about having a healthy baby. My question emerged; how their emotional reactions influenced breastfeeding? Looking at the story of the breastfeeding mother, her experience of hospital stay was described as feeling blue. However, somehow she managed to continue breastfeeding.

Three women's stories revealed the contradictory views on the current mutual aid of 'SATO-GAERI' (going back to her parents' home). In fact, their own mother worked for giving the practical support such as cooking, washing, and looking after the baby. However, 'SATO-GAERI' is not always described positively. The first woman's story showed the gap between how she wanted to be supported and how her mother supported her. I was concerned about the negative response to 'SATO-GAERI' and questioned why this was not working in the current social settings.

Yamamoto (1983) described the traditional mutual aid; the system of living in 'SAN-YA', where women were living in a small community hut during and after childbirth, whilst female relatives came to look after her and her new baby. In that setting, the women did not need to do housework or farming tasks. They could sleep or rest, as they wanted. The people offered a minimum help for the woman and her baby, which maximised the chance for women to live in a relaxed atmosphere. The current hospital birth could be a business, which required a clock for legitimating the number of people working within the organisation. In the

current 'SATO-GAERI' setting, the women and their babies had to adapt themselves to live with other people's time. The feeling of relaxing was dismissed due to the way of usage of time. Raphael (1976) argued U.S.A. milk companies in the 1970s spent much money on researching how relaxation such as good music influenced milk cows to produce good quality and an increased amount of milk, but no research was undertaken on human lactation. She suggested that the same effect would be found in human's breastfeeding. In Japanese traditional obstetric books; women should stay in a calm environment and avoid any emotional and physical stress after birth (Nishikawa 1992). In Japanese society, it is commonly known that breast milk would stop when women got into the emotional stress. The system of 'SAN-YA' is considered as a Japanese wisdom, in which the women could live with less stress and less physical work. It increases the chances their body to have enough breast milk. In the current hospital environment and the social system such as 'SATO-GAERI', some important elements are diminished. The women's emotions and physical changes should be supported as a whole, and the women could use their time and space by their own needs.

8-1-3. The feeling of women's uncertainty and the meaning of context in my research approach

In this section, I will look at the things that the women did not say in the interviews. I tried to understand why the women did not express their feeling of uncertainty to their husband or families or friends, even though they had a good relationship with them. I tried to understand the meaning of the unspoken part of women's emotions in relation to the meaning of uncertainty, and the cultural expectation of not talking about their own emotions.

Whilst the women did not express their feeling of uncertainty, I read the women's message in the interview setting. I could feel the women's feelings from seeing how they touched their baby and undertook child care. Entering the interview

setting, the women's homes, was the first step to feel the women's emotions to the interview as well as their child care. All three women had prepared a tea set, which I perceived as a message that my visit was welcomed. In the first case, the interview started from helping with the baby's constipation. I was concerned about its impact on the rest of the interview, but it did not influence. I identified that the relationship between the women and myself was dependent on the women's previous experiences of living with other people in their own environment.

The women's feeling of ambiguity and uncertainty were clarified by seeing their relationship with their own baby. For example, the mixed-feeding woman left her baby on the sofa during the interview and at the end asked me how much she could cuddle or touch her baby. I could feel something was not quite settled in her life. The bottle-feeding woman also mentioned the lack of 'SKIN-SHIP'. However, I had already seen that she cuddled her baby and sat for the interview, and her baby seemed so comfortable on her lap and happy to be with her mother, so I did not worry about the lack of 'SKIN-SHIP' in her case. In the breastfeeding woman, she managed getting her baby to sleep before my visit. In fact, until the end of the interview, her baby slept and she enjoyed talking with me as much as she had expected. I found their relationship with the baby told me more about their lives than the things through I understood them from their talk alone.

As a result of exploring the women's emotions, I clarified that anxiety and uncertainty could be a different emotional state. The anxiety was based on the temporary matter and the women knew the reason behind their feeling, whilst the uncertainty was a feeling that the women could not clarify the reason why they feel like this. In the story of the bottle-feeding mother, breastfeeding was characterised as a problematic event. On the other hand, the breastfeeding mother did not talk about breastfeeding whilst she was talking of her story following her own interests. In addition, she described the reason why she

wanted to continue breastfeeding as her baby favoured breastfeeding, as she described 'he likes it'. If she did not experience mastitis, she might not express her reason in an explicit way. In addition, I found that the three women did not make sense of their own experience in relation to their identity of a mother, in other word, 'motherhood', at this stage of postnatal period.

As a result of reading women's experience of breastfeeding from narrative account and then understanding them from chronological order, I came to question the limitation of researching breastfeeding by a one-stage type interview. I perceived that 'time' was a key to understand the different nature of uncertainty in childbearing, childbirth, and breastfeeding. Childbirth is an event that can be completed within 24 to 72 hours of time, and pregnancy is the event within 10 months. However, time for breastfeeding was vague or unlimited. In addition, the women's experience demonstrated how their immediate environment made an impact on breastfeeding practice; especially its meaning when the woman was not able to practice it. As a consequence of my exploratory work, I identified that breastfeeding research required a way of looking at it from the women's time and space.

8-2. The discussion: women's time and space and the meaning of breastfeeding

In my exploratory work, the women focused their attentions on practical aspects of breastfeeding and the Japanese concept of 'SKIN-SHIP', closeness to their own baby. In this section, I will explore those themes in relation to 'women's time and space' in the existing literature.

8-2-1. The meaning of women's bodies and breast milk

Comparing my empirical work to the Western research around reproductive health, a significant difference appeared; the women in my study did not describe

breast milk and breastfeeding, and their own body was not a subject to talk about.

In Western approaches, the meaning of breastfeeding was much constructed on the social and cultural notion of 'human body'. For example, breast milk has the social meaning of purity and dirtiness (Douglas 1984). Martin (1987) argued the blood of menstruation was considered as wasted bodily fluid, which meant the woman failed to complete her work of reproduction, just as technical machines failed to work. Bramwell (2001) discussed how the colour of bodily fluid was used to articulate the meaning of women's body and breastfeeding. The colour of red symbolised men's power and strength, but women's menstruation blood was described as a symbol of dirtiness (ibid.). The colour of white symbolised 'sacred or holiness'; therefore the colour of white in breast milk put breastfeeding into 'purity' (ibid.).

Krumeich et al (2001) described that in Caribbean villages where polygamy was the social norm, the male partner gifted formula milk and bottles to the female's family after birth. The partner demonstrated his wealth to other community members by sending those materials as a gift. In return, the community allowed him to have multiple numbers of wives and children. The community had the local belief that sexual intercourse brought a bad influence on women's lactation; no sexual intercourse was allowed during breastfeeding. As a result, breastfeeding was considered as a cause of the women loosing their male partner; therefore the women did not choose or practise breastfeeding long term (ibid.). In the catholic societies where monogamy was the social norm, breastfeeding was told as a promise with God (Obermeyer and Castrle 1997). The sexual intercourse was prohibited, since it ruined the women's sacred task of breastfeeding. It was the reason again why Western women did not choose or moreover the men hindered the women to choose breastfeeding (ibid.) Those cultural studies illuminated the value systems around breastfeeding. Maher(1992) argued that breastfeeding was often initiated by men's value system rather than the women's

wish. Therefore breastfeeding represented the social norm of marriage and having children, men's wealth and social status rather than parenthood, kinship or a mother and her child relationship (ibid.).

Looking at Japan, the current society has a system of monogamy. The general moral judgement is made through the mixture of Shinto, Buddhism, Confucianism, and Taoism. Breastfeeding is clearly discussed as a matter between the woman and her baby, which was illuminated by women's concerns about 'SKIN-SHIP'. Breastfeeding in a Japanese context seems something particular, and their husbands nor any religious thoughts are not in a position to force the women to choose either to breastfeed or not.

Anthropological approaches stimulated my question to enquire about the nature of breastfeeding; whether breastfeeding is either a matter of 'culture' or 'nature'. In a Western context, 'culture' was used for symbolising the result of civilisation, which is about the departure from the nature. Csordas (1999) criticised as it should not be the only way of looking at the meaning of 'culture'. The idea of civilisation influenced the framework of making sense of human experiences with the dualistic approaches; viewing body/mind, culture/nature, and emotions/reasons in separation (Williams and Bendlow 1996).

In my exploratory work, breastfeeding was illuminated as a part of women's everyday life, in which breastfeeding could be described both nature and culture. I quote the Japanese definition of 'culture' described by a Japanese historian as follows:

> *'The culture exists in all the phenomena that human-beings are involved in. As a result, culture gains three features. Firstly, culture has a reason why it is performed in a certain manner. Secondly, culture has its own character, structure, and own role in the setting. Thirdly, culture has its potential value, which could be passed from generation to generation',*

beyond people's wish to control of it.

(Ienaga 1982, p4, translated by author)

In the exploratory work, the women talked about the practical importance of breastfeeding. The women's stories also informed the nature of the research field. Their breastfeeding was supported by the traditional rituals and wisdom, and the closeness of women and her baby is considered as the importance of breastfeeding. The dairy products or meats or oily food would be inviting mastitis, which could be a new knowledge since Japanese people have shifted into the Western eating. From the prevalence shown in the Japanese national survey, I assumed the Japanese society may have shifted into a mixed-feeding culture. However, the women's stories illuminated that breastfeeding is a social expectation, not a question in the current Japanese social context.

8-2-2. The Western anthropological view of Japanese child caring

The physical closeness in child caring was identified as a significant part of Japanese culture, which was recorded in Western people's travel diaries in Japan. Anthropology was based on recording their curiosities about the things with which they were not familiar in their own culture, which often originated from simple travel diaries or records (Eriksen and Nielsen 2001). When the Japanese social system of 'SA-KOKU' (limited contacts with other countries) was demolished at the end of the 19th century, Western travellers visited Japan and the features of Japanese child caring were recorded with their great curiosities.

The concept of Japanese decency to children

The phrase 'KODOMO-TENGOKU' ('KODOMO' means 'children' and 'TENGOKU' means 'heaven') was found in a travel record written by Morse, who worked for a Japanese university as a biologist from 1877 to 1882. He described that children were running and playing in the streets during daytime, while the

mothers were talking and working together. In the evening, the fathers came out from their house cuddling small children in their arms. Children were always carried by somebody and always smiling and laughing, by which he guessed that Japanese children were the happiest in the world (Kiriyama 2004).

The physical closeness between small infants and their parents was identified as the key to making children happy and free spirited, but also well-disciplined (Kiriyama 2004). 'ONBU' (carrying babies on mother's back) and 'SOINE' (sleeping on the same Japanese mattress with own mother) was the secret of Japanese child caring (Yamamoto 1983). By doing 'ONBU' and 'SOINE', babies were breastfed whenever and wherever they were. Through the whole day long, it was very rare to hear babies' crying in the Japanese society (Macfarlane 2002a).

'ONBU' and 'SOINE' arrangements by their own mother were undertaken until the next baby was born. The baby was breastfed until the new baby was coming, which made Japanese breastfeeding longer, sometimes until the children were four or five year's old. When the new baby was born, the sibling stopped breastfeeding. The mother's back and breasts were occupied by a new baby, and the small toddlers were carried by other family members such as grandparents or siblings. By 'ONBU', the children experienced the different life settings, which were considered as the reason why Japanese children were well disciplined from a young age. It was described:

> *'For years the child is carried on the back of the mother, strapped or carried in a pouch-garment like fold of her padded over, sharing in a half drowsy state in mother's warmth and rhythm. It may rob the free movement of baby's limbs but feeling sheltered. Closeness to the maternal body means life, protection, company and goodness to the baby'.*
>
> *(Singer, cited in Macfarlane, 2002b p7)*

The reason for 'ONBU' in the Japanese context is based on the idea of protecting a small child from accidents such as falling over onto the floor or keeping them warm. The 'SOINE' was important to keep a small child in the winter season. It can be considered as 'wisdom of life' (*'SEIKATSU-NO-CHIE'* in Japanese).

The current modernisation changed the 'SOINE' and 'ONBU' arrangements. Young generations are living as a nuclear family and have a Westernised lifestyle. The Western bed instead of Japanese mattress is fashionable, but the women are concerned that their baby might fall off the bed. The 'ONBU' has been replaced by 'DA-TTUKO' (cuddling babies in front). The nuclear family leads to women having nobody around who can carry her baby. As a result, the new mothers start wondering how to discipline the children.

Breastfeeding in public in a Japanese context

Yamamoto (1983) commented that it was common to see breastfeeding in public until the 1960s. The women's upper bodies were not gazed upon nor the male upper body, which was possible in that people engaged in the tacit rule of 'MITE-MINUFURI' (means 'pretending not to see'). The idea is explained by the Japanese people's habit of bathing. Until the Edo period, it was common for men, women, and children to bath together. Basically, Japanese people were very open to their own body. The idea of 'MITE-MINUFURI' makes people create a private space whilst they were in the public space. By pretending not to see, the women did not have the feeling of being gazed at while breastfeeding. At the end of the 19th century, when Japanese society had visitors from the Western societies who had different views about the body, the Japanese society needed to change the bathing habit, and to separate men and women into the different spaces (Kiriyama 2004).

Until the 1960s, each house did not have its own private bath, and people went to a public bath called 'SEN-TOU' in the community, which is the place for people to

have a bath as well as to exchange the local gossip (Kiriyama 2004). 'SEN-TOU' is divided into women and men in separate places. However, small children were considered as 'gender free' and they could take a bath either in the male or female bath, which is dependent on who came with the children. By going to 'SEN-TOU', children see and know the aging bodies and individual differences in bodies including female and male bodies by a natural manner (ibid.). In the current society, very few 'SEN-TOU' are facilitated in the community, but Japanese hot spring baths in local areas are the places people take baths together. However, the Westernised idea of women's bodies has made women's upper bodies and breasts a sexual object. The young generation cannot take a bath naked with other people. Comparing the meaning of privacy, the Western idea seems to require the physically separated space among people, whilst Japanese privacy is created by this tacit manner; creating the space of privacy by a mental space, rather than making it by physical separation.

Japanese rituals showed evidence that colostrum was not given to babies, historically because of the yellow colour and dullness. It seems in general breastfeeding was started three days after childbirth (Yamamoto 1983). However, women's bodies and bodily fluids including breast milk did not appear in relation to power or the control in the social order. Comparing the different approaches to valuing a human body, women's bodies as well as men's bodies were not projected to be seen or talked about in the traditional Japanese context. From the differences across cultures, I assume that the Western approach of 'scientific knowledge' in breastfeeding is a way of objectifying women's breasts. The concept of objectivity would be required because it is the way that women and medical professionals are able to discuss breastfeeding overcoming the public notions of seeing 'women's breasts' as a symbol of 'sexuality'.

8-2-3. The language and translation work between Japanese and English

In my study, a case-oriented approach was used for understanding women's

message from both the things that were and were not talked about in the conversations. At the planning stage, I developed a case-oriented approach for my analytical framework. Through the process of working with the data, the framework was developed into a form of working with the context.

As I reviewed in chapter 5, I was very conscious about the conceptual differences that exist in the different languages. I discussed this issue with several experienced researchers. Some of them commented it was not a problem in their translation work, whilst some supported my point. I realised the difference arose from each researcher's sensitivity to language. Using the language differences between English and Japanese, I could learn more about the meaning of context.

Firstly, when I started asking the women; 'how do you feel about your life?', they expressed their feelings. However, in the rest of the interview, they did not express their emotions in a direct manner. They were talking about what other people said and did. Through describing others, the women tried to convey their feelings. This point is consistent with the idea of Japanese conversations as a form of wrapping; their message was wrapped by telling how others feel (Hendry 1993). I came to understand my role was to un-wrap the women's emotions and to convey their message into an explicit form that others could understand. As a result, I identified that the idea of 'self' is described in relation to others in a context of Japanese conversation.

Secondly, in the process of translation work, I did not use a word-to-word translation technique. As I clarified, language was a representation of cultural thoughts, I chose the approach to translate the 'context', which was called 'free translation'; translating the context from one culture into another language (Birbili 2002). The translation work was argued as translating 'modes of thoughts' (Asad 1986). It is the approach that anthropologists use to bring out the meaning of data with a native's framework, rather than their own framework. The reliability of the translation work, 'modes of thoughts', should be constructed by the factor of

'time' that the researcher spent in the field (Asad 1986).

Thirdly, the meaning of the conversation is constructed through my engagement with the place. The meaning of 'context' in my research was named the term 'women's message', which was identified the things that were not told by the women. For example, the value of breast milk was not talked about by the women, but I interpreted it as women's message of highly valuing it. I might be asked how I could know that. I have to say it is only based on the result of reading the women's message as a whole, which reflects Japanese cultural assumption of language; reading women's state of mind ('KOKORO' in Japanese) from the context.

Through the data analysis, I restructured a case-oriented approach, which could be used for describing the complex nature of breastfeeding in my research context. My analytical system has developed viewing human and environment in oneness and the researcher is a part of the context, which based on the following elements:

- Interviewing the women by open approach.
- Reading the message of whole settings including the initial contact and during and after the interview.
- Studying the context that could illuminate the significance of the experience.
- Representing it as a form of narratives that could help to understand women's experience with their unique context.

In the remainder of the thesis, a case-oriented approach will imply the above procedure.

8-2-4. The researcher's bias and the reliability and validity of the data

One of the aims of the exploratory work was to identify my personal bias as a

practitioner researcher, which I will reflect in this section.

My open approach was adapted from my intuitive knowledge as a midwife, which is used for understanding a woman, her baby, and her family as a whole. In practice, it helped me to identify the resources that were available in women's environment. I tried to be open during the interview. However, when reading the transcribed data, I identified my personal bias. I asked negative aspects first and then looked at positive aspects. I was reluctant as I tried to be very careful in the field and try not to follow 'a problem solving mind', as it exists as the potential bias amongst practitioner researchers. However, 'the personal bias' was described as a positive factor, which was replaced by 'self-consciousness' (Kvale 1996). It helps to work for formulating questions during interviews and extracting the ideas in the data analysis process.

The positive aspect of a practitioner researcher was identified. In the process of data analysis, the data were validated through my practical experiences and knowledge. The idea of allocating women's life events in chronological time is applied from my everyday practice. I considered that the exploratory interviews revealed my unconscious way of knowing in midwifery practices into a conscious process of knowing.

As I stated in chapter 6, I had a reason to use this open approach in my research field, which I defined as due to the unknown sensitivity of breastfeeding in a Japanese cultural context and the nature of Japanese communication. From my point of view, I was very certain about this approach fitting with my philosophical framework as well as the aim of exploratory interviews. However, when I presented my data in a research seminar in North America, it was criticised as too broad and not to focus on the research question. I have to admit my holistic approach has not been familiar to the researchers attending the seminar.

The narrative representation was used as the solution to answer the other

researcher's questions, and could be used by other researchers to discuss the advantage and the limitation of my research approach. I could also see a narrative representation in conjunction with the midwifery practice; everyday practice was based on direct involvement in the setting, attachment with the woman and her baby, and working with women's physical conditions as well as emotions. However, social scientists argued a narrative construction was challenging; they were unaccustomed to attachment with people's personal life and emotions, and more accustomed to present personal life as a typical rather than a personal experience, to give priority to theory over the story, abstractions over the details, the cool detachment over the warm involvement, and not used to be tolerant to ambiguity and uncertainty (Ellis and Bochner 1999). I considered that those elements could apply in the reverse task of informing my research approach and my position of being a practitioner researcher: being accustomed to be with people, there are no typical cases in practice, the woman and her baby are concerned as a unique couple, the detailed descriptions and narratives are the essence of developing a good practice, and tolerance to ambiguity and uncertainty was the way of living with women.

8-3. Designing phase two: more focused explanation of breastfeeding

In this section, I will report on the process of transition from phase one to phase two; emerging themes and research questions for the further empirical work and the theoretical and practical considerations of phase two.

8-3-1. Themes and research questions for further empirical work

My holistic approach was the way to bring the whole context together into developing a picture of breastfeeding from women's point of view. The previous Western research approach studied breastfeeding as a discrete event, in isolation from its context (Maclean 1989). In the way of knowing in anthropological approaches, the previous breastfeeding research was criticised

for its fragmented approach; breast milk as a food or baby's nutrition, breastfeeding as baby's psychological problem such as attachment theory or bonding, and women's reproductive health in controlling the number of children, and socio economic events due to women having to go to work outside the home (Maher 1992). My exploratory interviews within a holistic approach could identify the gap between theory and practice in breastfeeding, in which most research did not look at breastfeeding as it was happening within the women's environment. My research theme was identified:

• Women's time and space; biophysical, social and cultural components that influence women's experience of breastfeeding and also their whole context of child caring.

My research question for the phase two was:

• What is the real essence of breastfeeding?

The exploratory work also revealed the limitation of a one-stage type approach for breastfeeding research; the timing of 3-4 months after birth could influence the degree to which women could reflect on their own experience. Particularly one of the findings, breastfeeding was not talked about once it was embedded within women's everyday life, pushed me to think whether interview alone would be appropriate to study breastfeeding. These questions required a new aspect on my research. In my exploratory work, the women demonstrated their ability to talk about their experience and feelings in the interview setting, so that I became not to worry about conducting research in a Japanese cultural setting.

The phase two empirical work was designed in a way of describing women's biophysical shift and women's environment together. For the further empirical research, I chose a longitudinal approach as the research design, which is the most likely approach to describe women's breastfeeding in a continuous time

frame. I chose to use myself as a fieldwork researcher, which was described in the ethnographic approach (Emerson et al 1995). In the next sections, I firstly report the result of looking at the features of a longitudinal approach and discuss the elements of ethnographic fieldwork.

8-3-2. The idea of a longitudinal study

In the social sciences, a longitudinal approach was defined as 'collecting the data from the same data resources over time and analysing the data over time', which can be either a quantitative or a qualitative approach or combining both (Ruspini 2000). In a quantitative type of research, a longitudinal approach was used for measuring the 'social changes' by statistical analysis. A qualitative research in a longitudinal approach has the problem of theoretical framework in data analysis. The researchers had the problem of making sense of longitudinal components across the data collected through the time span. In addition, longitudinal study was not used often due to the problem of time and money (ibid.). I looked at some of the examples of studying breastfeeding using a longitudinal approach in order to identify the advantages and disadvantages of applying it in my study.

The quantitative longitudinal type of breastfeeding research was used for testing a theory or an experimental study such as measuring the impact of antenatal educational programmes. A social theory was applied for looking at breastfeeding as a human behaviour. For example, Dick et al (2002), a North American study, tested the Breastfeeding Attribution Prediction Tool (BATP) based on the theory of planned behaviour. The study collected the data twice, during pregnancy and eight weeks after birth, from the same group of women, and found that the women who had a positive attitude towards breastfeeding in the antenatal period continued breastfeeding longer than women who showed negative feelings. The paper concluded that BATP was a useful tool to predict women's early termination of breastfeeding. On the other hand, Goksen (2002), a Turkish study, tested the theory of reasoned action by collecting the women's attribution to

breastfeeding four times; after birth, and at one, two and three months of baby's age. The study concluded the women's intentions were not the main factor for why they were able to successfully breastfeed, which rejected the application of the theory of reasoned action. I considered the conflicting research results stemmed from other social and cultural factors. The limited application of the theory of reasoned action to breastfeeding research was argued by Kearney and O'Sullivan (2003), which breastfeeding was excluded to the evaluation study of the theory of reasoned action due to the complex nature of the topic: breastfeeding should not be comparable to other human behaviours such as quitting smoking or alcohol or losing weight, in which the result was strongly influenced by people's intention or decision alone.

The qualitative longitudinal approach was applied when the researchers worked to illuminate the women's perceptions or feelings towards breastfeeding. Earle (2000) interviewed 19 women, three times, about their choice of feeding methods and actual experience; at 6-14 weeks, 34-39 weeks in pregnancy, and 6-14 weeks after birth. The data were analysed by a cross-sectional approach. As a result, the women's reasons for not choosing breastfeeding were explained as breastfeeding hindered their partner's participation in child caring. Schmied and Barclay (1999) reported from a longitudinal breastfeeding project in Australia, which followed 26 first-time mothers' experience from pregnancy up to three years of baby's age. The research paper focused on reporting the findings from four interviews; undertaken at five to six months intervals from pregnancy to six months. The data were analysed from the feminist theoretical perspective. The women's experience of breastfeeding was generated into negative discourses; the loss of autonomy and control in their lives. In sociology, breastfeeding was investigated under the framework of women's choice for babies' food. Murphy (1999) followed 36 first time mothers' experience of breastfeeding from the late stage of pregnancy until baby's age of two years. The paper looked at the women's choice of breastfeeding in the antenatal period, and the reason was identified as the women's attribution of attaining a good motherhood.

My initial understanding of a longitudinal study would be the way of obtaining a holistic explanation of breastfeeding through looking at the topic in a continuous time scale. However, my review provided with negative ideas about designing a longitudinal study; no justification was given to define the appropriate timing and the duration of data collection, and the data collected by the longitudinal approach was analysed by cross-sectional approach, which could not illuminate the strength of looking at the phenomena under the framework of continuity, shift, and changes.

As a result of my literature review, I decided to make a further enquiry about a longitudinal approach.

8-3-3. Ethnographic research approach

A longitudinal study meant that I spent some time in the research field. The idea of an ethnographic approach was considered as the way of gaining a profound understanding about the research field.

In naturalistic inquiry, the ethnographic approach was considered as follows:

> *'Indeed, William Corsaro (1980) has strongly recommended the use of what he terms 'prior ethnography', becoming a participant observer in a situation for a lengthy period of time before the study is actually undertaken. Such prior ethnography not only helps to diminish the obtrusiveness of the investigator but also provides the baseline of cultural accommodation and informational orientation that will be invaluable in increasing both the effectiveness and efficiency of the formal work'.*
>
> *(Lincoln and Guba 1985, p251)*

In the exploratory work, I was very conscious about not mixing up my role

between a researcher and a practitioner. It was initially considered important to develop the clear analytical framework to extract something significant from the things that are familiar to me in everyday midwifery practice. Having a case-oriented approach as a framework, I decided to extend my researcher's role into the idea of 'becoming a fieldwork researcher' in ethnographic approach (Emerson et al 1995). The idea was described as follows:

> *'Goffman (1989) in particular insists that field research involves "subjecting yourself, your own body, and your own social situation, to the set of contingencies that play upon a set of individuals, so that you can physically and ecologically penetrate their circle of response to their social situation, or their work situation, or their economic situation"...'.*
>
> *(Emerson et al 1995, p2)*

The idea of immersion in the field includes the activity of being involved in the situation in which events are happening as well as the environment and circumstances in which the events take place.

The idea of a fieldwork researcher, writing field memos and reflections from everyday life experiences, was considered an important part. It can create the space for writing my reflection from my everyday activities as a midwife. Possibly it would help to establish the ground where I can integrate the formal data collection and informal information gained from the field as a whole product.

I redefined my longitudinal approach as 'follow-up interviews', which meant following-up women's experience of breastfeeding from time to time. The ethnographic approach was considered to increase my sensitivity and awareness in making sense of my interview data. My role in the field was modified while I was in the field, which will be discussed in relation to the framework of representing the findings in the next chapter.

8-4. Doing prior-ethnography: preparation work for the follow-up interviews

As a result of reviewing my theoretical considerations in light of the literature, I had two questions about conducting a longitudinal study; the timing and the duration of the follow-up of breastfeeding. Taking into account my resources and network in my field, I initiated four pieces of prior-ethnographic work before going to the main longitudinal part of study, which I will report in this section.

8-4-1. Clarifying the meaning of a longitudinal study

I planned this empirical work in order to gain practical understanding of a longitudinal study; what was meant by 'collecting the data from the same data resources over time and analysing the data over time' (Ruspini 2002). I returned to the three women in my exploratory work. As a result, I did a second interview with two of the three women. I could not contact the mixed-feeding woman, who seemed to have moved away from the area. The interview was undertaken using the same approach as in the exploratory work; an open interview approach, whereby the data were tape-recorded and analysed by a case-oriented approach.

In the second interview, breastfeeding was not mentioned by Mrs T (a breastfeeding mother) a great deal. I asked her about her experience of breastfeeding, and she confirmed my idea that she did not perceive breastfeeding as a special topic to talk about. She completed breastfeeding at 12 months. She had worried about how her child would respond to her, but her child was happy with only weaning food, and did not cry without breastfeeding. The bottle-feeding mother described the social expectation of child caring and breastfeeding made her unable to sleep and to feel isolated from others.

I compared the interview data to the first interview and tried to make sense of their narratives across the continuous time frame. I learnt three things about the

longitudinal approach from this experience. Firstly, the women were relaxed from the beginning of the follow-up interview, which shifted the interview into a form of dialogue between the two of us. Secondly, the women were able to recall their memory of child caring accurately. They could not remember the things they had talked about in the previous interview, but it did not hinder women to talk in the interview setting. Thirdly, I brought back my concern and question from the exploratory interview and discussed these with them. I found it was useful to increase my sensitivity to the topic and the credibility of my analysis.

8-4-2. Estimating the duration of follow-up interviews

From my practical experience, I had a kind of general idea about how long women were likely to continue breastfeeding. However, the women often decided to stop breastfeeding after 12 months under the pressure of medical professionals. I decided to interview women about their experience of stopping breastfeeding.

Using my personal network in my community, I interviewed five women about their experience and decision to stop breastfeeding. Their children were aged between 15 and 18 months. The women were sampled from my practical cases. I assumed that they might like the idea of longer breastfeeding. The following points were clarified as a result from the interviews:

- Three women intended to breastfeed for 1.5-2 years and they finished breastfeeding at about 18 months. The experience of stopping breastfeeding was described as a difficult time; mainly how they can negotiate with their child, the lack of human resources and information to ask for the practical support to finish breastfeeding
- One woman shifted from mixed-feeding to bottle-feeding at five months, because her child refused to suckle her breasts
- One woman, whose child was 18 months, was breastfeeding at the interview.

She started wondering how and when she might, should or must stop breastfeeding

The women's stories indicated that from 12-18 months the women started to think about stopping breastfeeding. I took into account the possibility that planning a follow-up interview prior to 12 months may not capture the women's experience of stopping breastfeeding. I will be required an alternative way to follow-up women's experience after 12 months.

8-4-3. The cultural features of breastfeeding: interview with a British woman

I interviewed a British woman who was living in my community and whom I visited at home after birth. The idea arose through discussing the cultural features of Japanese breastfeeding whilst I was in the U.K. academic setting. I had several questions about Japanese culture, which I wanted to clarify with somebody who had a real experience of breastfeeding in a Japanese setting. The woman I nominated for my interview was an English teacher, living in Japan for three years. I knew of her struggles to breastfeed her baby and had several communications with her after the visits. I interviewed her view of Japanese child caring from her lived experiences. The interview came up with the following points:

• At the baby's one month's clinic, she was told of her baby's poor weight gain. She was told the poor nutrition would damage her baby's brain. She felt intimidated by the doctor. After the consultation, she was sent to a breast massage room in the hospital, where she was given a breast massage with her husband was with her. She was embarrassed and felt she was like milking cows.
• She met other Japanese mothers in the baby's clinic and was surprised they did exclusive breastfeeding. Since they stayed in the same hospital, under the same protocol and the same staff, she wondered why they could breastfeed but she could not.

• She felt strong isolation from others. She knew the language was a barrier to talk with the people in her environment, mainly they were Japanese. She phoned the La Leche League in Japan, anticipating she would be able to discuss her concerns in English. However, she found that the information was too general. She really wanted to have somebody to talk with face-to-face. Especially, she wanted to have this for the first three months, whilst her baby was small and she could not go out as she wanted.
• After four months, she gave up the idea of breastfeeding, and shifted from mixed-feeding into bottle-feeding only. Her decision was made due to her baby crying after breastfeeding. She wanted to continue breastfeeding until 12 months, which was natural to her and somehow she did not like the idea of cow's milk.
• Joining in the community mother's meetings, she was surprised that the Japanese mothers were so easily going back and forwards between breastfeeding and bottle-feeding. On occasions, women gave bottles to their babies, on different occasions they did breastfeeding. She wondered why Japanese women were able to move between breastfeeding and bottle-feeding in such a comfortable way. From her point of view, breastfeeding and bottle-feeding were totally opposite ideas.
• Comparing the Japanese and Western child caring, Japanese women did child caring following their intuitions. She loved the idea of 'ONBU' (carrying the baby on her back) and 'SOINE' (sleeping with the child in the same Japanese mattress), and she found it was practically useful. For example, when her baby was crying in the evening, she could cook or do housework whilst she carried her baby on her back.

She concluded that Japanese child caring was based on physical closeness between mothers and their babies. She had assumed that Japanese culture was not based on close physical contacts such as shaking hands or hugging or kissing each other. However, the mother-infant relationship exists as the exception, which made her feel curious. I found her curiosity about breastfeeding and child caring was consistent with my questions, which I had whist having

physical distance from my own culture. The interview informed the different view about breastfeeding in the U.K. and Japan, and suggested Japanese women seem to follow their intuitive knowledge rather than following ideas of child caring found in textbooks.

8-4-4. The teenage girls' view on breastfeeding

The fourth prior-ethnographic work was co-incidentally took place, since I had the opportunity to take a class in a girl's high school where I graduated. I used this chance to explore the teenager's view on breastfeeding, which I could not find in Japanese literature. I considered their views would help me to see breastfeeding in the connection between the current and the future generation. I set homework for the students to prepare for the class; interviewing their own mother's experience of breastfeeding, and collecting the perceptions and the future intention about breastfeeding from five friends in the same grade.

On the day of the class, I asked each student to present her mother's story, and then discussed their views towards breastfeeding:

• I firstly noticed the students started their talk with; 'I have a brother/ a sister and my mother breastfed them like ~'. Following the story of their siblings in breastfeeding, they talked about their own story. This particular type of discourse seemed the way they can avoid peer pressure or protecting themselves from the embarrassment of talking about themselves.
• The students were born in 1983 to 1984, when the breastfeeding rate was reported as 56% and mixed-feeding rate was 32% at one month after birth (Mother's and Children's Health and Welfare Association 2004). The students' stories represent the various aspects of breastfeeding including the story of premature birth and the problem of jaundice in exclusive breastfeeding. One of the stories represented the mother's regret that she could not breastfeed her baby, because she was concerned it was practically important. Breastfeeding

was the best way to know the baby's physical condition.

• In the discussion, the students agreed the idea of breastfeeding was normal and best. All the students had experience of seeing their friends or cousins breastfeed their baby or had the memory of seeing their sibling breastfed.

• From the survey, 76 of 89 students had an experience of seeing actual breastfeeding. Sixty-seven students answered 'Yes' to the future intention of breastfeeding and the reason given was that breastfeeding was natural. The answer of 'I don't know' was found with 20 students, and two students answered 'They will not breastfeed'. The reason for not choosing was explained; no reality of becoming a mother, and disliked the idea of breast milk because it was her own bodily fluid.

From the atmosphere in the class, I was astonished to see student's active attitudes to discuss the issue, which was normally considered as a sensitive subject. The education approach seems to shift from the conventional teaching model. The students seem to have become used to discussing their opinions with others this did not happen when I was a student. I found it was useful to know the shift in the education model. The school was a private school, and the students came from more than a middle class background. I cannot generalise their ideas and also I did not have male teenagers in the class. However, their information is important for two reasons. Firstly, the teenager's perceptions of breastfeeding informed that the current Japanese culture is based on breastfeeding, which they described as natural. Secondly, this was the first time the term 'bodily fluid' was mentioned in the field, and I was concerned this could be some reflections from the Western notions of women's body.

8-5. Summary and the points for the next chapter

In this chapter, I described the result of my exploratory phase. Studying three exploratory interviews from two different approaches, narrative account and chronological time, women's time and space appeared as a theme for the next

empirical phase. The limitations of a one-stage type of interview were reflected into designing the next stage of research. The idea of a longitudinal study and an ethnographic approach was examined through indicative reading of the available literature and doing the prior-ethnographic work. The period of time I spent for prior-ethnographic work was considered as the transition of myself to become and to live in my community as a fieldwork researcher.

As a result of my exploratory work, I came to anticipate the longitudinal approach could transform the interview into a form of dialogue, which stimulates the women's self-reflections to talk about in the interview setting and my self-reflection to read the interview data. The ethnographic work increases the cultural accommodations, which stimulates my self-awareness to look at the cultural aspects of breastfeeding. The appropriate interval in follow-up was not clarified by the prior-ethnographic work. I decided to follow-up the women at approximately one month intervals, which was based on my intuitive knowledge as a community midwife. Alongside the prior-ethnographic work, I returned to my community midwife job, through which I maintained the network with other community midwives and developed a skill for writing field notes. In the next chapter, I will report on the detailed research design and method of the next empirical phase.

Part Three: More Focused Explanation of Breastfeeding

Chapter 9

Reporting on phase two: more focused explanation of breastfeeding

Chapters 9, 10, and 11 will report on my main empirical work; following-up women's experience of breastfeeding from the postnatal visit until the babies' first birthday. As I discussed in chapter 8, my research was designed through the indicative reading and the prior-ethnographic work in the field. The research was designed to visit women at their home every month and to interview them until their babies' first birthday, which presumably would collect a series of interviews such as a number of 10-12 interviews from each woman. This chapter reports on the detailed research design of follow-up study of breastfeeding; sampling, the process of data collection, the data analysis, and completing the study.

The second phase was developed as an emergent design, in which some theoretical and practical issues were explored through the actual fieldwork such as how to manage the ambiguity in doing a follow-up study and the role of a fieldwork researcher. For example, I could not anticipate how likely the women were to stay or quit from the interview. I decided to be flexible and be willing to make changes according to the women's requests. I found the theoretical framework was important, which I always referred to and checked; whether my decisions fitted with my research aim and framework. My study was not designed as a cross-sectional study, and I did not pressurise the women to be interviewed exactly once a month. After completing the fieldwork, I returned to the U.K. academic setting. As a result, I became more conscious of the meaning of my ethnographic approach with regards my entire research project, which was described by immersion in the field and the displacement from the field, and the researcher's reflexivity in and after leaving the field.

In this chapter, I begin with describing my research focus and report on my

reflection on becoming 'a fieldwork researcher'. Describing the actual research sampling and the process of study, I will discuss the closure of the fieldwork and the framework of thematic narratives.

9-1. Focus of the study: more focused explanation of breastfeeding

The research question for the second empirical work was; what is the real essence of breastfeeding? The key themes to develop in the research design were clarified as 'women's time and space in their everyday lives'. The follow-up study of breastfeeding was designed for achieving the following aims:

- To explore the nature of the topic into women's time and space.
- To obtain the broader context of breastfeeding from the ethnographic fieldwork.
- To study breastfeeding within each woman's context and to identify the real essence of breastfeeding from the women's point of view.
- To study breastfeeding across cases and synthesise the essential elements of understanding women's experience of breastfeeding under the theme of women's time and space in child caring.

I set my mind to look at the follow-up interviews as a main data resource to study breastfeeding.

While in the field, my role was developed combining two roles together, a practitioner researcher and a fieldwork researcher. As a practitioner researcher, I used my practical experiences, such as those gained from postnatal visits, as a reference, in which I could explore the issues that appeared during the formal interviews. As I used myself as a fieldwork researcher, I developed the skills for writing an ethnographic field note, which recorded my everyday life experience in my field. The following two sections will describe more detailed aspects of the character of my study; immersion in the field, displacement from the field, and the researcher's reflexivity.

9-1-1. Immersion in the field and displacement from the field

The element of the researcher's immersion in the field was discussed as the time when the researcher was engaged with the fieldwork (Emerson et al 1995). Clifford (1997) discussed the idea of fieldwork between two elements: immersion in the field and displacement from the field. The immersion in the field was the element which could be obtained through face-to-face and direct interaction with others. The displacement from the field was described as 'travelling to and out of the field', which would provide the analytical distance from the fieldwork materials. In this section, I report on my position in and after the fieldwork.

The ethnographic approach was generally used for the exploratory work; to identify a gap between those things that 'are known' and 'are not known'. However, the strong engagement in the field makes it possible to obtain some answers for research questions. A good ethnographic work could identify further research questions. Emerson et al (1995) described that ethnographic fieldwork was the time when the researcher participated in the local activities and was engaged with the local people. I experienced the follow-up interviews as a time when I was immersed in women's life settings. Visiting women at home, I saw their life setting was rearranging as their baby was growing up. When we reached the final interview, I had enough information to write about women's experience of breastfeeding and to bring out the answers for my research question; what is the real essence of breastfeeding? In addition, I felt that the women knew what I should write about more than me.

The researcher's physical presence in the field made it possible to see how people were interacting with each other, which was called 'casual observation' or 'shadowing key informants through their everyday life routines' (Clifford 1997). Clark (2004) described the concept of being in the field as 'hanging out and observing', which was a mixture of observation, dialogue, apprenticeship and

friendship. Choosing my community as a research field, I used my practice and attendance at the mothers' community meetings as an opportunity to hang out and observe others in the field. I found it was the best way for maintaining my curiosity on breastfeeding. The monthly mothers' meetings in the community were useful to do my casual observations, in which I could see between 70-100 pairs of a mother and her baby. I observed the variety of women and their babies interacting and also the women's attitudes to child caring. The women in my follow-up interviews also joined in those meetings, from which I could know about them apart from the interview settings.

The element of 'displacement from the field' was provided after I returned to the U.K.. When I was in the field, I started to develop the thematic narratives in a primary form. Those narratives were consolidated and explored whilst I was living in the U.K.. I observed the ongoing discussion among British academic scholars, which allowed a critical distance to examine the feature of my data and my research approach. From my reflections of living in the two cultures, I was able to illuminate the significance of breastfeeding.

9-1-2. The researcher's reflexivity and the researcher's skill of writing a field note

The researcher's reflexivity was argued from two aspects: while in the field and the stage of making sense from the fieldwork.

In modern ethnography, the researcher's reflexivity was discussed as the element of giving credibility and validity to the process of the writing as well as the final product (Davis 1999). In the anthropologist's work, the meaning of validity and credibility of the data was credited by the researcher's reflexivity; in other words, the researcher's self-consciousness and self-awareness. Wolcott (1995) argued that the researcher's bias could be transformed into a researcher's reflexivity; the researcher's attention to the field. In the ethnographic work, the

potential truth value was given by the researcher's presence in the field and careful documentation of the research process was required to establish the reliability of the qualitative fieldwork (ibid.). Emerson et al (1995) described the transformation process of using one's own reflexivity in the field as becoming a fieldwork researcher. The immersion in the field did not mean just to stay close to the informants but also the time when the researcher used own reflexivity for recording the things there (Emerson et al 1995).

The first task of becoming a fieldwork researcher was argued to develop a skill of writing a field note; 'how, when, and what to write' (Emerson et al 1995). Some of those skills could be learnt through doing, but it would be better to avoid 'sinking and swimming approach' (ibid.). As a practitioner, I was used to writing about my practice in a case report sheet. I wrote women's comments in my practical records, which made it easier for me to reflect on my practice and to integrate my theoretical knowledge and the practical experience. I expanded this writing habit into developing my skill of writing a field note. I chose an informal style of writing, so I could make memos or jot down my thoughts gained from daily activities such as reading newspapers, watching TV programmes, and listening to somebody's informal talk. Sometimes I had a day where I did not have anything to write in my field notes. I allowed myself to have a blank page for that day as it was a normal part of ethnographic work. The process of writing field notes requires time to make sense from them. I identified that the ethnographic writing has the advantage of being able to bring the immediate reflections and the long-term reflections together into the research process.

Emerson et al (1995) argued the writing process gave the meaning of monitoring the research process. Once I developed a rhythm of interviewing women every month and the skill of writing a field note, I became more relaxed to go back and forth between a researcher's role and a practitioner's role in the field. I brought my questions into the practical settings and discussed them with the women whom I came across in my postnatal visits. I asked my questions that I obtained

from the practice to the women in my follow-up interviews. I identified the key part of my ethnographic work was that I could evaluate and validate my research ideas through my day-to-day practice. I wrote my day-to-day questions in the field notes. Wolcott (1995) argued that ambiguity existed as a nature of fieldwork, therefore the researcher's role was flowing with events as they went, rather than controlling the situation. The field notes came to record my ambiguity in my everyday life.

9-2. Maintaining the network in my community and developing a strategy for sampling

The fieldwork was undertaken in the same community which I used for the exploratory work. This was decided upon after considering firstly the problem of ethics in a longitudinal approach. As I had been concerned from the beginning of my research, it was ethically and practically important to set the research activity within the network in which the women and myself could be supported by other midwives. Secondly, the issue of disadvantage of using a familiar place for the research field was reconsidered. I had planned to return to the U.K. after completing the fieldwork as I did for the exploratory work. The physical distance helped me to identify my personal bias in the field. Finally, I wanted to make some contribution to improve the community midwifery work. I perceived my decision was a positive one, as I could improve my community practice through day-to-day based reflections.

9-2-1. Sampling strategy

Concerning the timing of the sampling, I decided to start my interview from the women's experiences after birth, not from pregnancy. This was decided through my reflection from the exploratory work. I perceived that the women could renounce their initial idea and feelings about breastfeeding postnatally. In addition, my research was focusing on women's actual experience of

breastfeeding; not looking at the relationship between the women's intention and the initiation. As a result of updating the information about my community, I identified that 80% of women gave birth outside of the community, which meant they were likely to stay at their parents' home from the late pregnancy. It would be difficult to follow-up the women from the pregnancy in such circumstances.

The actual sampling was designed to start from observing another midwife's postnatal visits. My idea was developed considering an ethnographic approach; knowing women from observing them. In the exploratory work, I used the other midwife's postnatal cases for my interviews. I had to admit the process of reviewing the cases was based on the midwife's perceptions so this might give some bias in the sampling. I designed to start my encounter with the women in the setting where I could observe them, so I accompanied the other midwife's postnatal visit. I introduced my idea to the nine community midwives, and three midwives agreed to allow me to go with them to their postnatal visits.

The following strategy was set for the observation work:

• When the community midwives arranged a postnatal visit, she asked their permission if it was possible for another community midwife to come with them to see the postnatal visit in action for the purpose of a research project.
• During the postnatal visit, I put myself in a place of not interacting between the woman and the midwife.
• If the midwife and I could not perceive that the woman had a problem such as psychological stress or the baby's physical problem, I asked her permission to give her my invitation letter. The letter described that: the aim of the research was to follow-up women's experiences of child caring as a part of a PhD study, the visits would be made monthly up until the baby's first birthday, permission was sought to tape record the interviews, that their privacy and confidentiality would be protected and that they could withdraw from the interview at anytime.

I anticipated my follow-up study should be a small scale case study, in which I could focus on collecting a good quality of data in each interview and spending enough time to develop the profound understanding from the data.

9-2-2. The process of actual sampling

The actual sampling was undertaken using the following process:

I started with my observation work accompanying other midwives on their postnatal visits from December 2002 to January 2003. I went on eight postnatal visits and invited five women to my research project. The midwife and I decided not to include three women; two women seemed to have a maternal depression for which the midwife arranged the further follow-up, and one woman was already being followed-up by a psychiatric doctor. One woman agreed to take my invitation letter, but she did not respond to my contact. Therefore four women agreed to be interviewed.

The appointment for the first interview was made within one to two weeks after the postnatal visits, which started from January 2003. The interviews were undertaken at women's home. Using an open interview approach, the women talked about their lives and their questions to me. I found that the follow-up interview was different from a one-stage type of interview; the end of the interview was kept open to the next interview. After interviewing four women three times each, I decided to expand my sample size further and looked for women who have the background of working outside home. I did two accompanied visits in April-May 2003. The two women were on maternity leave and agreed to participate until returning to work.

Those six women remained in my study until their babies' first birthday. The women enjoyed my monthly visit. The interview was arranged every month but also sometimes rearranged due to the women or somebody in their family falling

ill or going on holiday or returning to their parents' home. As a result, the number of interviews ranged from eight to twelve. I found those gaps did not become a problem, since the women were good at updating the information in the next interview, or we had a conversation on the phone.

9-3. The process of data analysis

Each interview data was analysed by a case-oriented approach. I developed the data management system for studying each woman as a case.

9-3-1. Data management

Using a case-oriented approach, the women's messages were summarised after each interview:

- During the interview, I focused on listening to the woman's story.
- After the interview, the woman's message was described.
- My reflection and questions were added as the analytical memos.
- A database sheet was developed to sort out the information, which was designed to write the information such as baby's feeding patterns or sleeping patterns or physical development obtained from attending the baby's clinics.
- The interview was transcribed, and it was read as a whole; the things that were not clarified within the interview were written as my questions.

Each case was filed with the transcribed interview data, analytical memos, and a database sheet together. The file was checked before and after each interview and the emerging question was added accordingly.

9-3-2. Writing a thematic narrative

After completing the baby's first birthday interview for the first case, I started to

consider the way of integrating the series of interviews into a coherent story. I developed my own framework through which I could represent one woman's series of interviews as a case, in which could illuminate the sense of 'continuity' and 'shift'. In the anthropological field, representation was identified as a matter of the researcher's view towards understanding other people's world, which was described as how to integrate the micro level of data into the macro level of understanding (Clifford 1986). My understanding of 'micro' to 'macro' would be to transfer 'individual' experiences into a social and cultural level of understanding.

Considering the above points, I chose 'thematic narratives'. Emerson et al (1995) described these as a way of making sense from and of the fieldwork, and transforming the raw data into a coherent story. The actual writing was undertaken based on my philosophical position of 'learning from women and learning from the field'. I referred to writing thematic narratives with the idea of creating a field note centred text (Emerson et al 1995). A field note centred text was produced by staying close to one's field notes in order to produce 'a persuasive force', for which I could select the potential extracts in order to develop the storyline. When the researcher wrote thematic narratives, the researcher kept an analytical mode of exploring the ideas, moving back and forth between the data resources. Through the process, the understanding about the key themes was developed and discussed in-depth (Emerson et al 1995).

Approaching the baby's first birthday, I could see that the women's experience of child caring and breastfeeding had gradually developed as a whole picture. After completing the one year birthday interview, the series of interviews were brought into the further stage of data analysis; reading them as a woman's whole life story. As a result, the women's context was consolidated into the following elements:

- Biophysical shift which relates to pregnancy, birth, and postnatal period.
- Baby's growth and development.

- Relationship with husband, husband's role in child caring.
- Relationship with other family members.
- Relationship with her friends.
- Relationship with medical professionals.
- Other life events or incidents and environmental changes.
- Involvement in health services or attendance at clinics.
- Personal beliefs, decision making process.

The first thematic narratives were developed using Mrs M. The process of writing the thematic narratives was experienced as the process of further data analysis, which enabled me to study the woman's context in-depth. At the same time, I considered the time that was required for writing one thematic narrative. It took three months for writing up Mrs M's narrative; which was because it was my first case and I had to develop it by doing. In addition, the translation required more time than I had anticipated. I decided not to write the proper form of thematic narratives for each case, which meant I only framed the women's narratives in Japanese. Instead of spending my time for completing six narratives in English, the following procedure was developed considering the time line that I could spend for the fieldwork.

9-3-3. Making a closure of the fieldwork: planning for the final interview

In order to make a closure of the fieldwork, the series of interviews and the woman's message were brought together into the following process:

1). Going back to my original research question and tracking down all the research process.
2). Treating the series of interviews as a whole and writing key storylines for each woman's story.
3). Examining how the women's messages and key themes were relevant to the research questions.

4). Trying to find the gaps; what areas were not covered by the previous fieldwork?
5). Preparing for the closure of the fieldwork, including the final interviews with the women in the follow-up interviews.

The role of validation in ethnographic writing was undertaken by the researchers while in the field, by sharing the meaning with the local members (Emerson et al 1995). Taking into account this methodological consideration, the final interview was undertaken to reflect on their experience together. The detailed aims of the final interview were set as follows:

- To use it as time for each woman to reflect upon and discuss their experience of child caring over the last 12 months.
- To use it as time to discuss the experience of the woman interviewed, especially their perception of my role during the interviews.
- To obtain socio-economic information such as education, occupation, social income and family background, if the women agreed to discuss these.
- To ask the women my questions that arose from the series of interviews, to discuss them and to clarify the meaning of them.
- To give the women the opportunity to raise their questions about my research.
- To make formal closure of the follow-up interview settings, and to ask permission to make further contact if needed.

The final interviews were undertaken in April-May 2004. Some of the women had a three month interval from the baby's first birthday interview. Each woman used the final interview to her own accord, which I found useful to identify the women's perception towards time and space in child caring. The message from the final interview was compared with the emergent themes and messages from each interview. After having the women's feedback, the key message was refined and the thematic narrative was developed for each case.

9-4. Summary for the next chapter

I will close this chapter with my reflection from the fieldwork.

As a community midwife, I had some experience of working with women over a long period of time. However, the relationship was based on a problem centred approach, in which I was there for identifying the problem and solving it with them. The ethnographic fieldwork was different. I simply focused on listening and observing the women and their babies in the setting. This research brought a benefit of expanding my practitioner's knowledge and the way of understanding women's experience. I felt that my sensitivity to settings and the meaning of 'holistic understanding of the women's experience' was deepened.

Here I will explain more about the benefits of the ethnographic work on my practice. I felt that my capacity and flexibility of looking at the things were expanded, which I could describe as zooming in and out like a camera lens. Using both my research settings and practical settings, I developed a way of working zooming in and out from each woman's experience. The interview setting was the time of zooming in at the women and looking at their experience in very close proximity. Using other casual settings, I was able to zoom out from the interview setting. Through follow-up interviews, the process of talking with the same woman and visiting the same place, I repeated this zooming in and out movement. Coming towards the end of the ethnographic work, I was able to develop a broader picture of the women's experience within their social and cultural context.

The experience of displacement from the field and entering into another culture with my fieldwork materials added further explanation on the above point. Through observing the other cultural settings and comparing my pictures with other pictures developed by other researchers, I came to see the significance of a cultural and social framework and its influences on shaping the theoretical

framework of approaching breastfeeding.

In this chapter, I tried to describe the feature of follow-up interviews and the role of ethnographic work while I was in the field. As I described, when I started to view the entire research project as a product of ethnographic work, I became comfortable to write my reflections in my thesis. In the next chapter, I will begin with representing thematic narratives developed from Mrs M's experience, which I treated as a master case for developing the thematic narratives for the other five women.

Chapter 10
Reporting on phase two: women's thematic narratives

In this section, I will report on the results of studying breastfeeding from the six women's experience. Overall, the information obtained from the follow-up interviews, the six women's social backgrounds can be summarised as follows:

- Four of the six participants were housewives, and two were working outside the home.
- Four were first time mothers, and two were second time mothers.
- All of them lived with their husbands and their social income was stated in the average wage in their age group of the national survey.
- Their final education was at either the two year's female short college or the four year's university.

Concerning infant feeding, the six women started breastfeeding after birth in the hospital environment, and then shifted into the different pattern of breastfeeding. In my study, the women introduced weaning food accordingly, so that the term 'exclusive breastfeeding' means that the women breastfed their babies with the usage of weaning food at some point.

I will report the six cases in four sections. The first section will report on the first thematic narrative, which was the study of Mrs M, who breastfed her baby exclusively beyond the final interview. I will present the first case in particular in its full context, which should illuminate the woman's time and space for child caring in the current Japanese social context. The first narrative informed the essence of breastfeeding as being a process of the mother and her baby in tune, whereby I could use it as a master case to illuminate the significance of the remainder of the cases. The second section will report on two cases of breastfeeding mothers; one is from a first time mother and the other is from a second time mother. The third section will report on mixed-feeding mothers'

experiences, in which mixed-feeding was practiced as a consequence of not having enough breast milk. The Japanese concept of 'SHI-KATA-GA-NAI' was used to describe their feeling, which they perceived it exists as a part of natural law; the individual body has the different degree of capability to perform breastfeeding. The last section will be devoted to study a bottle-feeding mother's experience, through which I could study the meaning of support for bottle-feeding mothers.

Section one: Developing a thematic narrative

10-1. The case of Mrs M

In this section, I begin with describing my reflection from writing a first thematic narrative, and then present Mrs M's thematic narrative.

10-1-1. The experience of writing-up the first narrative

When I developed the first thematic narratives, I shifted my role as a mentor between the women and the audience. It means that my role was to deliver the woman's message to the audience.

I viewed each case as ideographic so that I could not use the word to describe one of my cases as a typical one. I chose Mrs M as the first case to develop my thematic narrative; she was a first time mother, breastfed exclusively, and her story contained the elements to inform the scenario which first time mothers were most likely to encounter in the current Japanese child caring. In addition, Mrs M kept her child caring diary, which we used to discuss any problems in the interviews. The diary was designed by a milk company and given as a gift from the hospital. Each open page was designed in a weekly diary, in which she could tick boxes for baby's urine, stool, sleeping, and feeding time. I asked her permission to use her notes for my research. After I developed the narrative, I went back to her diary and checked

the context of the narrative. As a result, I found that my thematic narrative was accurately developed, which supported the reliability and credibility of my data resources. It was important for me to be able to develop the narratives for the further cases.

10-1-2. Mrs M's story

Mrs M, 29 years of age and a housewife, and her husband, 31 years of age and a systems engineer, lived in a two bedroom modern flat in a seven floor apartment building. They got married in 1999. When she found she was pregnant, she left her administrator job and became a housewife. Their first baby, a girl named 'YU', was born in a university hospital, in December 2002, 3,050g in weight and 50.2cm in length.

<u>One: hospital stay and breastfeeding; 'people were very nice. It was comfortable!'</u>

My idea of 'BO-NYUU' [Japanese word of breastfeeding, 'BO' means mother, 'NYUU' means milk, which means mother's milk] is... I think... it is "HAHA-NO-SHIGOTO" (Notes: The emphasis was added as she emphasised it. 'HAHA' means 'a mother' and 'SHIGOTO' means 'a job or a task'. The word 'HAHA' was used when people gave great respect for a mother). *I could not think of anything... I only said it was "HAHA-NO-SHIGOTO". It is a bit different from something to say... (Breastfeeding is) natural. I can't find any other words to express my feeling. It is "HAHA-NO-SHIGOTO". (29/Jan.: one month).*

Mrs M had a gynaecological problem and an operation two years ago. Her pregnancy was found during her annual gynaecological check. As a natural course, she was followed by the same doctor. During pregnancy, she stayed in hospital at 34 weeks due to a small contraction in her womb, and spent two weeks in a hospital bed.

Her birth started from a natural onset and her baby was born with her husband's attendance. After their baby was cleaned and dressed, the midwife brought their baby to them and latched her baby onto the breast. Mrs M and her husband felt it was a miracle to see her baby suckling her breasts properly. Her baby was kept in the nursery room for the first 24 hours. The next day the midwife brought a baby-cot to her room, set with disposable nappies and clean wipes, and a clipboard. The midwife said to try to breastfeed when her baby cried. The clipboard was used for her to tick each time she breastfed or changed a nappy. Her baby awoke every three hours and suckled her breasts for 20 minutes. She did not expect breastfeeding took place such a regular and proper way soon after her baby was born, which she was amazed.

At each shift, the midwife checked her baby's body temperature and wrote a short comment on Mrs M's clipboard such as 'she (her baby) was good at suckling mother's breasts', 'she seems happy in sleep', 'she is a good girl, having a lot of wee', and 'today is snowing. Let's give a hot bottle in the baby's bed'. For the first few days, the midwife advised her to add formula milk. Mrs M heard that the other mothers asked for nurses to bring bottles through nurse call. It seemed to be normal to use formula milk. Other mothers told her about their experience of 'breast massage', which were painful. In her session, the midwife massaged her breasts, but she did not feel any pain. The midwife also advised her to stop using formula milk. Mrs M also felt her breasts became heavier and full of milk. In addition, she came to know her pyjamas got wet by breast milk in the morning. From the third day, she shifted into breastfeeding only. She attended hospital classes for the first time mothers. In the postnatal ward, she shared a room with two first time mothers, but they were too busy with their own matters, and did not talk much each other. Mrs M felt the hospital nurses were all nice and easy to ask for their help; even wanted to stay there longer.

Everyday her husband visited her. He saved his summer vacation for this time. He was happy to know she could breastfeed their baby. They did not have any particular favour on breastfeeding, but simply liked it. Staying five days in the hospital, she and her baby returned to her mother's flat for 'SATO-GAERI' (in Japanese, 'SATO' means 'an old nest', and 'GAERI' means 'returning') for one month.

Two: going back to her mother's home

When 'YU' cried, I cuddled her but she still cried. My mother took her and then she stopped crying and settled in my mother's arm. I understood what I should do seeing my mother... It is more likely to say 'WAZA-o-NUSUMU' ('WAZA means 'special skills or techniques or wisdom or secrets', 'o' is a conjunction, 'NUSUMU' means 'steal something'). Basically my mother does not say like I should do this or that. Only one occasion... when I tried to change a nappy and my baby cried, as if she said she did not want her nappy changed. She started screaming and I was getting frustrated. My mother said to me, 'You need to slow down. You have to wait. Try to find your baby's pace, the pace that you and your baby both feel happy'. I know my mother is right, but I feel it is difficult to do so... (29/Jan.: one month).

In the first few days, everything went busily and Mrs M could not remember what she did just a few minutes ago; getting up, breastfeeding, changing baby's nappies, bathing, changing baby's clothes and sleeping. Mrs M did not like the idea of paper nappies, and used linen nappies, which she felt were easy to use and no need to worry about the cost. Mrs M's mother took several weeks off from her work, which they planned in advance. Her mother did cooking, washing and shopping, so as she could spend her energy on looking after her baby and resting herself.

The hospital gave her a child caring diary, and she kept the notes in order to remember the time of the previous breastfeeding. For the first three days, she

counted the frequency of the breastfeeding; 12 times for the first day, eight times for the next day, and 12 times for the following day. The numbers were not stable and she realised nothing she can predict, thus she stopped counting it. Night breastfeeding was unpredictable; the timing as well as the length of time for it. One night Mrs M spent half an hour breastfeeding, 'YU' was not settled, did not like to take the breasts, and did not like to be left in the baby's bed. Her mother got up and took over 'YU' from her. Mrs M could return to sleep. She felt she could not survive without her mother's help.

Mrs M felt the basic attitude towards child caring was the same with her mother. However, she found some practical difference. For example, when her mother made preparations for baby's bath, she tipped warm water into the baby's tub, stirred it by her hands, and said it was ready. However, Mrs M used a thermometer to see if the water was the right temperature. One day Mrs M read the book to look for the information; how long she could leave her baby in the bath tub. Her mother said for her to follow her own intuition. She knew her mother was absolutely right but it was difficult to do it.

Two weeks later, she returned to the hospital for breast massage. Her baby gained enough weight. The midwife massaged her breasts again, and told her the breast condition was good. Mrs M felt relieved, even though she knew she had enough breast milk. Staying with her mother, she understood a bit about child caring, but apprehensively, she returned to her own flat.

Three: sleeping problem; from one to two months

The worst thing for me is... the lack of sleep. When I could not have enough sleep, I become easily upset. On one occasion, my baby cried and I felt like... too tired to cuddle her. I just left her in her bed. She cried.... Nobody around... I punched my pillow and shouted to her 'Stop it!' The sound of 'bang' was howling in the room, and 'YU' just...froze. Immediately I was back to myself. I cuddled her and said 'Sorry! I was wrong!' Sometimes I wonder... Is it only my

problem? I am sure other mothers must feel the same, do they? I wonder why there are no magical potions for making babies sleep'. (29/Jan.: one month)

For the first month, she breastfed her baby ranging between eight to14 times per day. Each breastfeeding took 40 minutes from changing nappies and settling down after breastfeeding. 'YU' needed to be breastfed repeatedly in very short intervals or no intervals; every half an hour breastfeeding, which continued over four or five hours. When it happened at night, she got up from her bed, breastfed, settled her baby, and returned herself to bed, which she found very tiring. When her husband was on night shift, she felt lonely and isolated from the rest of the world.

When Mrs M stayed at her mother's, her husband did not stay overnight with them and did not know the baby's crying at night ('YO-NAKI' in Japanese, 'YO' means 'night' and 'NAKI' means 'crying'). One morning when he returned from work, he found his wife awake but in tears, whilst cuddling 'YU' in her arm. Mrs M said, 'she didn't sleep the whole night...'. He had never seen his wife in such emotion, took over 'YU', and let her go to bed. Of course, he worked at night, but he thought shift work was good thing so he could help his wife with the child caring during the day.

At the end of one month, 'YU' came to sleep four hours after breastfeeding, which happened only once a day. The rest of the time, 'YU' was awake and asked for breastfeeding every hour. It also happened at night. In Japanese, it is called 'CHUYU-YA-GYAKU-TEN' ('CHUYU' means 'daytime', 'YA' means 'night', 'GYAKU-TEN' means 'reversing') and is considered a common problem for this age. One midnight around 3am, she got a text message from her friend; 'My baby is crying and crying. I could not sleep tonight. How are you getting on?'. She was a bit relieved by knowing her friend had the same problem. One night 'YU' slept eight hours without crying. Mrs M had to get up every two hours and check if 'YU' was breathing properly. In addition, when she did not breastfeed more than three hours, her breasts became sore and

she had to get up to hand express them. Mrs M found she could not sleep more than three hours in those days.

At one month's baby clinic, the paediatrician said everything was alright. Three days after the hospital clinic, Mrs M had a postnatal visit. The community midwife asked her feeling of child caring. Mrs M showed her child caring diary to the midwife and asked if she did the right things. Mrs M asked about her baby being awake at night, and the midwife advised to open the curtains in the morning and to bring some sunlight for her baby.

The midwife checked Mrs M's breasts, which showed a good let-down reflex. Looking at the firmness of the breasts, the midwife said Mrs M definitely had enough breast milk. One of the milk ducts was blocked, and the midwife massaged the nipple. Two minutes later breast milk started flowing. The midwife, Mrs M, and her husband moved to the baby's bed. As the midwife touched 'YU', she opened her eyes very slowly, but she did not cry. Checking the whole body through from head to feet, bowel condition and hip joints in a lying position, the midwife started massaging the baby and 'YU' started smiling. Mrs M said to her husband, 'Look! She is smiling!'. The midwife said that it happened because Mrs M and her husband looked after 'YU' really well. Mrs M breastfed, whilst the midwife checked baby's suckling and advised to try the different cuddling positions if she could. The husband asked about baby's bathing, which was his job. When Mrs M finished breastfeeding, 'YU' was settled in the bed and the midwife moved back to the living room. Her husband stayed with the baby and massaged the baby as the midwife did. Mrs M asked about the rash around her baby's face and neck, which was advised to wash with soap.

After one month, Mrs M wanted to go out for a little walk, but her mother stopped her because it was too cold outside. Some of her close friends visited her at home and brought some nice gifts; a pretty dress and baby's shoes. She was looking forward to the days she could dress 'YU' in them. At two

months Mrs M and her husband went shopping and bought a dummy, which they just fancied using.

Coming to two months, 'YU' slept 6-8 hours at night waking twice for breastfeeds. Mrs M sometimes felt apprehensive when 'YU' was crying. When 'YU' continued crying, she started wondering, 'There might be something wrong' or 'she must be sick'. In that case, Mrs M spent her time looking for the cause that made 'YU' cry, and could not find anything wrong with her, she felt helpless. One day when 'YU' started crying, she took two or three breaths for allowing 'YU' to cry. And then, she slowly cuddled her. Surprisingly it worked better and 'YU' settled easily. Since then she felt she could understand a bit more about 'YU'.

In the middle of the second month, she joined a mother's community meeting and met the mothers from the hospital antenatal classes. Since then they visited each other's home every two weeks. The date of the visit was arranged via text messages, so they did not need to worry about interrupting baby's sleep. One of the friends did not have a mobile phone and was the only person to bottle-feed in that group. She seemed uncomfortable to bottle-feed whilst her friends breastfed, and gradually disappeared from the group.

After two months, 'YU' called her mother from her bed. Mrs M carried a Japanese baby mattress as she moved from room to room. The first winter was cold and many people caught bad flue, which stop her to go out from home. Mrs M and 'YU' stayed at home, and she enjoyed sharing the space with 'YU' all the time. She felt she came to understand more about what 'YU' was going to ask for next. When 'YU' wanted to change her nappy, she said 'Ah-, Ah-.' whilst flapping her hands and feet together, which was different from the signs that she showed when hungry or asked for cuddles. When Mrs M and 'YU' went out using a paper nappy, 'YU' did not show any signs and Mrs M forgot to change it. They returned home, and found 'YU' was in a wet nappy. Mrs M realised she had to change it according to the clock. In addition,

she felt she lost the communication with 'YU', and she did not like the idea of doing child caring by clock time at all.

Four: about her husband

Husband: We have not changed since 'YU' was born, have we?
Mrs M: Yes, we have.
Husband: Have we?
Mrs M: Yes, you told me I became less generous to you. I was more generous to you before she was born.
Husband: What are you talking about?
Mrs M: Yes, that is about me.
Husband: Well... I think we are the same.
Mrs M: No, I have heard you talk to 'YU'; "your mum was very kind to me, like she does to you now. Your mum is very sweet to you but not to me anymore".
Husband: Did I?
Mrs M: Yes, when you bathed with 'YU', I heard you talk to her like that.
Husband: I couldn't remember.
Mrs M: I think you did. And if I became less generous to you, I have to say sorry to you, but it happened as you know... I was and am too busy. I have to say... It will not continue for the rest of our life'. (29/Jan.: one month)

I read a reader's column in a child caring magazine. A mother wrote... she could not enjoy child caring. The adviser wrote, when mothers have nobody to support them, they have more emotional difficulties. I felt I am very lucky, because I always think I love her. I am lucky because my mother and my husband help me a lot... If I am alone, I could not enjoy everyday...' (17/Apr.: 4 months)

Her husband helped with housework such as washing and folding clothes, and cleaning rooms. He also helped with the childcare, bathing, changing nappies, and cuddling the baby. She felt she was lucky comparing her

husband to other Japanese men in general. However, sometimes she felt a bit frustrated. For example, Mrs M wanted to change her baby's nappy soon after it got wet, whilst her husband did not mind leaving it. She was nervous about nappy rash and stressed when she found 'YU' was left with a wet nappy. Mrs M wanted to bath her baby in warmer water but her husband felt it was warm enough. They had a bit of a row over petty things everyday.

Her husband was happy with breastfeeding. However, when she wanted to go out, they found it was a bit of a problem. The first time when she went shopping, her mother looked after 'YU'. 'YU' didn't take any formula milk, and her mother waited for her coming back. When she went to have her hair cut, her husband looked after 'YU' by himself. When 'YU' started crying, he tried to give a bottle. 'YU' refused it and slapped it away with her hands. At the end, 'YU' took the bottle, which her husband was proud of. Mrs M was happy to know she could leave 'YU' with her husband.

Everyday Mrs M enjoyed the time with 'YU'. However, she found even when 'YU' was sleeping, she could not totally relax. She only had several days to do child caring without her mother's and husband's help, which she was fortunate. Child caring was hard work, but she felt 'YO-YU' ('YO' means 'extra or optional', 'YU' means 'a broad space', which totally means that people have extra time and space for reflecting themselves). She found that child caring was not a routine work, as she could find something new everyday.

Five: from three to four months; baby's eczema - 'Is she really atopic?'

I was so shocked when I heard 'YU' was diagnosed atopic. What should I do for her? I don't have any allergy neither my husband. I said to the doctor, "My families have no allergy". He said, "It happens not only because of genetic cause. Sometime it happened for one particular person in the family", which made me feel worse. (17/Apr.: 4 months)

Coming towards three months, she breastfed 6-8 times a day and 'YU' slept well at night, which was considered a good time for starting weaning. Following the leaflet given by the community midwife, she introduced fruit juice and vegetable soup at three months. 'YU' took only two spoons, but she felt this was a good progress. At three months, in March, they went for a walk with a baby buggy. After the walk, 'YU' seemed excited and did not sleep well at night. 'YU' seemed to understand things more than Mrs M and her family assumed.

Mrs M noticed her baby's rash was spreading, even though she washed often. 'YU' showed her itchiness by pressing her face on her shoulder. When she applied steroid ointment given at one month clinic, they were gone. However, the rash appeared again and again. Her friend recommended a good dermatologist. The doctor diagnosed her baby with eczema and said to stop fruit juice and vegetable soup, and for herself to go on a strict diet if she wanted to continue breastfeeding; do not eat any eggs nor cow's milk. Mrs M returned home feeling disappointed with the doctor. She talked to her friend again, and changed her appointment to one with the female doctor. The female doctor had a child with eczema, and explained the reason to stop fruit juice. Following the first consultation, she started her own strict diet and the baby's rash improved. The doctor said she could go back to a normal diet, but once she knew about her diet and its effect on breast milk, she could not return to her ordinary food.

At the 3-4 months' baby clinic at the public health centre, the public nurse asked her about feeding, and the usage of fruit juice and vegetable soup. In the baby's weaning food class, the dietician explained how to step up weaning food. One of the mothers mentioned that her doctor told her not to give fruit juice due to her baby's allergy. On another day, she visited the public centre to obtain more information about egg allergy. The dietician gave general information and advised her to visit the specialist. From those experiences, she found nothing certain which she could follow.

The female dermatologist did a skin scratch test on 'YU' before starting weaning. The result showed strong allergy to 'eggs' and weak allergy to 'beans'. She had to cook weaning food without eggs and beans, and not to eat any products herself containing eggs. She checked all food packages before buying, and her diet and the weaning food were based on basic Japanese food: Japanese rice, vegetables and fish.

Her friend gave her information of some medication for babies with eczema, which was given 10-15 minutes before breastfeeding to prevent baby's bowel tissues absorbing proteins. Mrs M asked her dermatologist about it, but it was not applicable for them. Her other friend was advised by the doctor to stop breastfeeding at seven months due to the allergy, and Mrs M felt sorry for them. One of her friends in her mother's group told her that the hospital antenatal class told the information about the egg allergy and not to eat many eggs if they wanted to breastfeed. Mrs M did not have this information and felt sad because if she knew, she might have prevented her baby's eczema.

When she had some visitors at home, they brought some nice cakes, which meant she had to explain about her strict diet. She sensed that some of her friends considered why she did not stop breastfeeding and simply shift to formula milk. However, Mrs M believed that breast milk was better than formula milk, whereby formula milk gave the same taste for each feeding. Mrs M came to know that breast milk tasted differently according to her diet. This seemed more natural, from which she believed that breast milk helped to develop baby's sense of taste. She cooked her own diet and her husband's separately. Even though she made extra efforts for cooking, she wanted to continue breastfeeding as long as they could. She felt lucky her husband did not say anything about breastfeeding and her special diet.

Mrs M felt her friendships in the mother's group were different from her ordinary ones. They did not talk about personal things. Their ages varied from

20 to 40 years, as well as their backgrounds. One day during chatting, 'YU' started crying. Mrs M tried to breastfeed, but 'YU' refused it and just cried. It lasted for half an hour, and suddenly Mrs M started crying. Her friends were surprised, and one of them said she had to see a psychiatric doctor due to maternity blues. Other mothers said they were sometimes smoking in order to cope with the stress. Mrs M did not know why she wanted to cry there, but since then they became closer and talked about their difficulties in child caring.

After four months, 'YU' started turning over, and 'YU' became too big to sit in the A-type of baby buggy. Mrs M wanted to buy a new B-type one, but her cousin gave a used B-type buggy and her husband was not happy to buy a new one. She discussed the money that her husband spent on a computer and got a budget. The new buggy was lighter to carry and easy to handle, which meant she could go out much more easily. 'YU' came to show her ideas clearly. When she was offered something she disliked, she flicked her face. On one occasion she took tea from a training mug, but refused it the next time and asked for breastfeeding. Mrs M realised even though her child came to grow, it did not mean child caring was going to easier.

Six: from five to eight months; more weaning food, more rash, and taking a blood test

Last Monday, when I gave 'YU' bread gruel (cooking bread with cow's milk), rash was developing... It was not usual one. I screamed. Her face, especially her eyelid, was swelling... I took the photo of that (by a digital camera). I want you to see it. (Mrs M brought a digital camera and showed it to me). I took her to the dermatology clinic, but it was too busy and I couldn't see the doctor on that day. Her face came back normal by that evening. I knew the cause was flour. The previous scratch skin test was done for only three factors, egg, beans and cow's milk... So now I started thinking to take 'YU' to another clinic which offers a blood test. What do you think? (24/July: 7 months)

At five months, 'YU' was breastfed 5-7 times a day and began to get up at night for breastfeeding. The amount of rice gruel was stepped up to 10 scoops and she added some mashed potatoes or carrots or pumpkins. When she introduced a new menu, she followed two rules; try only one new product for a day, try it during the morning in case she needed to take her baby to the doctor.

'YU' knew who was a good person to her. When her grandmother (Mrs M's mother) came to her, 'YU' showed her best smile. When 'YU' heard her grandmother's voice, she stopped breastfeeding and turned her face towards the direction. Mrs M had to ask her mother to leave there otherwise they could not finish breastfeeding. It was the same for her husband and Mrs M asked her husband to go out from the room whilst breastfeeding. 'YU' sometimes screamed at night. Mrs M anticipated that it might happen when she had wet nappies. Mrs M started to use paper nappies at night, and since then 'YU' stopped to scream at night.

Towards the sixth month, somehow Mrs M started to compare 'YU' with other babies, which was not recommended by any child caring books. She considered it as a positive because she could have some 'YO-YUU' (She had some time to reflect herself) and have an open mind to see other things. 'YU' definitely seemed good at physical activities and responding to others. However, she was smaller than others. She took 'YU' to the public health centre every month to check her weight, which showed average in the number. However, when 'YU' started to get up at night for breastfeeding, Mrs M was concerned she might not have enough breast milk as 'YU' required, and a dummy made less chances 'YU' could be breastfed. The dental hygienist, the dummy will affect the development of the teeth, and better to stop to use it. However, 'YU' could not sleep without the dummy. Mrs M wanted to step-up weaning food, but the incident of bread gruel made her nervous about weaning.

Mrs M easily identified flour as a cause of allergy, but she was not sure it is the best way to find the cause by giving each product to her baby and seeing its response. The further skin scratch test showed flour as a positive cause and she was advised not to use any wheat products until three years. At 6-7 month baby clinic, the paediatrician considered the dermatologist's advice was too strict and a blood test was not reliable. She was not surprised by the different opinions and visited the other allergy clinic. The doctor listened carefully to her and did a blood test. One week later, 'YU' was found not atopic, but had a strong allergy to eggs and flour. Beans were found negative, which was good to know that allergy factors would be withdrawn according to the baby's growth. The doctor told that her special diet was not essential, but if she wanted, it would be enough to do until ten months. She could step-up weaning food to twice a day and 'TOFU' was added to their menu.

In the six months, when 'YU' slept through the night, Mrs M found her breast developed a hard lump. She hand expressed her breasts and breastfed as much as she could during the day. Considering her breast's condition, she wanted to start with breastfeeding in the morning. However, she had to start from weaning food otherwise 'YU' did not eat them. She felt her breasts became dull, as the hot summer affected her general well-being. She read a cartoon that described the breast milk becoming rotten inside the body. She wondered if it was true or just a joke, but she noticed her breast milk became thicker. She expressed her breasts before each breastfeeding and tasted it to make sure if it was not rotten.

Just after six months, 'YU' came to sit by herself. The rest of summer was not too hot, but 'YU' developed prickly heat. Mrs M gave her an extra shower everyday. At the beginning of August, YU's temperature was 40.5 degrees and three days later she had some spots around her body. Around that time, 'YU' went to sleep very late at night and got up at 10am, which is considered as a bad 'SHI-TSU-KE'. A good 'SHI-TSU-KE' is told as mothers should make

children sleeping at 8pm and get up at 8am. Her friend had the same problem and was told by her own mother; 'It happened because you are too lazy. It is much better to take the child to the nursery and the nursery nurses could train your baby properly'. Mrs M felt sorry for her friend. Fortunately, Mrs M's mother said, 'Don't worry. When the time is coming, everything is going well. When 'YU' will go to the kindergarten, she will come to get up early'.

At seventh month, 'YU' was able to stand up whilst holding the table or walls but fell down unexpectedly. Her mother and husband wanted to use a playpen to keep 'YU' safe. Mrs M did not like their idea, kept the room open, and followed 'YU' whilst holding a cushion with her hand. As soon as she found 'YU' lost balance, she fetched the cushion on the floor so as 'YU' did not hit the floor. Mrs M followed after 'YU' the whole day, but she enjoyed it.

At the eighth month, 'YU' started to follow her mother ('ATO-OI' in Japanese, 'ATO' means 'after or somebody's back', 'OI' means 'following or trying to catch somebody'). If Mrs M left her outside the toilet, 'YU' cried. She let 'YU' in the toilet. 'YU' crawled, stood up, and walked alongside the wall, and was able to reach the place where she wanted. She felt that 'YU' became 'a grown child', not 'a small baby'. 'YU' developed one month earlier than average in terms of standing, but she wished 'YU' was going to grow up as the average child.

Seven: from nine to ten months; family funeral and grandmother's hip fracture

I watched news that a mother killed her two year old girl and committed suicide. Everyday I heard something... child abuse ... I just couldn't understand... It is me who gave a life to 'YU'. Through everyday life, I am always with her... I could make up a story like...if now hospital staff came and said to me like... 'Sorry we gave you a wrong baby and 'YU' was not your baby. Please exchange her for yours'. I could say, 'She is my daughter. I will

look after her'... I think... the time we spend together became important as well as the fact I gave birth... I talked about breastfeeding with other mothers. They said... their babies did like... holding their breasts [by both hands], and pumping it whilst they were suckling. 'YU' did not do that, I wish I could see it. She touches my breasts, pulls my hair, and I grab her hands to stop it. She grabs her feet with her hands and to flip it like that... Now breastfeeding time is very busy... (08/Nov.: 10 months)

In her mothers' group, all babies were breastfed partially or exclusively. When their babies were hungry, they just breastfed. However, when one mother stopped breastfeeding at eight months and brought baby food to the visits, it became a problem. Her friend gave chocolate and crisps, and complained that her child did not eat rice or vegetables. She and her other friends were all agreed it was not a good idea to give sweets and snacks to a baby, but they could not mention it to her, which was a kind of tacit rule; do not interfere each other.

At nine months, 'YU' played by herself, picked up toys or flicking the children's books, and did 'HITO-MISHIRI' (in Japanese, 'HITO' means 'people', 'MISHIRI' means 'to identify somebody as a stranger'); 'YU' started being shy or crying with strangers. 'YU' had more interest around her and could not sit in the buggy. On their way shopping, 'YU' saw something on the road and dived into the pavement. Nothing wrong happened, but after, she had to stop using the buggy.

Her mother-in-law was diagnosed with cancer before their marriage. When she got married, her husband agreed to live as a small nuclear family. She was the only child in her family and her father had died in her teenage years. After their marriage, her mother moved into a flat in the same apartment. After having a baby, her mother visited her everyday and helped them a lot, which her husband was pleased with. Mrs M sometimes visited her parents-in-law's home, just five minute's walk from her home, but her visit with a small baby

was not welcomed. When her mother-in-law became very ill, her grandmother-in-law, who was 80 years' old, did all the housework. At the beginning of September, her mother-in-law stayed one month in hospital and passed away.

When the family funeral was held, Japanese traditional custom was carried out. One of the neighbours visited each house in the area to announce the day of the funeral, and each neighbour gave some money (10 yen = 5 pence) into a small wooden box. At the end, the person who visited the houses brought back the box to the host family. The family kept the box until another person died in their small community. It was called 'KOU-JU' ('KOU' means 'mouth', 'JU' means 'giving', which means giving an announcement by visit). Her husband found the newspaper sheet in the bottom of the wooden box was dated 1934, which means at least this custom was carried out for the last 70 years. She was born in the south part of Japan and moved into Tokyo as a teenager, and did not know about it. She did not like this type of traditional local custom.

The mother-in-law's funeral took place on a cold day in autumn. 'YU' seemed to know what was happening and was quiet during the ceremony. A few days later, 'YU' was coughing at night. Mrs M took 'YU' to the paediatric clinic:

The paediatrician: 'What do you do when your baby gets a fever?'
Mrs M: 'I will make her cool and feed more'.
Dr.: 'Yes, you are right. Do not call an ambulance or go to an emergency clinic. Is that OK?'

Mrs M knew that the paediatrician considered she was a stupid young mother, who did not know anything about her child and visited the doctors without knowing what was happening. She knew the paediatrician was not popular in the area, but did not mind if the doctor considered her as a stupid mother. The most important thing was to make sure that her baby was alright as quick as

possible.

After the funeral, her grandmother-in-law fell down and fractured her hip, had an operation, and then returned home. Her husband's parents' house was a traditional Japanese house. The house had many gaps across the floors, very cold in winter and each room kept warm by oil stoves, which was too dangerous for a small baby to be around. The house had a big garden, but in summer many insects were around there. Mrs M did not like the environment, but had to visit them and to help with housework. She found it difficult to think about the menu, go shopping, and cook whilst her baby was following her.

Her husband talked with his father and told her that they might move into his parents' house sometime in the future. Mrs M started smoking and drinking even though she knew they were not good for breastfeeding. Her mother noticed her stress and advised not to think about it. However, she felt tired and restless in her mind, and she felt her breast condition became soft with the feeling of emptiness. 'YU' cried more often and came to her and pulled her tops, and asked for breastfeeding. Mrs M knew she could not spend much time for 'YU', sitting for breastfeeding as long as 'YU' wanted. Under this condition, she could not think about stopping breastfeeding, which added extra stress on 'YU' as well as herself.

At nine months, she heard that some people said that breast milk became like water after the eighth month. The medical professionals advised breastfeeding mothers to use follow-up milk. However, she did not like the idea of follow-up milk and decided not to use it.

At ten months, 'YU' took a daytime sleep twice. When she took a sleep between 10am-4pm, her bedtime started at 10-12pm. However, she slept from 8pm, got up at midnight, and played until 4 am. She went for a walk everyday at the same time, but her sleeping did not follow the same pattern. 'YU' started to grab everything and to bring the objects to her mouth. Mrs M had to keep

her eyes on 'YU'. One day, 'YU' found a ladybird, grabbed it, put it in her mouth, and showed a bitter face. Mrs M could not stop laughing. 'YU' bit the house wall and props. Mrs M always found something peculiar in her nappies including paper chips from the wall papers. In November, 'YU' had to wear winter clothes, which took more time for changing nappies. 'YU' showed no co-operation and tried to move whilst her nappy was still open not, so Mrs M changed to use disposable nappies.

Eight: breastfeeding; should I continue or stop?

Two of the mothers in my group stopped breastfeeding... I talked with the other friend like... Do we need to stop breastfeeding now? But the problem is... We are breastfeeding whilst our babies are going to sleep. Sometimes 'YU' was crying at midnight. I latch her on my breasts and she calms down very quickly, and 'YU' and I sleep together...I wonder how formula-feeding mothers handle the baby's 'YO-NAKI' (night crying). The other day I tried not to breastfeed, just 4-5 times a day... 'YU' cried a lot and I felt it is awful to leave 'YU' crying. I know she wanted breastfeeding. Now I breastfeed her as she asks as I feel how much she loves it ... Ideally I would like to wait until 'YU' will say like... 'Thank you, Mum. I don't need breastfeeding anymore'. I wonder... one day it would happen... (07/Nov: 10 months)

(She visited the hospital for annual gynaecological check). This was my first time the doctor said to me 'no problems'. When I told the doctor I did not get my menstruation back, she advised me to stop breastfeeding now. I think... the doctor was considering the next pregnancy. At four months, she advised me to continue breastfeeding as long as I could, which was good for my hormones, and now she said to stop it... My feeling is... I could not think about the next child. I just want to think about now. If I couldn't fall pregnant again, I think it would be OK. My husband thinks the same. I just don't want to stop breastfeeding now. (04/ Dec: 11 months)

Her mother: You can continue breastfeeding until 'YU' started biting your nipples. Children used to be breastfed until 3-4 years.
Mrs M: Really?
Her mother: No, No. I am saying it used to be, and it was not even in my generation. It took place before Western child caring dominated like now. I don't know if Western child caring is something better than the [Japanese] traditional idea... If you stop breastfeeding now, 'YU' would feel like.... it is like I was prohibited to drink a beer... You can continue breastfeeding, until 'YU' really does not need it. Could you think like that???...I think now you could... (04/Dec.: 11 months)

When one of our friends told us she would finish breastfeeding at eight months, I felt it was too early. But I could not say anything to her. I think... it is hard to say something to other mothers. I think...we [mothers] considered each other in equal position. This is what we like to be, but I felt it hard just ignoring the things that I felt were not alright like... giving chocolates or crisps. I think you are a midwife and you could say something to her...' (08/Jan: 13 months)

At 11 months' gynaecological check, the doctor told her, 'You will spoil your baby, if you continued breastfeeding'. She knew some of the older generations had negative attitudes to longer breastfeeding. Mrs M felt awkward that the young female doctor told her about breastfeeding in this manner. Between September and November, 'YU' gained 100g in weight. 'YU' was very healthy and very active, and showing good appetite in eating weaning food and breastfeeding. However, she wondered how she could think about little weight gain and its relation to breastfeeding.

Her mother supported the idea of continuing breastfeeding. At 11 months, 'YU' started to say 'Pa, Pa', when she wanted breastfeeding. When 'YU' encountered something that made her 'painful' or 'scared' or 'worried', she said 'Pa, Pa' and asked for breastfeeding. At night, 'YU' sometimes woke up

and cried, 'Pa, Pa' and looked for her mother. As soon as 'YU' was breastfed, she went back to sleep. The first word coming from 'YU' was 'Pa', which she considered breastfeeding must be the most important thing for 'YU'. Mrs M, as well as her mother, decided to wait for the time when 'YU' became alright without breastfeeding. She bought a new bicycle with a child seat, in which 'YU' could sit. They could go shopping, visit friends by bicycle, and Mrs M felt it was easy to go out.

The day of her first birthday, 'YU' did not start walking, which Mrs M and her family were disappointed about. In one aspect 'YU' was very adventurous, but concerning her walking, she was very careful; giving a half step putting her feet forward and then squatting down to the floor. Six days after her birthday, 'YU' took her first step and one week later walked properly. In the mother's group, the babies started to interact each other, even getting into a fight to take their own favourite toy. As the physical development was different, each baby had their own character; very active, challenging, or very shy. Mrs M liked other children, but felt 'YU' was special, of course she was her own child, but she developed a special feeling with 'YU'.

Nine: the experience of interviews

About my experience of breastfeeding?... No, I do not need to say anything more. You know all about that. The timing of interview?... One month is best. I have enough to talk about, but not too much…. It is not important if you are a midwife or not. I could talk to anybody, at least somebody listens to me, but it should be a woman. The only problem was I had to clean the rooms for your visit. I learn a lot of things from you… how other mothers are doing. It is the best part of the interviews… How many mothers did you interview? Only six, so I am very lucky. My friends in my group asked me why I have your visit every month. My mother asked me why I have my midwife. I answered because I am interviewed for her research. They said it must be really good to have the visit every month, because I could ask you anything that I wanted to

know.

(About her hospital stay)... it was long enough to know about 'BO-NYUU' [breastfeeding]. 'BO-NYUU' is different from the other ordinary activities, which I can only do once or twice a day... like baby's bathing or meals. I do at least eight times a day. So five days is enough to know about 'BO-NYUU'. I don't need more than that.

Now 'YU' is breastfed twice a day, in the morning and before going to sleep. In the morning, she gets up and asks me to breastfeed. But I first need to go to the toilet. While I make her wait, she is just crying and saying 'Pa! Pa!' I have no idea how I can stop the morning breastfeeding. But I would like to wait until she becomes O.K. without breastfeeding. (May: 17 months: final interview)

From the first interview, Mrs M talked about what was happening to her and her family in a very spontaneous manner. When she had different information from different professionals, she asked my opinion. I firstly asked what she thought about it and discussed it with her. At the end of each interview, she asked me to check her breast condition. When Mrs M developed mastitis, she phoned me and asked how she could manage it. She told me that the cause of mastitis was due to too much eating of Japanese sweets the previous day. When she developed mastitis at ten months, she phoned me again and explained 'YU' refused to take her breasts as her breast milk tasted very salty. She could explain the reason why 'YU' refused it. I recognised that she developed a good awareness to her breast condition and her skill to deal with the problem by herself.

Mrs M and 'YU' developed a rhythm for the day. Their day started from 7am with breastfeeding, playing and having a small snack in the park, coming back home and sleeping, having lunch at 2pm, playing and eating dinner at 7pm, taking bath at 8:30pm, breastfeeding and going to sleep at 10pm. 'YU' used a dummy at night. When she needed it, she looked for it by herself, and put it in

her mouth. Sometimes 'YU' got up at 4am for breastfeeding, but generally she slept through the night.

In the child caring diary, she illustrates baby's face in each day's column and recorded the area of baby's rash. She also recorded the name of visitors, and the place of their visits, and the special events such as 'Start to clap hands', 'Pointing fingers', 'Starts to sit up, that is great', 'Try to walk, nearly come to walk, great!' 'At last, she starts walking!!! A great day! Congratulations! (with an illustration of a big clap!)'. I could see that she enjoyed keeping the diary. Looking at her diary, my visits appeared as a day event. I noticed that she wrote it as 'a midwife (my name) visited' for the first and the second visit, and then it was changed into a form of 'Ms (my name) visited'. Taking account of her comment in the final interview, I could explore the meaning of my role in the interviews, and my presence on her experience of breastfeeding as well as her child caring as a whole.

10-1-3. The key themes and my reflection from Mrs M

Mrs M's narrative will inform the following two points:

- Breastfeeding was not talked about once it was embedded as a part of her ordinary life.
- Her time and space was expanded by the three different time frames: the social time that regulated her attendance at the baby clinic, the Japanese rituals that indicate when and how the mother and her baby could go out, and the seasonal time that influences the time and space where they could go out.

My research approach was focused on illuminating the above time frames from the women's perceptions. Mrs M was capable enough to create the sense of own time and space within the above social time frame. In the first two months, Mrs M had very few people around her time and space, only were her mother and husband. It was winter time and she also felt

apprehensive to go out with the small baby by herself. Her space of life was within her house. However, she could create the space and time to enjoy everyday life, which I found her thinking was very practical. In the following section, I will explore the meaning of breastfeeding and discuss the real essence of breastfeeding within her context.

Her attitudes towards breastfeeding and her decision making process

At the first postnatal visit, her husband let us into the living room whilst Mrs M breastfed her baby in the Japanese room. I felt that the atmosphere was very relaxed, and her husband was relaxed to stay whilst his wife breastfed, which added a positive message. I instantly felt that breastfeeding had been their ordinary part of life.

In the first follow-up interviews, she mentioned that she liked breastfeeding from the first time and described it as 'HAHA-NO-SHIGOTO'. The word 'HAHA' means 'a mother', but it is a special word to use for showing a strong respect for 'a mother', and 'SHIGOTO' means 'a job'. She added she could not explain breastfeeding more than that, which I felt she was very proud of. After that, she did not talk of any value of breastfeeding, even in the final interview. In the actual child caring, she experienced the baby's crying at night and breastfed a maximum of 14 times a day. However, she seemed very sure about breastfeeding.

In the interview, she talked a lot about baby's eczema and her staying on a special diet, and visiting different medical doctors, which I could imagine made it hard to continue breastfeeding. However, her breastfeeding was not interfered with by any of those events, and her positive feeling of breastfeeding was developed from time to time. As she became more comfortable, breastfeeding was mentioned less. I found it was important to attend her home repeatedly and obtain her emotions not being voiced in the interview, which was about observing and feeling from her atmosphere in

which she and her baby were spending their time.

Between four to nine months, Mrs M did not talk a lot about breastfeeding. During the interviews, I was with her when she was breastfeeding. As her baby grew, her baby was more involved in the interview; joining in the conversation, tapping on the table, touching the tape-recorder or trying to reach our tea and sweets, and asking for breastfeeding or eating weaning food. Whilst her baby was moving, Mrs M and myself were working together for the baby. Coming to the ninth months, the baby said 'Pa! Pa!' and was breastfed and I could see how they loved it. Mrs M talked a lot about her concern about the timing of stopping breastfeeding. However, I could see that they worked really well and assumed that they would know the best time by reflecting to each other's feeling.

In the final interview, I asked about her experience of breastfeeding and she answered that she did not need to say anything. I also noticed that she did not change her discourse, in which she could see now and the future of child caring. She was not interested in making sense of her past. I asked her view of breastfeeding, which she explained:

'... Breastfeeding is different from something doing only once or twice a day... The hospital stay is long enough to know about breastfeeding...'.

Her answer illuminated the message from the series of interviews, in which her narrative was about she came to know about her baby, and to know about child caring from doing. This significant difference in breastfeeding was compared with other child caring, for which she required measurements to know if she did it right. In the process of learning other child caring skills, she used the words *'stealing her mother's skill'*, which meant her learning was based by seeing what her mother did. Her mother encouraged her to follow her sense rather than measurements, which Mrs M found hard to follow. Mrs M's story illustrated the differences between breastfeeding and other child

care, which gave me a clue to think about the real essence of breastfeeding.

Concerning her decision making, Mrs M collected information talking with her friends, using books and magazines and the Internet, which gave conflicting views of child caring. She gradually developed her way of child care, which was following her feeling and her baby's response. Her decision is following 'knowing her baby and child care from doing'. Her baby-centred attitude was fully supported by her mother and husband, which made her able enough to believe her decision as right. She addressed the sense of 'YO-YUU', which was the space and the time she could reflect herself and her child caring. In her story, the sense of 'YO-YUU' is the most important and provides the meaning of support for her child care.

The main theme: breastfeeding as the mother and her baby are in tune

As I assumed from the exploratory interview, Mrs M's narrative informed the point that breastfeeding could not be talked about easily since it came to be embedded in the woman's life. Some events were required for women to think about breastfeeding in an explicit way. In Mrs M's narrative, breastfeeding was talked about in her first experience of it, and then it was talked about in relation to the episode the other mothers stopped breastfeeding. I had to understand her experience of breastfeeding from the things that were not told in the interviews.

From my monthly visits, I observed breastfeeding as a physical shift, in which Mrs M and her baby were engaged. It might be similar to such as 'walking' or 'eating'; which people do not need to explain the meaning or the reason of doing it, whilst it exists as a part of normal life. Especially when breastfeeding was embedded in their lives, the meaning of its presence was not necessarily to be considered. It is again very similar to the situation where people start to think about the meaning of food, when they had a problem with eating.

In my research approach, breastfeeding could be understood following the woman and her baby's biophysical change. Looking at breastfeeding from the point of 'women's shift in time and space', the real essence of breastfeeding is identified as the process of 'the woman and her baby in tune'. Breastfeeding was described as 'bodily experience' involving two people's bodily parts and bodily contacts between them. She developed the sense of living with her baby and her family together in harmony, the sense of uncertainty seems to be the essential nature of child caring, the meaning of which I will explore in other cases.

Section two: studying other women's experiences of breastfeeding

In this section, I will report on two women's experience of breastfeeding. The first case illuminates the baby's role in breastfeeding. The second case reports on a second time mother's perception of breastfeeding.

10-2. The case of Mrs K

10-2-1. The main theme: 'My story is all about breastfeeding'.

When I first came across her, Mrs K mixed-fed her baby due to her cracked nipples, which illuminated the baby's role in breastfeeding. Mrs K moved to another part of Tokyo at the end of three months, in which she could live with her own family in 'NISETI-JYUUTAKU' (a house designed for two families to live in the same property). When she developed cracked nipples again, she visited 'Oketani massage room' and the midwife pointed out the problem of baby's tongue-tie, and advised to go to the special clinic for the treatment. At the end, she decided to take the operation for her baby and they could breastfeed exclusively since then. I represent her narrative in three time blocks:

- From the first visit until moving.

• The experience of frenotomy (a surgical release cutting the frenulum under the tongue).
• After five months until the final interview.

In the following descriptions, I used the following Japanese word indicating the following meaning:

'BO-NYUU': 'BO' indicates' a mother' and 'NYUU' indicates 'milk', 'BO-NYUU' means 'mother's milk' or 'breastfeeding'
'MILK' (all in capitals): It is used for indicating 'formula milk' or 'powder milk'.

10-2-2. Mrs K's story

Stage 1: The early postnatal period; getting through the problem of cracked nipples

Mrs K and her husband, both 28 years of age, lived in a three bed semi-detached town house. They got married at 26 years and soon she fell pregnant, and had strong morning sickness, which she had to stop working. Her baby was born in January at a small private obstetric clinic which she chose for their water birth facilities. Soon after starting breastfeeding, she developed cracked nipples. She suspended breastfeeding and expressed her breasts by hand. After six days staying at the clinic, she returned home and her mother sometimes came to visit her.

The community midwife visited her on the 24 days after birth. She could not breastfeed due to the cracked nipples. Instead she expressed her breasts every three hours. Checking the nipple condition, the midwife asked her whether she would like to try breastfeeding. They tried to breastfeed together, but Mrs K said that she did not have enough breast milk due to having 10ml breast milk from hand expressing. The midwife advised she could combine breastfeeding and bottle-feeding for a while. The midwife made an

appointment to visit one week later. Within the next few days, she developed a cracked nipple, phoned the midwife and asked for a visit. The midwife came and massaged her breasts, and since then she did not have any problem of breastfeeding.

1 month: The first interview

Mrs K:

All my friends use MILK [formula milk], so I have no idea about breastfeeding... I never imagined it was so painful. I know 'BO-NYUU' [breastfeeding] is good for babies... and I would like to do it if I could have enough 'BO-NYUU' [Breast milk]. I know a bit about 'BO-NYUU' [breastfeeding]... the best nutrition for babies... But I think... nowadays, MILK [powder milk] is as good as 'BO-NYUU' [Breast milk]? Other people could help me... like my husband could feed at night... I found it was not easy to 'BO-NYUU' [breastfeeding], when somebody is around me... going shopping... no place really... So I feel... 'BO-NYUU' [breastfeeding] is a bit like...between good and bad...

Her mother:

I found the things are so different from my child caring... in my generation... like my parents, grandparents, relatives... or even neighbours helped me... I came to know about child caring by seeing other people helping me... I can borrow their wisdom ('CHIE' in Japanese)... [Her daughter] exchanged the ideas with her friends... no chance to borrow wisdom from others... Visiting here and seeing the massive piles of maternity journals, I am wondering... is it the current way of child caring?... Now child caring becomes more complicated... they need someone to give the right advice... I am working in a medical service... but when I came here, I am only a mother who could just worry about my daughter. I cannot give any advice...

2 months

At the last interview, I could not tell you about my feeling of breastfeeding... My relatives visited or phoned me... asked me 'Do you 'BO-NYUU' [breastfeeding]?' I felt a bit blue...My aunt is a midwife...but I could not tell her about my cracked nipple... I also wondered... how other mothers cope with the other life matters. I mean about my husband...

3 months

Now I only 'BO-NYUU' [breastfeeding]...My baby started to refuse bottles, just crying until he got my breasts... My husband was a bit reluctant...but I am happy... I would like to 'BO-NYUU' [breastfeeding] as much as I can. My breast condition became really good...I could easily hand express 100ml 'BO-NYUU' [breast milk]... To my surprise, having more [breast milk] means no interest to the other matter, I mean with my husband thing... I think it is the natural kind of law??? Maybe...

At three months, she became able to breastfeed exclusively. She considered the new life with her own family and also being busy for moving. The appointment of the following interview was made to happen sometime later after her move.

Stage 2: Moving and developing mastitis: her decision to frenotomy

When she moved into a new house, she developed cracked nipples again. She talked with her neighbour and found the 'Oketani massage room' near the main station. She visited there and returned to breastfeeding. The midwife identified the problem of her baby's tongue-tie, which caused her cracked nipples, and advised to visit the special clinic. She had a shock and talked to her mother. Her mother searched the Internet and gave the information, which reported frenotomy was not recommended. Spending one week considering

the information, Mrs K, with her husband visited the clinic.

The clinic was a two hour journey by car, and the clinic was full of mothers and babies. Firstly she met a midwife and breastfed while her baby's oxygen level was monitored. The doctor checked her baby's tongue by microscopy and explained; tongue-tie was genetic, so some other family members would have the same problem. A tongue-tied baby had problems sleeping, their joints and muscles were stiff, and their hands and feet were cold due to the ineffective breathing. She noticed these conditions with her baby. The doctor advised to arrange her baby's operation as soon as possible. The operation took place the next day, a few minutes under local anaesthesia. Mrs K was in tears with other mothers in a waiting room. Soon after the operation, she could breastfeed. Returning home, she found her baby did not cry through the night. She did not need to cuddle him and walk around the room at night as she had repeated every single night until previous night.

The following day, they returned to the clinic and the baby's oxygen monitor showed 100%. The midwife checked her breast condition. After that, she followed up at 'Oketani massage room' every week. After one month, she did not need breast massage. Mrs K and her baby could breastfeed comfortably, which made her feel able to continue breastfeeding as long as she could.

Stage 3: The experience of breastfeeding after frenotomy

5 months: July

I [breastfeed my baby] every two or three hours maybe...I am not sure how many times I do [breastfeeding]... maybe... eight times a day... I latch on, when my baby needs... [After operation] He is very quick to breastfeed and sleeps well during the day. Definitely the treatment changes our life... In the last week, I gave a few spoons of rice gruel. He eats really well...Before the operation he was 6.3kg, and now 6.5kg. Still he is small, but I don't mind... I

know 'BO-NYUU' [breastfed] babies are smaller than MILK [formula milk fed] babies as I was told by breastfeeding mothers... It is important to talk with breastfeeding mothers...

I was worried about weaning food... Do you know?...There is a kind of theory mothers can only breastfeed until 12 months without weaning food...I also read... weaning food and the idea of not cuddling babies (in Japanese, 'DAKI-GUSE', 'DAKI' means 'cuddling', 'GUSE' means 'a bad habit', cuddles should be abandoned because it will spoil babies) was introduced from the North American... Now we are told 'DAKI-GUSE' was wrong and we should cuddle our baby. However, no change in weaning food... we should start from two months. One third of Japanese babies are suffering eczema, because of this early weaning... How do you think about this?

7 months: August

Her baby fell over from their bed, when she forgot to put her baby back between her and her husband (She does 'SOINE', she and her baby sleep in the same bed) after breastfeeding. The baby also fell over from the baby chair while her husband was changing the nappy. Her mother came down to them and looked after the baby, whilst her husband was frozen and she was in panic. She could not sleep that night. She did not talk about her breastfeeding unless I asked about it:

I don't know... how many times I breastfeed. I have no schedule... I do so when he needs... maybe eight times a day... The first three months was the worst time... the weather was too cold and no way to go outside... My breasts were always sore. I was always thinking when I could stop 'BO-NYUU' [breastfeeding] and when I could shift to MILK [bottle-feeding]. Everything was negative. Now, I would like to continue 'BO-NYUU' [breastfeeding] until 'SOTSU-NYUU' ('SOTSU' means 'departing', 'NYUU' means 'milk', It means graduate from being breastfed)...Honestly when I was told about the problem

of tongue-tie, I thought I should not have been here. I felt I got extra suffering…. Now I feel I am lucky. I can say I am enjoying breastfeeding… Of course, it takes a bit of time to say it is a good experience. But I could not tell my experience to others or could not recommend it to others. It is difficult to tell….

At the beginning of living in 'NISETAI-JYUTAKU' ('NISETAI' means 'two generations', 'JYUTAKU' means 'house', living in the same property with the parents), I was a bit concerned it might be difficult. But my baby is much happier with my family… he is waiting for my mother, father, brother coming back from work and he is very happy to see them… Talking with my female friends, it seems a trend to live with own parents in 'NISETAI-JYUTAKU'… but definitely not with husband's parents…

8 months: September

I step-up weaning food, rice gruel, vegetables, and fruits. But he became constipated. I give weaning food less and more 'BO-NYUU' [breast milk], and his constipation has gone. More 'BO-NYUU' [breastfeeding] makes my baby healthier…Looking back on my child caring, I found the Japanese traditional idea is the best … 'ONBU', breastfeeding, and linen nappies. I am doing just the same as what my mother did…Honestly, I would like to do my child caring in a 'fashionable and smart way'… wearing fashionable maternity clothes and walking with a fashionable baby buggy… 'ONBU' (The woman carries baby on her back) is the best way to carry my baby, breastfeeding is easier, and linen nappies are best…I made a long journey to look for the best way and landed on the very simple ways… One thing… I can say now is… the fact I can 'BO-NYUU' [breastfeeding] provides me with a bit of… like confidence… Maybe it is a word? I can believe that I am doing the right thing for my baby...

Her mother:
I know how my daughter decides. I know she does not like to ask me how to

do it. I need to wait and to see what she finds. I just need to be 'MI-MAMORU' ('MI' means 'seeing', 'MAMORU' means 'protecting', which means to give attention to her idea, but not to make any interference to the settings). I was very impressed her husband supports her really well. So, now I think... it is the way of young couples to do things...

9 months: October

I am trying to use weaning food according to his bowel condition. Now he has no constipation. Increasing the amount of weaning food, he takes less 'BO-NYUU' [breast milk]. Now I breastfeed him like... 2-3 times a daytime, and during night 3-4 times, average ... eight times a day...it does not make any difference in total, I have not noticed it...

He is now 'TSUKAMARI-DACHI' (= standing using objects like legs of tables or sofas). He can play by himself and I don't need to 'ONBU' (=holding him on her back). He would also like to eat himself, holding the weaning spoon and tried to use it... Now I can go out without him. When he is not with me, he does not ask for 'BO-NYUU' [breastfeeding]. He is so clever...Now I have my time to do my things while he is sleeping during the day. I have got 'YU-TORI' (feeling of not rushing, and being able to stay in herself, in own time and in own space)... When I am going out, I find 'DATTUKO' (cuddling her baby in front with the cuddling belt) is the best way. Other people are holding his hand or touching his face while I am waiting for a bus. He always enjoys and responds to them like... 'AH-! AH-!'...

10 months: (The early) November

At the 10 months' baby clinic, his weight and height were average, but the paediatrician told her to think about stopping breastfeeding:

I said... I want to continue breastfeeding until two years. He said it is alright,

but I should start to prepare to stop now. I can't say anymore... I would like to breastfeed until... [My baby] shows more interests in other things and less interest in breastfeeding... the doctor also advised to use follow-up milk. I talked with other breastfeeding mothers. They said it was alright to continue breastfeeding as long as I wanted and no follow-up milk. But they could not say it to paediatricians...

12 months: (The late) December

She started to go to the park near her house:

... He became more active. He falls asleep in a few seconds. I felt he grows from day to day...He plays well with other children...This year... I felt it was time I came to learn the meaning of being 'patient' with everything. I know more about my true self, and my husband's true character ('HON-NE'). We [she and her husband] need to talk a lot. Our life is becoming very child-centred, and we need to work to co-operate. My husband has changed a lot. Simply, he didn't know how to play with children. At the beginning, when he did... like... bottle-feeding and changing nappies, he did it in silence... maybe he was too embarrassed to talk in baby's language...

Her mother:
I think that the most important thing is the baby is healthy... She (her daughter) seems very laidback to her child caring. I asked her about his weight and she said she did not know. I felt like ... why did she not know it? I was surprised that she could believe... seeing he eats well, breastfeeds well, sleeps well and she knows everything is alright. No interests in weight or other mothers... I wondered whether it was the best way to live in 'NISETAI-JYUUTAKU'. But now I want to say... At least we [she and her husband] can create a 'YO-YUU' (making a time and space for her to be relaxed), which needs money as well as space... I don't know how the current young generations are thinking about 'life'. But I hope... they [young generations]

can see the importance of knowing the value of life from child caring. Only we [the older generations] can help to create a better atmosphere for them, giving some practical help...

15 months: The final interview

Yes... He is breastfed... maybe eight times a day... he now goes to sleep at 9pm, at night I feed like... 12am, 3am, and 6am, because he crawls towards me to ask for 'BO-NYUU' [breastfeeding]. He has got his front teeth... A scar has developed just above the nipples where his front teeth attach when he suckles. The scar needs to be covered with tape... He knows it. When he wants 'BO-NYUU', he brings the tape to me...I would like to carry on breastfeeding a bit more... if he needs to be until... like two years? Do you think... is it alright? I would like to wait until he says he does not need it anymore...

10-2-3. The key themes and my reflection from Mrs K

<u>Her attitude towards breastfeeding</u>

From my first encounter with Mrs K, I could not think that she would become such a happy breastfeeding mother. From the follow-up interviews, I came to understand it was difficult for her to think about the meaning of breastfeeding whilst she was experiencing physical pain in her breasts and nipples. In the final interview, she described her feeling in the first few months as follows:

I still remember the feeling, when I had a problem with cracked nipples and could not breastfeed properly. Even though I added some MILK [powder milk], he was not settled. I could not leave him in the bed... I just cuddled him and sat in the living room. I could see the sun setting and the room came into dark... and felt I was alone... my clock stopped... I cannot tell how things have changed since I have been able to 'BO-NYUU' [breastfeeding] without

any pain...I appreciated the people who helped me. I feel it was fortune I could see the right people in a right time. (15 months)

Her positive feeling towards breastfeeding started to appear in the seventh month interview. Mrs K did not describe how her baby's suckling was different before and after frenotomy. However, I noticed the difference in her physical relaxation. Before frenotomy, she seemed to have some tensions around her shoulder. After frenotomy, when Mrs K started to say that she enjoyed breastfeeding, I realised that Mrs K breastfed her baby in total relaxation. The incident of baby's frenotomy could illuminate the baby's role in breastfeeding; especially its biophysical function, which could not be addressed in the story of Mrs M whilst breastfeeding itself did not give any problems.

Her feeling of being settled: Japanese concepts of 'YO-YUU', 'YU-TORI', and 'MI-MAMORU'

Mrs K collected the information from books, the Internet, and attending child caring seminars. She then tried them and chose the best for her baby. At the end, she found the Japanese traditional child caring was the best. Even though her result was not dictated by her fashionable image of child caring, she was happy with the outcome. Mrs K mentioned that her mother was very popular among her friends, and they phoned her mother to ask about their child caring. Her friends said that Mrs K was lucky to have her mother close to her. However, Mrs K said she could not ask her mother about child caring and her mother also said she could not advise her daughter, which illuminated the Japanese idea; 'A close relationship such as mother-daughter will invite more emotions and conflicts in their talk'. They respected each other's time and space, which was described in the following two words:

- 'YU-TORI': It was mentioned by Mrs K at nine months.
- 'YO-YUU': It was mentioned by her mother at 12 months.

The Japanese words 'YU-TORI' and 'YO-YUU' mean to have one's own time and space for reflecting own thought by oneself. These Japanese explanations brought the meaning of time and space in one word, which I could not translate into English.

I identified three reasons for her to say 'YO-YUU'. Firstly frenotomy meant her baby slept longer at night. During the day, she could leave her baby by himself, by which she could physically have some distance from her baby. Secondly, she did not need to worry about her breast condition. Thirdly, her living in 'NISETAI-JYUTAKU' enabled her to gain practical help from other family members. The idea of 'NISETAI-JYUTAKU' was not considered by either Mrs K or her mother as a good option at the beginning. In the end, they admitted it was their best decision.

The idea of 'YU-TORI' was described in relation to the meaning of support for child caring. It was explored more in the word of 'MI-MAMORU':

• 'MI' means 'seeing' and 'MAMORU' means 'protecting', which means 'giving a protection by seeing'.

Her mother actually provided physical support such as looking after the baby whilst her daughter was doing housework. The most important part of 'MI-MAMORU' was that Mrs K was given the 100% assurance that her decision was right. In the story of frenotomy, Mrs K and her husband made a decision, whilst her mother and other family were 'MI-MAMORU' to them. Her mother did not say anything to her, but she was prepared to take a responsibility for their decision with them. The concept of 'MI-MAMORU' is very cultural, which is based on the idea; not saying anything gives better support than saying something.

The concept of time in life: learning from her mother

I learnt two things from her mother; the meaning of 'wisdom' in child caring and 'MEGURI-AWASE'.

In the first interview, the dialogue between Mrs K and her mother illuminated the meaning of wisdom in child caring, which discussed the difference between 'wisdom' and 'information exchange'. The wisdom could be created when the different generations were participating in the exchange of knowledge. The information across the same generations required the professionals who could support and help them to choose right information.

From the final interview, the feeling of gratitude to people was explained by her and her mother, which was told 'MEGURI-AWASE' in Japanese. I identified 'MEGURI-AWASE' represented the Japanese people's view of multi-dimensional cycles of 'time and space'. 'MEGURI' means 'circling', and 'AWASE' means 'coming across or together'. The encounter amongst people is based on the complex circling of each individual time and space. It is very rare people can come across a right person, in a right time, and in a right place. In her story, moving to the house, seeing her neighbour, going to 'Oketani massage room', and having frenotomy, and also being invited to join in my research were all described 'MEGURI-AWASE'. It gave the great meaning of her child caring, as she perceived it brought the best consequences to their baby's life and also their breastfeeding. I perceived that Japanese people use the phrase 'MEGURI-AWASE' to show their gratitude to others. I feel myself being fortunate that they viewed my interview as one of their opportunities 'MEGURI-AWASE', in which her mother and family were supported by my presence in their lives. This point will be discussed in the meaning of support in the final discussion.

What is the real essence of breastfeeding?

The significance of Mrs K's narratives appeared in her shift in breastfeeding. Mrs K experienced both mixed-feeding and breastfeeding, which illuminated how mixed-feeding made her life difficult. Her experience of mixed-feeding was about her cracked nipples, sore breasts, and baby's crying. When she was relieved from her physical pain and could breastfeed, her life started to get a rhythm, and the sense of 'baby and mother are in tune' started to flow in their life. Her story illustrated breastfeeding was not simply a matter of doing it, but includes the baby's physical features and functions.

10-3. The case of Mrs O

10-3-1. The main theme: how she can make a balance between a new baby and her eldest child

I will present Mrs O as my third case of studying breastfeeding. She is a second time mother, and experienced exclusive breastfeeding with her eldest son. Breastfeeding appeared as an embodied knowledge from the beginning, so she could directly talk about her feeling of child caring in the interviews. Mrs O's experience was about how she could make a balance between herself, her three-year old son, and a new baby girl. She talked about breastfeeding from three points:

- The comparison between her first baby, who was born pre-term and her second baby, who was born full-term.
- The comparison between a boy and a girl.
- Her concern of stopping breastfeeding.

10-3-2. Mrs O's story

Introduction: about her family

Mrs O and her family moved to Mitaka-city in 2001. Until she married she was a full-time administrator, and since her first pregnancy she became a housewife. Their second baby, a girl, was born in December in a private obstetric clinic, whilst she and the eldest son returned to her parent's home in 'KYUU-SHYUU' (a southern part of Japan, two hours flight from Tokyo). They stayed there from late pregnancy until one month after birth, whilst her husband was too busy at work and could not help with child caring.

The community midwife visited her on the 57th day after birth. She breastfed six times a day, and the baby gained 48g/day in weight, which led her worry about obesity in the future. She perceived her breasts were too hard, so the midwife checked the condition and advised to make sure to breastfeed as her baby cried. The eldest son was 'AKACYAN-GAERI' ('AKACYAN' means 'a newborn baby', 'GAERI' means 'returning', it means a child behave like a small baby, for example, crying a lot or asking for help to do the things that he/she could have managed by him/herself before), and he needed to hold his mother until he fell asleep. They talked about this problem whilst the midwife was playing with the boy.

Her attitudes towards breastfeeding

In the first interview, Mrs O described her clear view of breastfeeding:

I did not like to use my breasts like… for comforting or making my baby sleep. I considered breastfeeding as equal as meal. So, I stopped breastfeeding him at the first birthday, and I only breastfed him three times a day. When I stopped, he didn't cry, but started to suckle his fingers… This time, I would like to stop breastfeeding earlier, because I need to go out with my eldest and it is

not easy to breastfeed outside. He can wait whilst I breastfeed, but in other situations he cannot wait…. He sometimes comes and says to me; 'my tummy aches'. I wonder that he felt like… not happy… (2 months)

I have heard… at 12 months breast milk is thin like water…no nutritious… colostrums are good for baby's immune and brain development. However, we [mothers in peer group] cannot mention the positive aspects of breastfeeding, because some mothers cannot breastfeed, especially it is difficult for working mothers. I also heard that breast milk tastes differently according to mother's diet, which is good for baby's brain development… (2 months)

Now I have two focuses in my life… one for my boy and another for the new baby. It is difficult to decide what I should do next… For my first baby…after premature birth, I had to express my breasts every three hours, freeze the milk and take to hospital. When he returned home, he cried every three hours. It was so easy. This time, I need to breastfeed when she cries. It is a bit inconvenient… A good thing is I can sleep longer, because she can be stronger [than the elder boy]… My breasts are always hard since the birth. In hospital, I attached a cooling bag onto my breasts. When I produced too much breast milk, the hospital staff came to me and hand expressed… (2 months)

She described two clear ideas:

- Breastfeeding is equivalent to meal.
- She wants to stop it before 12 months.

The following narrative will illuminate the complexity of breastfeeding, which followed her idea of making a good balance in her life.

From her feeling of unsettled to settled in her life: from the first interview to four months

In the three months' interview, she described her targeted duration of breastfeeding for this time as follows:

She is constipated... for the last six days. It happened to my boy so I do not need to worry this time. The problem now is I cannot go out, because she excretes a large amount. I had to go back home and clean her properly... I breastfeed six times a day. I give her fruit juice, but she does not like it...My breasts became softer and I wonder if I don't have enough breast milk... My body feel a bit of cold, because of the wet weather or too much eating of cakes. It might cause the problem of baby's constipation?... The hospital staff said to breastfeed within 10 minutes, but she needs 20 minutes... if I stop before she becomes fussy... Concerning 'DAN-NYU' (= to stop breastfeeding according to mother's plan)... I decided to stop at 10 months... I have no choice in the clothes I could wear... Of course I know it is up to her eating, but 10 months is my target... (3 months).

Her husband was very busy at work. However, she could not manage to bath her eldest son and her baby's breastfeeding at the same time, and ordered her husband to come back by 9 pm.

At the 3-4 months' baby clinic, she found it hard to make her eldest son to wait a long time there. He stopped to say his tummy was aching. She also started to take him to swimming and gym classes whilst she could not play with him in the park. Her mother-in-law, who lived one hour's travel distance, started to visit her again:

... My life becomes very settled... I breastfeed five times a day and also give fruit juice. The breastfeeding is dictated by my son's schedule, even if she was not hungry, she needs to be breastfed. She still gets constipated. Maybe she

needs more liquid... Now she calls me or her brother from the bed... My mother-in-law visited and said to me like... 'Child caring in my age was more difficult. We [in her generation] did not have paper nappies'. I am wondering why I feel so busy... I think, maybe... the expectation of child caring becomes higher and I have to expect much on children. On the other hand, some mothers don't care about making disciplined children... They give junk food whenever or wherever children ask...I do not like their idea... (4 months)

Getting with her life: from five to seven months

At five months, she introduced weaning food. Her baby was constipated and Mrs O tried to give some Japanese tea. Her baby started to sit by herself (OSUWARI in Japanese), and Mrs O did not spend her time after breastfeeding winding her. She started to take her son to pre-nursery classes in one of the kindergartens, which was the preparation for next April.

If I leave her in the baby bed, my boy climbs and gets into the bed, and they sleep together in that small bed. He wants to play with her, but he really doesn't know how to play with her... It is a bit dangerous and I need to keep my eyes on them... (5 months)

Coming to six months, Mrs O breastfed her baby more often:

... She started to cry at night... maybe the weather is too hot and she is maybe thirsty. I don't like to breastfeed at night, but it is easier than giving some other liquid ... Now, I have two children...but I have more time... my work is breastfeeding, and other times I can leave them by themselves. Of course I am busy to take him to the gym or swimming classes, but I have time to cook... (6 months)

She returned to her parents' home during summer. She developed mastitis, which was treated by the hospital in which she gave birth. Her sister and two

children stayed at her home for a week, during which she had a lot of rows with her sister due to their different perceptions of child caring.

The story of stopping breastfeeding: from eight months to ten months

In the eight months, her baby started to 'TSUKAMARI-DACHI' ('TSUKAMARI' means 'holding, 'DACHI' means 'standing', it means standing up whilst holding something like chair's legs or sofas) and in the eighth month she started 'TSUTAI-ARUKI', to walk whilst holding the wall or the legs of stools.

She eats weaning food twice a day... rice gruel 50g, some miso soup... Breastfeeding is six times a day. Recently she started to get up three times at night and I breastfeed her, I don't know why she needs it...As you know I don't like the idea of using my breasts for easing her, but I need to breastfeed when she falls asleep. She could say 'OTTU-PAI' (a Japanese word to express breasts, but the meaning is breastfeeding) to ask for breastfeeding. I had to decide the time for 'DAN-NYUU' (= to stop to breastfeed). It is too hot to breastfeed in this weather...No, I have not decided yet. I have to wait until she could eat three times... But I wonder... if she says 'OTTU-PAI' to me, can I really say no to her request? It is better to wait until 11 months? At my parent's home, if she could not find me, she cried until she found me. She is always 'NIKO-NIKO-SURU' (a metaphor, smiling), when her brother is coming to her. He also likes her, and wants to help when I give her weaning food... it is a bit annoying... (8 months)

In the interview, she could not find any differences between the traditional word 'DAN-NYUU' (stopping breastfeeding to mother's accord, which is restricted by 12 months) and the new word 'SOTSU-NYUU' (graduating the baby from breastfeeding by baby's accord, which presumes baby's 18 months).

Her baby started to 'HITO-MISHIRI' [She cries when she sees a stranger],

'ATO-OI' [She tries to follow her mother], to say 'OTTU-PAI' when she wanted breastfeeding. Mrs O gave weaning food three times, but her baby only ate twice. Breastfeeding took place three times during the day and three times during night, which gave her a bit of difficulty to decide to stop breastfeeding:

A few days ago, she bit my nipple and it bled. Yesterday accidentally she fell asleep without breastfeeding, but the problem was my breasts became sore. I had to get up at night and hand express them. I considered it was a good chance to stop breastfeeding. Do you think it is too early to stop at nine months? Next month, my mother is coming to stay with me for one week, so she would be able to help me and I would have time to look after my breasts... I breastfeed at night, because I cannot leave her crying for a long time...My husband could not sleep and my son gets up... If I decide to stop, I will definitely stop... So, so I need to give a teddy bear, towels or blankets for her? (9 months)

During the tenth month interview, she decided to stop breastfeeding. At the 10 months' baby clinic, everything was alright. She ate weaning food, took 150ml cow's milk twice, no constipation, and no crying at night and no need for breastfeeding:

... I tried to breastfeed after bathing, but she said she did not like it. In the last two weeks I have breastfed only once a day. I have no pain in my breasts now. Is it alright to stop now? I thought she would cry a lot without breasts, but she was alright. She eats more and I do not need to wait for my mother... She did not say 'OTTU-PAI'. She goes to sleep at 8pm whilst suckling her fingers and breakfast starts from 7am with some toast and banana. She likes eating with us [her husband, her son, and herself]. So do you think it is alright to stop today? [I checked her breast condition] Is breast milk still flowing? Yes I know it. So it will develop a problem ... She 'ATO-OI' [She follows her mum] and 'AMAERU' [She asks for cuddling to enjoy skin- to-skin contact] and I am always cuddling her, but it is also normal for her age. Yes, I will stop from

today. It should be alright... (10 months)

Life after stopping breastfeeding

She stopped breastfeeding from the day of the last interview. Her baby did not ask for breastfeeding, ate more weaning food, and took 300ml cow's milk, but started suckling her finger:

... The problem is... I still eat the same as when I breastfed. I must stop eating... I just feel girls are so easy to cope with a change. Now I don't need to spend my time breastfeeding, and feel 'YO-YUU' [She has extra time to think about the things in calm and cool mind]. I do not need to say to my son like, 'do that' or 'don't do that'... Last September, my husband was sent to the other branch and had no time to play with him. Now I am sorry for my son. My mother said to me, 'Don't become so angry about children!!' I knew that, but..just it was difficult to stay calm... (11 months)

The 12 months' interview was spent with her talking about her experience of child caring.

I firstly thought she is very calm ('OTONA-SHII' in Japanese, 'OTONA' means 'an adult', and 'SHII' means 'like'), but also she is very strong, hardly cries, and understands everything ... Now she is sleeping well, eating well, and I do not need to cook weaning food. The last 11 months was cooking and breastfeeding. I got married and soon fell pregnant. I had no break between work and child caring. So, now I sometimes feel... I would like to have my time. It is my dream.

... My boy was born in June. In summer, I felt very hot to cuddle him for breastfeeding. But he wore a short cotton shirt, so I can feel him and always touching his hands and feet, even his tummy. I felt I knew him really well. However, this time... I suppose it was winter and I could not remember so

much touching and feeling of her. I mean... I did not have a real chance to feel her (12 months).

The final interview was undertaken in May after her son started to go to the kindergarten:

... Now the girl started to take a sleep before lunch in her bed. The problem is... when my boy is around, she can play with him, and I can leave her with him. But now she has only me, so she is always trying to hold me, 'ATO-OI' (= following after her) and I feel less time for housework...

My parents visited recently and said like... 'Girls are sweet and very different from boys', because the other grandchildren are all boys... She is very skilful, using spoons and managing to feed herself. She dances to the music whilst watching the TV programmes. My son didn't do this. She also tries to attract other people like...sitting in the chair and calls 'Papa! BA-!'... She talks a lot and people feel 'she is very sweet!' I sometimes wonder how different boys and girls are... (15 months)

10-3-3. The key themes and my reflection from Mrs O

<u>Her time and space in child caring</u>

Mrs O's story illuminated that her life dictated her concern for the eldest son, and she planned their life considering the April when he started to go to the kindergarten. She described that she had two focuses in her life; one for the eldest, and one for the youngest. I perceived that Mrs O was very honest to me to tell her feeling to breastfeeding, in which she was not comfortable with her body being occupied by breastfeeding. However, she breastfed her baby in a practical manner. It may be considered that her emotions and her actions did not give the logical sense.

I felt Mrs O was not negative about breastfeeding as she talked about in the interviews. I perceived her feeling to breastfeeding and their children from seeing the interviews settings. Firstly, she was very close to her baby during the interviews. Secondly, in her discourse, she said; my baby said like~, which seems she could understand her baby's message and deliver it in an explicit manner to other people. Lastly, her discourses contained a lot of children's language, which I perceived that she was viewing their life from the children's point of view.

In the interview, unless I asked her about breastfeeding, she did not acknowledge it. However, when I asked her questions, she was good at describing it. I found her breastfeeding was practiced in a baby-centred manner. For example, her baby's night breastfeeding was described as her baby being thirsty. She breastfed due to practical reasons such as saving her energy, not disturbing her husband and her son's sleep.

I perceived her idea of breastfeeding became more apparent in the process of her decision of completing breastfeeding. Her approach seems also very practical and child centred, which I have summarised into the following three points:

- Baby's health and emotional issues: physical growth, the amount and the balance of weaning food, sleeping pattern, and weather.
- Her breast condition.
- Her baby's feeling towards breastfeeding: her baby could ask for breastfeeding by 'OTTU-PAI', baby's night crying and sleeping, other activities and relationship with other family members.

I could see and feel that Mrs O and her baby became in tune, and also as a whole family in tune, which took five months. I could feel she could make a decision using her reflection with her baby. As she trusted her senses, she and her baby did not develop any problems and the message of she and her

baby in tune was flowing through the final interview.

My role in the interviews

In the final interview, Mrs O said that a monthly interview helped her, especially when she felt a bit of difficulty with her son. She invited me to sit at the dining table, served tea and asked her son not to disturb us because it was important. Of course, he came to us and we stopped talking. However, Mrs O responded well to him, from which I could feel comfortable enough to continue our talking. As I observed the interaction between her and her son, Mrs O also observed how I talked to him, which gave opportunities her to think about her child caring. This was the main reason why she decided to have my interviews monthly until baby's first birthday. Her son looked forward to my visit and he said I was his guest. After the interviews, I stayed for some time to play with him. When he could not wait, we moved onto the floor and talked while I was playing with him. Mrs O said she could learn a lot from me, which I did not particularly aim to perform in the interviews.

From her feedback, I found that our interview was based on four people's involvement: Mrs O, her son, her baby and myself. The context in this interview included a lot of physical activities and the children were also the key informants to know about the life of the second time mother. The real essence of breastfeeding was informed by its practicality, which is more important the reasons that were given by her theoretical interests or her emotions alone.

10-3-4. A brief summary

I studied breastfeeding from three women's narratives. Within my holistic approach, breastfeeding appeared as the women and their babies' biophysical shift. Three women's experience informed me that breastfeeding involved complex interactions, which could not be performed by learning the

techniques and skills of doing it alone.

In the final interview, three women did not make sense of their experience from the perspective of motherhood, and I could see their perspective was more on future, rather than the past. I clarified that the real essence of breastfeeding from their whole context was that breastfeeding could be a condition of two people engaged in the bodily performance. When breastfeeding was embedded as a part of women's ordinary life, the importance of physical closeness with their baby, the value of breast milk, or their body in breastfeeding were not so likely to be talked about in their narratives, which I will explore in the comparison with the remainder of the cases; whose experience's involves the usage of bottles and formula milk.

Section three: Learning about breastfeeding from women's experience of mixed-feeding

In my study, the word mixed-feeding was clarified to use of formula milk when the women felt their babies did not have enough. In this section, I will study mixed-feeding; one a first time mother and one a second time mother both of whom came from a background of working outside the home.

10-4. The case of Mrs H

10-4-1. The feature of Mrs H's discourse

The significance of Mrs H's experience became clearer when I translated her story into English, in which she talked about her wondering about child caring:

My feeling towards the interviews is.... I could ask anything I would like to know... like why it did happen or what is going to happen. I did not need to do much wondering or worrying, because I knew I could ask you. It is really important for me that you are a midwife..... I have got a kind of 'YO-YUU'

(thinking and reflecting herself in her own time and space) to talk with you (The final interview: 13 months)

I considered her feeling of uncertainty was quite normal for a first time mother. She was very honest about her uncertainty, by which I could experience her uncertainty in child caring as my uncertainty. I especially felt I became a part of the data. As she perceived, my role was to listen to her and to think through her problems together. Of course, I could not turn her uncertainty into 100% certainty, as I believe there are no certainties in human life. The difference was I had a bit more knowledge and practical experience as a midwife, which assist me to understand the nature of medical discourse and to help her make sense of her situation. At the end of each interview, Mrs H asked me to check her breast condition which I did for other mothers. However, my feeling of involvement in her life was stronger than with the other cases. Her interview required more time, during which she described several different issues: basically her experience was talked about breastfeeding, formula milk feeding, and as a working mother she was concerned about her work and her baby's nursery care.

In her case, mixed-feeding was practiced as the extension of hospital practice. I will describe how hospital practice informed her initial engagement with breastfeeding. Her narrative is about her development of positive feeling towards breastfeeding.

10-4-2. Mrs H's story

<u>The story of mixed-feeding</u>

Mrs H and her husband moved into a new modern house in 2002, as they were working in the same public sector in the main area of Tokyo. They were both 30 years of age, and the husband was busy at work and they hardly talked or saw each other during the weekday. She chose a general hospital

for her maternity care for its convenient location from her workplace. Her baby girl was born in April, and she started to breastfeed soon after birth. Staying five days, she returned home, and her mother came to help her for the first month. The community midwife visited her on the 35 day. Mrs H mixed-fed her baby; 80ml formula milk after each breastfeeding. The midwife checked her breast condition and suggested that she could breastfeed more, but she did not respond well to the midwife.

In the postnatal visit, she did not talk about her hospital practice, but described in the first interview:

Every three hours, I went to the feeding room, changed the nappy, checked her weight, breastfed, and then checked her weight. If it increased by 2g, I wrote two in the sheet. The midwives came to express my breasts each time. It was really painful. The hand expressed breast milk was topped up with some formula milk and I fed it to her. For the first few days, I only had a few drops (breast milk). The midwife said 'Nothing'. On the day of leaving hospital, I got 20g gain [after breastfeeding], but the midwife told me 'Nothing'. I saw other mothers had massive breast milk and they used a breast pump to make their breasts empty. So, it is 'SHI-KATA-GA-NAI' (means accepting the things that happened to the person are a consequence of nature), if I was considered nothing.... I enjoyed talking with other mothers in the feeding room. In the class, we were told that breast milk was good for preventing infections and good for 'SKIN-SHIP' (skin to skin contact with the baby). But at the same time, formula milk is as good as breast milk. It sounded like breastfeeding and mixed-feeding were both alright... (1 month)

Her feeling was illuminated by the phrase of 'SHI-KATA-GA-NAI'. She reflected back her feeling of hospital breastfeeding in the final interview:

I think the hospital stay was not good enough to learn about breastfeeding... As you may realise, the postnatal visit was the first time I was concerned

breastfeeding could be my thing. The hospital practice is like... 'I had better use formula milk'. Of course I was reluctant. So I never imagined I would have been breastfeeding for such a long time... like until now... (13 months interview)

I identified the keyword to understand her experience, which she tried 'to learn' about breastfeeding. The following story informed how her attitudes 'to learn' influenced her experience of breastfeeding.

Her breastfeeding: from one to four months

The midwife visited her a few weeks later, during which she told me that her situation with breastfeeding had not changed. The first interview was undertaken two weeks after the second postnatal visit, over which time I found she gradually changed her approach to feeding:

I have not enough breast milk... because my baby starts to cry one hour after breastfeeding. So I add formula milk. At night, when she cries I use formula milk and then the next time I breastfeed... I want to breastfeed her as much as possible. When the hospital midwife said I did not have enough breast milk, I was so disappointed. My mother also said to me that breast milk was best. She had a lot of breast milk, so she could not understand why I could not... I felt the left breast has more milk than the right side... I really enjoy my life...just watching my baby, I am happy... (1 month)

In the two months' interview, she had a problem with baby's constipation and the incident of her baby to refuse bottles influenced her breastfeeding:

My baby refused bottles and I had to breastfeed every two hours... I knew that I did not have enough breast milk, so I was really worried. Suddenly she returned to bottles, but now she asks me more to breastfeed. I feel exhausted and asked my mother to come to my house again... Now I started to think

about weaning food... My mother said, if I breastfed longer, it would become harder to stop it. I am thinking about her nursery from April...Is five months long enough (for breastfeeding)... How about other mothers?... Now I realised... Yes, before she started to refuse bottles, she vomited massive MILK [formula milk] after I gave 80ml MILK...I also realised since I add more formula milk, she became constipated... Do you think it is relevant? (2 month)

At three months, Mrs H returned to her parents' home for one month, which she travelled three hours from home by train. Her husband was busy at work and could not help with child caring. She could manage to breastfeed most of the time, and used 140ml formula milk once before going to sleep. She introduced weaning food; 40ml of fruit juice and vegetable soup. The three months' interview was spent describing her concern about her own physical condition:

.... I don't know exactly... three months after birth is the time mothers' hormone balance starts to change? My gums were swollen and the dentist said that it relates postnatal something... Anyway I took antibiotics and painkillers, so I had to stop breastfeeding for a while. I had to hand expressed my breasts. I suffered tooth pain and breast pain. After three days, I returned breastfeeding. It was such a relief... I also found my hands swelling in the morning. I went to a clinic, but x-ray and blood tests were all normal. I had massive hair loss. It also relates to the postnatal hormone change?... She is not a fussy baby, so I do not breastfeed to comfort her. I feel like... She seems happier when she is on my breasts, so I leave her as long as she wants there... Until now I had no chance to meet other mothers in my community... Could I go out? I would like to know how other mothers deal with both housework and child caring... (July: 3 months)

At 3-4 months' baby clinic, she was concerned as her baby was a bit smaller than average but the paediatrician said it was not a problem. Coming to August, she tried not to use the air conditioning too much. Mrs H started to

feel her life was settling:

... She has got a kind of rhythm for sleeping... I continue to breastfeed, but I feel she does not get enough. She does not cry, but I just feel she may not get enough. So I give 100ml formula milk twice a day [after breastfeeding] just in case. Sometimes I give 150ml. I breastfeed five times (a day). I started to think about some rice gruel, but it might be too early? I think... when she has not enough, she suckles her fingers... This is the reason why I use formula milk. I think everything is going really well. She is very healthy and happy... I have not my menstruation back... During breastfeeding, I would not have it? I have got enough to do for my baby, so no better not to have... But I also heard a story who menstruated during breastfeeding, and without knowing she got pregnant... [When she went to the mother's community meeting] I was so surprised that almost all the mothers around me were breastfeeding. One of the babies was so big and I am sure the baby must be formula fed. But I was wrong... The mother must have a massive amount of breast milk... (4 months)

In this interview, I noticed she came to be settling in breastfeeding. She started to use the word 'feeling' rather than 'thinking' to describe child caring, which I identified her attitude towards child caring started to show positive feeling.

From six to eight months

Mrs H returned to her parents' home during the summer and the following interview was undertaken at six months. She described her breast milk was starting to diminish:

My baby is still constipated. She only gives... rabbit's droppings... In the morning, I breastfeed and then give some weaning food at 9:30am. Basically I breastfeed every two hours, and give fruit juice and mashed banana between

breastfeeding…I give 120ml [formula milk] at 4pm, and then 130-150ml at 10pm. She sleeps through the night without breastfeeding. Is it enough for her? Coming to September, I feel my breasts become softer. Is it because the hot weather? When I returned to my parents' home, my mother looked after my baby. So I did not breastfeed as often as I did in my home. It was not so good for my breasts maybe… (September: 6months)

In the seventh month, Mrs H's baby started crawling and her life started to gain a good rhythm:

I have started to give babies' yogurts. Do I need to use this special baby's one? She is constipated, although I give her yogurts… I breastfeed six times, from 6:30am, 9am and then 3-4 times until her bedtime. She eats fish, meat, vegetables and rice gruel. She turns over and very active… The other day I did hand express breast milk, because I just wanted to know how much breast milk I had. It was 20ml. When I breastfed her, I noticed her throat made sounds to swollen breast milk and I am sure she has enough. I think [my breasts] worked really well around two months, because... when I did not breastfeed for more than three hours, my breasts became hard like melons. But now, a whole night without breastfeeding, my breasts show nothing. I looked at the Internet about 'Oketani breast massage'… Should I go there?…[I explained about Oketani massage]… I feel... when her tongue touches my nipples, my body responds to it. I feel like that… It seems like magic. I think the nature could make my body work in a very mystic way… (October: 7 months)

She came to describe her bodily sensations in breastfeeding, and also talked about her reflection about her child. She seems to develop her bodily reflections through breastfeeding, which was not found in the previous interviews. She could reflect more about child care, which would be a key to understand her attitude to handle baby's weight problem that happened in the following month.

The problem of baby's weight: 'she is not well-fed'

At the 9-10 month's baby clinic, the paediatrician mentioned her baby's poor weight gain, which showed in the lowest part of 90% percentile, and gave her the following instructions:

- Increase the amount of formula milk up to 800ml for a day, since formula milk is the only food to cover the amount of calorie required for this age of baby.
- Do not increase weaning food, which would not help to increase baby's weight.
- The baby's constipation happened due to the poor formula feeding, so she could take more formula milk, it would be no problem.

Following the instruction, Mrs H introduced two additional bottles. However, her baby concentrated less on breastfeeding, and the total amount of formula milk did not change. She described her feeling as follows:

I was so confused... How could she jump from 270ml up to 800ml formula milk? It seems impossible. Anyway I tried two more bottles, but she became less concentrated on breastfeeding, because formula milk goes into her mouth without proper suckling. She is too clever and still constipated. I wonder what I should do.... She [her baby] is 'GEN-KI' [full of energy] and her 'KI-GEN' [emotional status] is fine... From just a few days using additional formula milk, her face became round, but no change in her weight. It seems unhealthy.... I am always wondering whether I should or should not add formula milk. When I used 80ml after the evening meal, she only takes 80ml before sleeping. There is no difference in the total amount. I talked with other breastfeeding mother and she was also told to add more formula milk by the doctor. She likes it because she does not need to get up at night.... I feel like walking in a never ending journey. I am always wondering about feeding, her constipation, and now about nursery [from April]... From tomorrow I will go

back to my parents' home. So maybe I would just follow my idea, breastfeeding more and not to use much formula milk... (9 months)

As a working mother, she started to prepare the application to the nursery in November. She was busty to visit several different public nurseries, talked with the nursery nurses, and felt alright to apply for one of them. However, at the same time, she was worried about breastfeeding, because her baby fell asleep whilst breastfeeding.

Whilst she returned to her parents' home, she got very bad flu, took strong antibiotics, and had to stop breastfeeding for two days. Her breasts became very sore without breastfeeding, which she had to hand express. From the reflection of this experience, the ten months' interview was spent talking about her feeling towards breastfeeding:

... It was the worst experience in my lifetime. Of course my child was always crying and my mother had to cuddle her all the time. I was determined I will never get any illness. When I expressed my breasts, I had massive breast milk... I really wanted to breastfeed. It is a kind of sensation... I felt something inside me told like that. I don't know what it is... When I returned to breastfeed, I felt very calm and my baby became very calm ... I was so glad (10 months)

After being instructed, she was still confused about feeding. She continued to use formula milk three times and increased weaning from two to three times a day. When she went back to her parents' home, her baby started crying at night.

My mother said it was normal to have the problem of 'YO-NAKI' [baby's night crying]. When she cried at night, I just breastfed. Once she was latched on, she became quiet. Seeing I breastfed her six times, my mother said my breast milk had no nutrition and better to stop it. My feeling is like... 'Why should I

stop now?' I just wanted to continue it... My mother said nothing more. I know I changed myself a lot. I feel very strange to see formula milk fed babies; how can they grow by formula milk? Especially they did not have real skin-to-skin contact. How can formula milk feeding mothers cope with 'YO-NAKI'? ... My friend had flu and her baby was formula milk fed. So, I feel breast babies are stronger. Because... when I had flu, my baby did not. I believe breastfeeding helps make my baby healthier ... (10 months)

At 10 months, she returned to the paediatrician and her baby showed sufficient weight gain. She believed this happened due to the weaning food, but she did not tell this to the doctor. The doctor also advised to use follow-up milk, but she decided not to use it. She also attended the weaning cooking seminar at the public health centre, which she really enjoyed. When her menstruation returned, her mother told her it was time to stop breastfeeding. However, she decided to continue breastfeeding. She felt she was enjoying child caring:

Her fifth tooth has come through and I feel her getting heavier. I feel I can enjoy more to play with her... Her face has become round and she looks more like a girl... When she comes across someone who is new to her, she just stands still like...she is thinking who the person is... (11 months)

The story of returning to work

Whilst she was on maternity leave, her friends from her work visited her:

... Talking to my friend, I just feel like... I do not want to return to work. It seems so hard... taking my child to nursery, cooking dinner, bathing my child, and then doing other housework... I feel a bit blue about how hard it is going to be... (4 months)

In a few weeks time, I will get the result of my application. I feel a bit blue. I

don't want to go back to work. But nobody in my family takes it seriously. My husband does not say anything. At the end, he said 'But you cannot stop working. You like it'. He is right. I just feel... After going back to work, I could not have time with my baby... talking and playing or maybe no time for 'SKIN-SHIP'.... (10 months)

Her baby had a place at the public nursery. In the first week of April, she returned to work, whilst her mother stayed two weeks to help her.

I was very tired. I forgot everything about my work... I am taking one hour child caring time, so I could leave one hour earlier from work... I get up at 6:30am, leave home at 8am, and am at work at 9am. I am back home at 5:30pm and breastfeed, until she is settled. I breastfeed her two or three times at night. I fall asleep whilst breastfeeding, so we are comfortable with it. In nursery, she eats a lot...The nursery nurses said she was perfectly alright there. But coming back home together, she wants me. Our time is very limited, but I am happy to go to work now... My breasts are alright. I do not need to express them at work. I wonder... when she will stop taking breasts. I really do not mind, but... some children seem to stay on breasts until 18 months...My mother has not said anything about breastfeeding now... I am just wondering... (12 months)

The final interview was undertaken at 13 months. Breastfeeding developed into a part of her new life, which she and her baby were happy with:

I just feel so tired after one month. My girl is always unwell like... running nose. Last week, she was very ill. I could not take a day off from work, instead my husband looked after her, but it was awful. My husband changed the nappies twice. He fed only half of the food. When I came back, she was hungry. It was the first time my husband looked after her by himself, but it was too bad... I registered at the special private nursery which looks after the sick children, but since then she is well and I did not use there... The nursery

checked her weight every month, and she did not gain any weight in the last two months. The nursery nurse said to use follow-up milk. But she does not like any powder milk and she did not take it... Yes, I still breastfeed... once we have returned home, before going to sleep and then during the night 2-3 times or maybe more. After recovering from her sickness, her 'KIGEN' [emotional condition] was worse. I think... breastfeeding is the best medicine for her... I want to think... my baby is healthy because she has been breastfed. Before going to nursery, she did not get diarrhoea or infections. So, I want to believe she is very healthy, because of my breastfeeding. I might be biased ... When babies start to cry at night, the bottle-feeding mothers have to get up from the bed and walk around until babies are settled... I am lucky because I latch her on my breasts. That's all... Without breastfeeding, I could not manage my work and child caring, maybe...

10-4-3. The key themes and my reflection from Mrs H

Mrs H's time and space in child caring

Mrs H's narrative gave a different time and space in child caring from the one's described by the previous cases, those which are based on the views of being housewives.

Firstly, Mrs H did not have time to attend antenatal classes either in hospital or in the community. My concern was not only about the time, but how the physical condition might or might not influence the remainder of her child care including breastfeeding. Especially she mentioned about her feeling of not well at three months after birth. Secondly, she was doing child care within the time frame of maternity leave. She viewed her time for child care was limited, until she returned to work in the next April. The idea of returning to work was always in her thought, which seemed to influence her to be able not totally relaxed. Thirdly, she made a value of breast milk and breastfeeding in the final interview. Especially after she returned to work and her baby joined in the

nursery, it came to very important for the whole family.

Concerning her space in child caring, she spent a lot of time at her own parents' home. She described this as the first real time to spend her time with her own parents since she started to work in Tokyo. She perceived childbirth and maternity leave as a good chance to spend her own time as she wanted, which I found a different perception of 'own time' from the ones told by housewives in the previous interviews.

In her story, her husband was not described as a person who could help with the child caring, which was not perceived as a problem. It seems very natural for them to deal with each individual life as own. In her story, her mother took the key role to support her child caring. Mrs H described two aspects about her mother. Firstly, as she was brought up seeing her mother was working outside the home, she could not think she herself became a housewife. Secondly, she asked her mother about child caring a lot. Her mother and herself had a different view of breastfeeding. However, it did not lead to a conflict over breastfeeding, from which I found that the meaning of support should be understood within the individual context.

Her feeling of uncertainty and the message of 'her and her baby is in tune'

As I summarised, Mrs H's story is about a shift from 'to learn' and 'to know', her narrative clarified her shift in the self-reflection about her own body and her baby. I was concerned that the hospital practice was not helpful for mothers to breastfeed at all. Moreover, her narrative illuminated the impact of hospital practice on the rest of her breastfeeding practice. The hospital practice gave a negative impact on the women's perception of their own body. Mrs H described her condition of 'not having enough breast milk' as 'SHI-KATA-GA-NAI', which she accepted as the natural consequence of her body was not capable enough to breastfeed. However, as the community midwife

and I discovered at the first postnatal visit, her breast condition was not bad as Mrs H perceived. However, she seems very uncertain about our advice. Unless I interviewed her, I was not able to understand the cause of her uncertainty. Even we perceived she was uncertain, Mrs H described our postnatal visit made her to rethink about breastfeeding. As the interviews went, she changed her direction of reflecting herself; from relying on measurements or the theoretical information to trusting her intuitive feeling.

I will study Mrs H's narrative from the perspective of 'skin-to-skin contacts'. I developed Tables 5 and 6 to compare the bodily contacts between Mrs M and Mrs H and their babies, which showed they experienced a comparable amount of frequency in breastfeeding. However, Mrs H's narrative informed that she required seven months to feel breastfeeding through her bodily sense. The following attempts to explain their differences:

Table 5 - The pattern of mixed-feeding by Mrs H

	At 1 month	2 months	3 months	4 months	5 months	6 months
The frequency of breast feeding/day	5 times	5-6 times	7-8 times	6 times	5 times	5-6 times
The usage of bottle feeding	80ml x 5	60ml x 5-6	Refused	140ml x 1 100ml x2	150m lx 1	120ml x2
Weaning food	N/A	N/A	Fruit juice (F.J.) Vegetable soup (V.S.)	F.J. 40ml x 1 V.S. 40 ml x 1	F.J. x 2 V.S. x 2	Rice gruel x 2

	7 months	8 months	9 months	10 months	11 months	12 months
Breast feeding	6 times	5-6 times	More than 3	More than 3	More than 3	5-6 times/day
Bottle feeding	120m lx 1 150ml x 1	120ml x 1 150m lx 1	Refused	Cow's milk 50ml		
Weaning food	2 times		3 times/day			

Table 6 - The patterns of exclusive breastfeeding by Mrs M

	1 month	2 months	3 months	4 months	5 months	6 months
Breast feeding/ day	10 times (maximum 14 times)	5-6 times	10 times	6-7 times	5-7 times	6-7 times
Weaning food	N/A	N/A	F.J.	Rice Gruel	1 time	2 times/day

	7 months	8 months	9 months	10 months	11 months	12 months
Breast feeding	6-7 times	6-7 times	5-6 times	4-5 times	3-4 times	3-4 times/day
Weaning food	2 times		3 times/day			

In Mrs M's case, she just allowed her baby to latch onto her breasts until her baby finished suckling. In my point, breastfeeding was observed as 'one complete action'; when the baby left the breast, she was contented. On the other hand, when Mrs H was breastfeeding, she constantly touched her breasts and also checked the clock. I could see her mind was racing with the idea; how much she could latch her onto the breasts and how much formula milk she needed to add. I perceived that she was not immersing herself in breastfeeding. In Mrs H's narrative, the experience of her baby refusing bottles was described as a negative incident. However, I perceived it was the time when she got into breastfeeding without considering bottles, which might be a turning point her came 'to know' about breastfeeding. After that time, the message of her baby and Mrs H as being 'in tune' appeared in her narrative.

Mrs H's experience suggested that mixed-feeding could be considered as the category of breastfeeding, in which the woman and her baby have chances to reflect each other through breastfeeding. In this context, the keyword was the women's self-reflection; how they could develop a sense of connections each other through direct bodily attachment whilst breastfeeding. In the next section, I will study the aspect of reflection within the context of the second time mother's experience of mixed-feeding.

10-5. The case of Mrs N

10-5-1. The features of her discourse

Mrs N was a second time mother and working outside the home. I found that her narratives were significant from three aspects. Firstly, as a second time mother, she could describe her experience of child caring in an explicit manner, which first time mothers could not easily do. In addition, as a working mother, she could articulate her experience of child caring taking account of other working mothers' views. As a result, her narrative itself delivered a clear message to me, whereby her thematic narrative was developed with the following four themes:

- The meaning of mixed-feeding.
- The working mother's view of child caring.
- Her eldest son's view of a new baby.
- Her experience of being interviewed.

10-5-2. Mrs N's story

<u>The meaning of mixed-feeding</u>

Mrs N and her husband were 34 years of age, and they lived with their five year old boy in a three bedroom flat nearby the main station. She was an administrator and her husband was a journalist in a public organisation. As was the nature of his job, her husband could not help with the child caring. In addition, for the previous three years, he worked in a local branch. Therefore they lived in different places. Her second boy was born in May in the hospital in which eldest was born. The community midwife visited her 21 days after birth.

I breastfeed seven to eight times and if he does not get enough, I use MILK

[formula milk] once or twice a day. I just breastfeed, when he cries... The third or fourth time when he cries, I add some MILK [formula milk]. Early in the morning, I need to add MILK... just like 40ml. He takes maximum 80ml. For the first boy, I tried to breastfeed only, no MILK [formula milk] for the first three weeks and then started to add some formula milk... (At postnatal visit: 21 days)

As Mrs N described, she used formula milk in a flexible manner. Until she stopped breastfeeding, she continued this approach, which I summarised in table 7:

Table 7 - The pattern of mixed-feeding by Mrs N

	1 month	2 month	3 months	4 months	5 months	6 months
Breastfeeding (BF)	7-8 times/day	2-3 times BF+FM 60-80ml x 2	5-6 times BF+FM 30ml x 2	4-5 times	3 times	3 times/day
Formula milk-feeding (FM)	100-120ml x 4-5	FM only 120-170ml x 4-5	FM only 100-140ml x 2	40-170ml x 4-5	200ml x 5-6	200ml x 5-6 times/day
Weaning food	N/A					

	7 months	8 months	9 months	10 months	11 months	12 months
Breastfeeding	BF+FM 180ml x 3 and then stop	N/A				
Formula milk feeding	220ml x 3	220ml x 3	Follow-up milk 120ml x 2, 200ml x 2			
Weaning food (WF)	1 time	2 times+ FM 160ml	3 times			

I perceived that her mixed-feeding was embedded in her, as the following actions were observed in a spontaneous manner:

- She touched her breasts and latched her baby onto the side she felt was harder, she checked the clock.
- Whilst breastfeeding, she touched her breast. When the breast became softer, she described it as the condition of emptiness.

• She changed the side and then latched him onto the other breast.

She checked the clock, but she was more absorbed in the interaction with her baby, which she described as follows:

I sometimes feel I do not have enough breast milk. At night, I don't need MILK [formula milk]. During the day, when I do housework and get tired, I feel my breasts become soft. I don't mind him suckling as long as he likes. I know breastfeeding is very hard work, but I would like to do it. It is convenient. When he is thirsty, I could simply latch him onto there ...and it is good for 'SKIN-SHIP'... From the experience with eldest, I know breastfeeding [this means mixed-feeding] helps my eldest to be healthy... As a working mother, it is important for me that my children are healthy... (July: 1 month)

Her baby's role in breastfeeding was described as follows:

When I latched him onto my empty breast, he stopped suckling and left the breast. So, he could tell me whether I had enough breast milk or not... Now my baby is happy to take just about 120ml MILK [formula milk]. I tried more, but he stops just at 120ml. When he took more, he made a strange noise like... snoring... Now my breast milk is only 80ml... [She checked the baby's weight before and after breastfeeding]. Last month I had 120ml [breast milk]. I know... it has become less... (2 months)

After having this conversation, she asked me to check her breasts. We found that her breast condition was good enough, which she felt able to breastfeed as much as she could.

Mrs N's flexible manner towards breastfeeding was reflected in her attitude towards weaning:

I am concerned about the season... summer is not a good time for weaning. I

don't want him to have any diarrhoea, so maybe I will start it later, maybe sometime in September... (August: 3 months)

The pattern of mixed-feeing was developed dictating her baby's response:

He took 170ml MILK [formula milk] or 40ml... [Onto her breast] he is trying to squeeze my breast milk like that [showing her hands to hold from both sides] getting the last drops... At the beginning of September, he lost his appetite, maybe it was too hot. Now he sleeps from midnight to 7am. My first boy was fond of MILK [formula milk], did not suckle my breasts, and naturally he stopped to take my breasts at seven months. I think my baby likes breastfeeding and I wish I could do for longer (September: 4 months)

The interview was suspended for two months; she had to return to her parents' home and then Mrs N caught flu and developed further nasal infection. The medical doctor prescribed strong antibiotics and told her to stop breastfeeding. She phoned me to discuss her problem:

The doctor advised to stop breastfeeding. Now my breasts have become hard, and I am wondering it might be mastitis. I did not breastfeed for last 24 hours. I don't like to stop breastfeeding now... I nearly spent two months with this infection and visited several different doctors. I was told to stop breastfeeding. At the pharmacy, the pharmacist phoned the doctor to minimise the dose... My baby eats weaning food, but then got diarrhoea. The paediatrician advised to stop weaning food and to use special formula milk... We are both ill. What should we do? (Extracts from telephone conversation: 6 months)

I checked the name of the antibiotics and gave the information about breastfeeding. She said she would continue breastfeeding. However, her physical condition affected her breasts, which meant she had to give up breastfeeding a few days later our telephone conversation:

Medical doctors had no idea it was not easy to suspend breastfeeding for a while [when they prescribed medications]. They do not know what it means for us [breastfeeding mothers]. As you know, my breasts became sore. I had to get up at night and to express breast milk. I could not rest at all... As a result, three days later, my breast milk stopped. My baby became used to formula milk. I had to give up breastfeeding... I breastfed him for the same time as for the eldest. However, I enjoyed breastfeeding this time... It is partly because... every month you checked my breast and said to me, 'Everything is alright'. I can believe 'I am alright'. I felt more relaxed and my breast milk came more. For the eldest, I checked his weight and expressed my breast in order to know how much breast milk I had. You could not imagine how much I had been nervous for my eldest... (7 months)

Between eight to 11 months, her eldest son caught chicken pox, and then all her family got it. She was busy preparing for returning to work, and she had other infections, whilst we continue to talk about through phones. She told me, having an older child meant the new baby had more opportunities to catch infections and there was no question that working mothers preferred breastfeeding. Her baby was happy, eating well, taking formula milk well, and started to sit by himself.

The final interview was undertaken just before she returned to work. The final time was the first time she described her feeling of mixed-feeding as 'SHI-KATA-GA-NAI':

The first time, I didn't know about breastfeeding. My eldest was not good at suckling my breasts. The hospital midwives said I should breastfeed every three hours. In the hospital, other mothers... like... the second or the third time mothers did really well in their breastfeeding. However, I found breastfeeding was difficult... I went back to my parents' home. My parents told me to eat more, to breastfeed more, but I was exhausted. I felt my breast

condition got worse. This time I decided not to spend my time for making efforts. I know it is 'SHI-KATA-GA-NAI', if I could not have enough breast milk. I know it is how my body works…. This time, I decided not to spend my time for making efforts of breastfeeding. It was too depressing… (12 months)

For me, breastfeeding is not something learnt from other people. If ten women tried breastfeeding, ten different experiences occur… Some mothers will have enough breast milk, but some mothers will have little… It is natural… I need to know about how it works from my own 'KARADA' [it means body and her feeling] …At the beginning, the midwives taught me how to do it… starting from like… 'Hold your baby' like that… I gradually gained a clue how to do it… For my eldest, I did not have enough breast milk. I assumed that he needed more breast milk than my 'KARADA' produced… (12 months)

From the previous experience, the overstretched efforts for breastfeeding impacted negatively on her 'KARADA'. Her story represented breastfeeding as about her physical condition.

Her view to work and child caring

In my follow-up interviews, when I recruited working mothers, I came across Mrs N and Mrs H within two weeks, which I felt just a kind of luck. However, Mrs N described it would not be a co-incident:

I planned to have this baby in May. As you know, April is the only time to get a place at the public nurseries. If I can give birth in May, I could take maternity leave nearly one year. In that time I could have time for breastfeeding and starting weaning. I really don't like the idea of 'control' and 'family planning'. However, working mothers have to plan to have a baby. As we [working mothers] want to enjoy child caring as much as our work. I know that some working mothers had to give up their job, because too much stress caused infertility… (1 month)

From seeing her doing breastfeeding, I perceived that Mrs N was comfortable with breastfeeding, because she perceived it as the way of nearing her favour of 'being in natural rhythm'. Mrs N described mothers who work outside the home as liking breastfeeding and the nursery nurses supported their ideas. However, the following episode revealed the different social expectation of child caring:

The paediatrician has children and uses a nursery, so she knows that the public nursery does not give any medicine. She chose the medicine that I only give twice a day. However, other paediatricians said, 'why couldn't you take time off from work?' They could not understand. It is not so easy to take time off from work due to children being ill. (12 months)

In her view, breastfeeding existed as a social expectation, but she had her own reason to favour breastfeeding:

... [from the previous experience] I know somehow breastfeeding helps my 'KARADA' [it means body and her feeling]... I lost my weight easily and felt my hormones came to be in a good balance. I had decided to breastfeed as much as I could this time. Now I feel very healthy and I am ready to return to work. Without breastfeeding, I could not recover as healthily as I am now... (12 months)

She described the practical side of breastfeeding as in her favour. Mrs N and Mrs H talked about their concern about physical recovery from the pregnancy and childbirth, which I perceived as important for them being able to return to work.

The eldest boy's response to a new baby

In a Japanese child care, the eldest children should be carefully looked after

when family has a new baby. Mrs N was concerned about her eldest child:

If the baby cries at night, my first boy also gets up. When my baby cries and I cannot go to eldest, he sits on the bed and waits for me... My eldest likes his new brother, but he sometimes says like... 'Babies are so nasty'... I had to say... 'Please eat now' or 'Do not be late'.... He cannot really understand how he should do or do not... (1 month)

... Until very recently when he drew a picture of our family, there were only three people, his father, him and me. I am a bit concerned about it and make a note for the nursery nurses. Today the nursery nurse said to me, 'he has drawn a picture of four in the family'. The baby appeared in the picture... I was cuddling him. I am glad that he could see the baby as his family. Now I realised how he has been sensitive since he was born... (3 months)

He goes to music class. When he practises the piano, he positions his brother near to him and says... 'Listen to my music'. It is really funny. The baby says 'Ah' or 'Uh', as he plays. Last week, I took my baby to a play-day at the nursery, which I could not think about the first time (4 months)

Yesterday my eldest boy made a bridge, and then he went to the next room and came back... he was so angry to see his brother destroyed all his crafts. They fought. Maybe... this is the reason... I have no problems with making my baby to sleep. He goes to sleep at 12am and gets up at 7am. I found why mothers said the second child was easier... (7 months)

The eldest son required some adjustment to the new environment. Her narratives illustrated the process of the eldest and the new baby getting in a good rhythm.

Her perception to the interviews

I found that my role during the interviews was defined by the women's perceptions. Mrs N clearly illustrated this point as follows:

At the first birth, I realised the midwives were the people looking after us, not a doctor ... In the postnatal ward, we always chatted about midwives... like... who is good or bad... from my intuition, I know who is good... and I found my intuition was always right. So, of course, for me, it is important... you are a midwife. I feel you are good... My baby was constipated and you massaged around his tummy. When I saw your hands, I just felt you are a good midwife. I held my baby's hands. As you massaged, I felt my baby's hands were getting warmer. I just feel... your hands were performing some magic... (12 months)

This episode led me to think how I was observed by the women. Mrs N asked me to check her breast condition at the end of each interview, but I did not know her request was based on trust of my hands. In the final interview, Mrs N concluded her view of the interviews as follows:

If somebody like a researcher or a student, I would have said 'No'. Because... I would not have any benefits from spending my time. It may also be difficult to understand what my life is like. Maybe if the person has children, it might be alright... It is also a good thing for me you visited every month, because I did not need to explain the things from the beginning. Moreover, I feel that you shared my experience of suffering as well as good things in child caring ('KURAKU-o-TOMONISHITA' in Japanese, 'KU' means 'suffering', 'RAKU' means 'joy', 'o' is a conjunction, 'TOMONISHITA' means 'sharing'). You always asked me 'how are you?' You always looked after me, which is not a normal thin to happen in general, especially at work. We are much more individualistic. If you were not a midwife, maybe I would have not stayed in the interview to the end... (12 months)

Mrs N's final interview was undertaken in the middle of April, whilst her two children were at the nursery. The interview setting had changed. When the baby disappeared from the interview setting, I felt I missed something. In turn, it informed that the interview was undertaken as interactions amongst Mrs N, her baby, and myself. The baby had an active role to stimulate our talk.

Section four: Learning about breastfeeding from a woman's experience of early shift into bottle-feeding

In the final part, I will report on one case, which informs the early shift of mixed-feeding into bottle-feeding. I considered this case as one of the variations of mixed-feeding. However, as a result of detailed study of her context, her experience was different from the other mixed-feeding mothers, which is the reason why I represent this case in a different section.

10-6. The case of Mrs I

10-6-1. The features of her discourse

The final case represents a woman's experience of shifting into bottle-feeding at two months. When I finished the 12 months' interview, she asked me to come to visit for further interviews, which did not happen with the other five women. I decided to respond to her request. As a result, I found she reflected more in those further interviews. In her narrative, many characters were described; her husband, her parents, her brother and his family, her parents'-in-law, her husband's sister and her child, her husband's grandparents, and her fellow-mothers and the nursery nurses in the community. Her narratives were about other people. In the final interview, she concluded her experience of child caring was about the problem of weaning food, which was not the message I had illuminated from the series of interviews. I start with describing the complexity of her feelings towards breastfeeding, comparing the first and the final interviews.

Her experience of breastfeeding

Mrs I, 30 years of age, and her husband, 34 years of age, had a boy in November. Her husband was self employed and she became a housewife since her pregnancy. Her parents live one hour drive from her home, and her brother's family lived nearby her parents' home. Her parents-in-law live 10 minutes walk from her home. Recently, her husband's sister's family, who was a working mother, moved into the city in order to ask her parents' help for child care.

She had a caesarean section, started to breastfeed, and then spent one month at her parents' home and returned to her home 45 days after birth. When she left the hospital, she was advised to combine breastfeeding and formula milk. She visited the hospital for the one month baby's clinic, and her baby had gained 800g in weight. The community midwife visited 47 days after birth. The baby gained his weight at an average 57g/day, and the midwife advised not to increase the amount of formula milk. She breastfed twice a day and added 100-160 ml of formula milk five times a day. When the midwife checked her breast condition, she and I anticipated she would not continue breastfeeding. However, I kept my invitation of interview open and she was very excited about joining in the interview.

The first interview was undertaken two months later because she caught flu three days after the postnatal visit and returned to her parents' home. At the first interview, she had shifted into bottle-feeding. She described that she took antibiotics so the doctor said to her to stop breastfeeding. Her parents were very fond of children and she was brought up in an environment in which many children were playing her home. She was considered to be used to child caring:

The hospital is not strict about breastfeeding and I did not much consider

about antenatal preparations. I was very optimistic. If I had not enough breast milk, I am alright with formula milk... I know breastfeeding is the best and good for skin-to-skin contact... I saw one mother was crying because she did not have enough breast milk. I cannot understand why mothers were so stressed about not having enough breast milk... We have good MILK [powder milk] now...

My mother had enough breast milk and said to me that breastfeeding is best. But when she found I had not enough breast milk, she stopped talking about it. She said if my baby is hungry, use formula milk. So, nobody tells me about breastfeeding...I was a bit nervous until five months [pregnancy], having morning sickness and I ate a lot. I gained 10kg in total, and the hospital doctor said 8kg was the best for my body ... I can ask my mother first, my mother-in-law, and also my brother's wife, so I am alright about child caring... (2 months)

The first interview gave me the following messages:

- She felt alright about formula milk.
- She was confident with child caring.
- Her child caring will be supported by her family members.

However, the final interview informed her feeling of unhappiness about her not being able to breastfeed as follows:

[In hospital], I did not have breast milk. It was a problem with my 'KARADA' [body and her feeling]. It was not my skill of breastfeeding. Maybe, my caesarean section [CS] affected my body. I had to wait three days until my first breastfeeding... I had nobody to talk with about breastfeeding in the hospital. I met one mother, who had a CS, but she had enough breast milk... My CS took place on a Thursday. Over the weekend, the ward had less staff and I had to wait even for painkillers. I was given strong antibiotics and had to

wait for breastfeeding... I don't know... If I would have started earlier, I could have enough breast milk... (17 months)

She added the further comment on seeing other mother's to breastfeed in a public play room (which is facilitated by the community called 'SUKU-SUKU-HIROBA'):

You should come with me. When babies started to cry, they [their mothers] opened their tops and breastfed there. They do not care about others. I was worried if male administrators came into the room. My boy went over there and looked at them. I stopped him to go to them and this made me very embarrassed. I was a bit annoyed with them. You are a midwife, so you can say something to them, can you? (17 months)

This is the first time she talked about something negative about breastfeeding. I realised that she might have a strong desire to breastfeed her baby more than I perceived during the previous interviews. Following this final comment about breastfeeding, I consolidated her message; her feeling of child caring and the relationship with other people.

10-6-2. Mrs I's story

From three to five months

During this period of time two changes occurred in her family environment:

- Two months: Her husband's sister's family moved and lived close to her parents-in-law, so that her sister-in-law was able to be helped for her child caring.
- Five months: The second child was born in her brother's family, and her parents became busy to look after her brother's family.

Table 8 shows Mrs I's feeding pattern:

Table 8 - Feeding pattern of Mrs I: from one to five months

	1 month	2 months	3 months	4 months	5 months
Breastfeeding	1-2times	N/A	N/A	N/A	N/A
Bottle-feeding	160ml x 5-6	120-140ml x 5-6	160ml x 4-5	180-200ml x 5	180-200ml x 5
Weaning food	N/A	N/A	Fruit juice (F.J.) 30ml x 1	F.J. 30ml x 1	N/A

In my view, her baby took enough formula milk. However, her view was different:

Everyone said it was unusual for babies to get up at night after three months. The amount of milk is... still 160ml. He only takes 160ml. When he took 180ml, he vomited. However, he takes less at night 140ml or 120ml or 100ml. I have to wait until he stops. It was very tiring.... (2 months)

At three months, she started to give some fruit juice. Her husband strongly requested her not to use any instant baby food.

Only once I was in tears. When he was crying, I started to cry. As I was crying more, he was crying more. I realised he was crying because I was too anxious. I stopped crying and then he stopped crying. Reading a book, I think I had maternity blues, like somebody who lacked support... (3 months)

At four months, she talked about her problem with sleeping.

The last feed is at 8-9pm, and then he sleeps until around 4-6 am. He is fed at 6am and sleeps until 8-9am. Now he takes 180-200ml milk and also 30ml fruit juice. I have not started vegetable soup, because I am too tired to cook... In the last month... he got a cold and went to a doctor... Yes, I use a dummy, and now he is suckling properly. I don't mind it at all (4 months)

At 3-4 months baby clinic, his weight was 6.5 kg and no problems in his

development:

Some of the mothers seemed very nervous. Of course, those babies with anxious mothers cried a lot... Luckily I met a mother who lives near my house... Before going to the clinic, I tried to think what I should ask. But I and my husband had nothing to ask. In fact, I was told everything was alright... (4 months)

In Japan, May 5th is a national holiday, named 'a children's day' ('KODOMO-NO-HI', 'KODOMO' means 'children', 'HI' means 'day'). 'KODOMO' meant children in general, but this day was particularly important for boys; each family decorates special dolls to pray for boy's healthy growing. Mrs I did not want to have the set of dolls; because her house was not big enough and her husband has his own one from his childhood, which they could inherit to him.

Mrs I had a cold and been unwell since childbirth. Her brother's family had a new baby and stayed at her parents' home. While she was unwell, she and her baby could not return to her parents' home:

I give some rice gruel, but he does not like it. The last bottle-feed is at 9-10pm. I don't need to get up at night for feeding, but now I need to get up more because he gets stuck while he is turning over... while he sleeps at daytime, I also need to sleep otherwise I could not survive... I was unwell for the last few months. My husband said to me to stay at my parents, but I could not be there... My husband went to play golf. We had a bit of a row ... My son has developed his 'JI-GA' ('JI' means 'self', and 'GA' means 'ego state')... My niece is a bit of a problem in mother-in-law's house. She starts to scream and my son mimicked it. Now I don't like to go there... (5 months)

She looked for the place she could visit and spend her time. In the five months' interview, she described her unpleasant experience of breastfeeding as follows:

• While she stayed at her parents' home, her mother cooked rice cakes and asked her to eat as many as she could. Her mother was a strong believer in breastfeeding. Even though she did not have enough breast milk, her mother was against using formula milk as well as a dummy.
• Returning to her home and visiting her mother-in-law, her mother-in-law told her that her baby was too big due to formula milk feeding.

From six to 12 months

The day before the sixth months' interview, her baby vomited, and she took him to a paediatric clinic. The week before Mrs I had a virus and this was her first time to phone her mother and her mother-in-law to ask for help. After they were unwell, her baby stopped eating weaning food, and the paediatrician said to her to stop it for a while. Instead her baby got up at night and asked for formula milk.

Table 9 shows the feeding patterns:

Table 9 - Feeding pattern of Mrs I: from six to 12 months

	6 months	7 months	8 months	9-10 months	11 months	12 months
Bottle-feeding (daytime)	200ml x 5	200ml x 5	160-180ml x 5	200ml x 4	200ml x 1	200ml x 1
Weaning food	F. J. and V.S.	10 spoons of mashed vegetables	Refused	3 times + snack (3pm)	3 times	3 times
Night bottle-feeding	200ml x 1	N/A	200ml x 1	200ml x 2	200ml x 2	200ml x 2

In the interview, she talked about how her sister-in-law (brother's wife) breastfed her baby exclusively, and she slept well at night. I did not take it as she described her contradictory view to breastfeeding. However, as the interview went, Mrs I seems to think; if she was able to breastfeed, she did not need to have a problem of night bottle-feeding. When she did not go out due to her unwell, her baby started 'HITO-MISHIRI'. When they visited her parents'

home, he refused to be cuddled by any family members, which invited an argument about child care with her mother:

I would like to escape from his eating problem. He does not eat any rice. My mother tried. He took 10 spoons of vegetables, but no rice. I give less formula milk, but he can only eat vegetables. It's the same... Last week he got some virus. Every month I see the paediatrician. There is a dietician in the clinic, so I can have some advice from there... (7 months)

In Japan, the week of 15th of August was 'OBON', whereby people returned to their own home and visited graveyards to pray for the peace of ancestor's souls. However, her brother's children caught infections, admitted to hospital, and then returned to her parents' home. Meanwhile her nephew also caught infections. She could not visit either her parents or parents-in-law. She had to stay in local and manage the problem of weaning food by herself. He did eat mashed vegetables, but no rice, breads, and noodles.

I told my husband he did not eat and my husband said it was because I was frustrating. I said, he did not open his mouth and my husband did not believe me... One night, my husband tried to give weaning food. As a result, he closed his mouth tightly as usual... My mother brought instant baby foods. He did not eat because my cooking was too bad. She tried and he did not eat them. Now I can say, that happened because he does not like to eat ... (8 months)

Mrs I had several short trips over the summer, and the following interview was undertaken at 10 months. Her baby suddenly started to eat, three times a day and 'OYATSU' (= at 3pm snacks), but he still got up twice for night bottle-feeding. He moved by 'HAI-HAI' [a metaphor, it means crawling] or 'TSUTAI-ARUKI' [walking whilst holding walls or legs of chairs to support himself]. When she visited her husband's office with him, he fell from the writing desk. Mrs I could not tell this to her mother, because her mother always told about

her carelessness in child caring:

The only thing I don't like is the night feeding. My husband said he gets up at night because he is not fed enough during day... When I went on a short trip, I did not have any problems with his eating. In my hospital, I was told weaning food helps to develop baby's digestive system. My sister-in-law said her hospital was very strict about breastfeeding and not recommended to wean earlier. When she started weaning, her child ate really well. It is a very different story... (10 months)

The interviews from 11 to 14 months were about her baby's night bottle-feeding. Her baby ate three times, but did not take any formula milk after eating. He took a bottle before going to sleep, and got up at 3am and 6am for bottle-feeding.

Do you know... How can I stop him waking up for a night feed? My mother was surprised to see my baby got up at night. He takes 200ml formula milk. During the day, he takes tea from his cup, but no formula milk (11 months)

On the day of her baby's first birthday, her parents and parents-in-law visited her. They brought 1.5kg size of rice cake for the baby, which was tied on his back. It is based on the belief that babies should not walk before the first birthday, which would bring some bad luck for the future.

In the twelve months, her husband became busy and could not help with the night feeding:

... My husband is now too busy and I also need to help his work... He eats his dinner at 6:30-7pm. Can I give something late at night? What should I give him? Is it like mashed sweet potatoes or vegetables? I wonder why he is so hungry? But I think there is no difference whether he eats a lot or less. He just needs formula milk at night... The paediatrician told me best to stop night

feeding, because it will decay his teeth. I am feeling so tired and dizzy... I could not think anything properly. (12 months)

At 14 months, the baby slept through the night and she was relieved from their pressure to get up at night for bottle-feedings.

10-6-3. The themes and my reflections from Mrs I

In her narrative, she and her baby were not well and attended the paediatric clinic regularly. She had advice from the paediatrician and the baby's development was checked. However, in her perception, the objective numbers or the medical advice did not help her to feel alright about her child care. Her narrative also illustrated her expectation towards child caring was different from fellow-mothers, her own parent, and parents-in-law.

The relationship to other people

After the 12 months' interview, Mrs I started to explain more about her family background; she was expected to have a boy, because her husband was the eldest son, her husband's great-grand parents were so glad to hear when she had a boy. She did not fall pregnant after their marriage, which she and her husband felt a pressure to have a child. In addition, her position of being a housewife was not supported by other families, especially her mother-in-law. It was not direct told to her, but she felt she was expected to do perfect child care whilst she was being able to be a housewife. In addition, she was not helped by her mother as she had expected, whilst her brother's family required more help. Her husband supported her and gave practical help such as night feedings. However, at the end, he could not help as he came to be busy at work.

I also perceived a gap between her and her fellow-mothers. From the 3-4 months baby clinic, Mrs I was keen on making friends with fellow mothers.

However, she came to know that it was not easy to become friends just because they were housewives, which was described as follows:

I wonder why other mothers always cuddle their babies. I think babies feel alright as long as they can see their mothers. Now I know mothers are told best to cuddle their babies as much as they could. As a result, children are spoiled... I found that many mothers are looking for advice how to stop breastfeeding. They continue breastfeeding until 12 months or 18 months... (10 months)

I bring a lunch box with us, when we go to a public playing space. When he starts to move while he is eating, I ask him 'would you like to eat more?' I take back his lunch box into my bag. The other mothers said I was too strict. But I do not care. The important thing is he needs to learn... (11 months)

As I identified in the first interview, Mrs I was brought up whilst her parents looked after other children from neighbours. It reflected her view of child caring was closer to her parents' ideas, which makes her feel gap between the fellow-mothers' ideas of child caring.

Does the different bodily experience lead to a different message about child caring?

Mrs I was my first case to study the bottle-feeding women's experience of child caring in detail. Mrs I also kept a child caring diary as Mrs M did, and I asked to borrow it, from which I could study her experience of breastfeeding before my first interview. The following sign indicates the different pattern of her feeding method:

- BF only: breastfeeding only.
- BF+FM : combining breastfeeding and formula milk feeding.
- FM only: formula milk feeding only.

Mrs I returned to her parents' home eight days after birth, and Table 10 shows her feeding pattern the first weeks of postnatal period as follows:

Table 10 - Feeding pattern of Mrs I: from eight to 14 days

	8 days	9 days	10 days	11 days	12 days	13 days	14 days
BF only		2 times	4 times	2 times	1 time	4 times	6 times
BF+FM	BF+ 40ml x 5	BF+40ml x 4	BF+40ml x 3	BF+30-40ml x 2	BF+ 40ml x 1	BF+40ml x 3	BF+80ml x 1
FM only	65ml x 1 80ml x 1	60ml x 1 80ml x 1	60ml x 3	60ml x 3	80ml x 2 60ml x 2	60ml x 3	80ml x 2 60ml x 1

I could not identify any rhythm across the days, but she seemed to try to breastfeed as much as she could. I remembered this happened whilst her mother said for her to breastfeed as much as she could. I picked up further feeding patterns for every week until stopping breastfeeding:

Table 11 - Feeding pattern of Mrs I: from 21 days to 49days

	21days	28 days	35 days	42 days	47 days	48 days	49 days
BF only	2 times	3 times	1 time	0	1 time	1 time	Stop
BF+FM	BF+60ml x 4	BF+60ml x 2	BF+40ml x 3	BF+40,80, 120ml x1	N/A	BF+80m lx 1	N/A
FM	30-40ml x 2	100ml x 3	60ml x 2 80ml x 2 120mlx3	100ml x 1 140ml x 1 160ml x 1	30ml x 1 80ml x 1 100ml x 2 140ml x 2	70ml x 1 90ml x 1 140ml x 2	140ml x 6

Within her interview, I perceived her struggle to make a rhythm between her life and her baby's life. On 37 days after birth, she returned to her own home, which was the time when she had to manage housework and breastfeeding by herself. On the 49 days, she had bad flu and stopped breastfeeding due to taking antibiotics. I felt she was relieved from the pressure of breastfeeding.

I perceived Mrs I's rationale for not being able to breastfeed was due to her poor physical condition. She described the skin-to-skin contact in breastfeeding as not her main concern. However, the following episode led me to think about the practical side of breastfeeding:

I did not realise that my baby was so ill. During the day, he ate and played well. In the evening, I found he was quiet, but I just considered he was tired. When my husband came back and cuddled him just wearing his under shirt, he said our baby's body was boiling. I checked his body temperature and we took him to the emergency clinic. It was nearly midnight. I did not realise his body was so hot... (10 months)

I first considered Mrs I's experience as a pattern of mixed-feeding, in which she experienced breastfeeding for at least one and a half months. However, as a result of following her child caring, her narrative illuminated that her experience of breastfeeding seemed not to give enough time to develop bodily reflections or interactions with her baby. This is not the thing that I had expected to obtain from her experience. I reflected back on the length of engagement in breastfeeding in the previous cases, in which the sense of the mother and her baby in tune started to flow in their lives at about baby's fourth months. It seems important to think about the meaning and the length of time to require for the women to knowing their babies, and also the meaning of support for bottle-feeing mothers.

10-7. Summary and points for further discussion

The six women's narratives illuminate the nature of uncertainty in child caring. Breastfeeding appeared as 'bodily experience' between the mother and her baby, which is experienced through bodily reflections between them.

As I presented each woman's narrative as a case, my holistic approach was demonstrated through bringing my reflections within each context. In my research, when I collected more contexts, the essence of breastfeeding was illuminated more clearly. It could be an important point to reflect on my methodology in the further discussion. In the next chapter, I will discuss the features of breastfeeding in relation to my primary question; what elements or

factors hinders or encourages women to breastfeed?

Table 12 and 13 will show the features of each case, which will assist reading the comparative discussion across cases in the next chapter.

Table 12 - Summary of cases: exploratory interviews

Case	The features of case
Mrs D	First time mother, early shift into bottle-feeding, feeling isolated, anxiety at the lack of 'SKIN-SHIP', the experience of outsider's questioning; 'are you breastfeeding?'
Mrs T	First time mother, breastfeeding, wanted to talk about her child caring, the experience of mastitis,
Mrs S	First time mother, mixed-feeding mother, used medical jargon, did not want to talk about breastfeeding

Table 13 - Summary of cases: follow-up interviews

Case	The features of case
Mrs M	Master case, first time mother, her child named 'YU', breastfeeding, the problem of baby's atopic, her special diet
Mrs K	Start from mixed-feeding due to cracked nipples, moving out, mastitis, 'Oketani massage room', baby's frenotomy, shift into exclusive breastfeeding, strong wish to continue breastfeeding, her mother joining in the interview, 'YO-YUU', 'YUTORI', 'MEGURI-AWASE'
Mrs O	Second time mother, exclusive breastfeeding, breastfeeding as equal as meals, three year old son, the decision of stopping breastfeeding at 10 months, girls are easier
Mrs H	First time mother and working outside home, mixed-feeding, feeling of 'SHI-KATA-GA-NAI', lost in the never ending journey, the experience of baby to refuse bottles, the baby's poor weight gain, developed a positive feeling to breastfeeding, returned to work at 12 months
Mrs N	Second time mother, working outside home, five year old son, embedded knowledge of mixed-feeding, the story of my hand, the eldest son's family picture, planned pregnancy
Mrs I	First time mother, CS delivery, confident with child caring, early shift into bottle-feeding, feeling of not being supported, night bottle-feedings, baby's refuse to eat weaning food, regularly attended paediatric clinic, a public playing space -'SUKU-SUKU-HIROBA'

Part Four: Reflections from the Empirical Work

Chapter 11
Discussion

In this chapter, I will discuss women's experience of breastfeeding bringing my reflections gained whilst I was in the fieldwork, and after returning from the field. The women's narratives illustrated breastfeeding as 'a woman and her baby in tune' and the following themes were clarified as the key elements of breastfeeding:

- Breastfeeding appeared as the women's interaction with their babies, which illuminated the baby's presence in breastfeeding.
- Breastfeeding appeared as a part of women's everyday life; its interactions with other everyday activities such as sleeping, eating, and doing housework.
- The experience of lactation also appeared as a part of women's everyday life; which was influenced by her stress, emotions and other environmental changes.
- It took at least five months until the message of 'a mother and her baby in tune' appeared in women's narratives. Breastfeeding took the central role to get the women, their babies, and their family to live in tune.
- The women considered that breastfeeding helps their everyday life to make easier.

I also identified 'uncertainty' as a common theme in the women's narratives, which described the uncertain nature of breastfeeding and child caring as a whole. The women's feeling of uncertainty was influenced by other people's expectation to child caring.

This chapter is structured in three parts. I will begin my discussion by revisiting the theoretical consideration of understanding women's experience. Secondly, I will explore the meaning of the mother and her baby in tune across the six cases,

which includes the baby's role in breastfeeding, the Japanese concept of 'MI-MAMORU' (protecting by seeing), and my role in the interviews. In the final part, I will introduce the concept of 'embodiment' and 'craft', through which I could challenge a dichotomy of breastfeeding between art and science, and culture or a natural law. I will conclude this chapter with Mrs M's narrative, which narrates her experience of completing breastfeeding.

11-1. Theoretical consideration of understanding women's experience of breastfeeding

Although I considered that doctoral study was a researcher's personal philosophical activity, its own idea has to be evaluated through other scholars' consideration and discussions. When I was developing my final discussion, the critique of the conventional scientific research became more apparent.

The concept of 'uncertainty' has been discussed as a main theme for medical sociologists. Conventional research has aimed to decrease the sense of uncertainty and to increase the sense of 'control' and 'predictability' in human live. Steiner (2002) raised her enquiry about the idea of 'control' in Western research paradigms, in which all forms of research were valued by objectivity, rationality, and aim of generalisability. This could be referred to Heidegger's term of living in 'an epoch of technicity', in which all researchers view their world with the rigour of rationality. In other words, abstractions and reductions were believed to be the best approach to produce knowledge. Even within a qualitative research context, researchers are unconsciously influenced by this notion of rigour, in which the data are analysed through detachment from the context and the researcher's disengagement from their own world. In order to make a departure from the domination, Steiner (2002) suggested that qualitative researchers should make a shift in their 'attitudes' towards the data; firstly attending more closely to examine their own understanding and to reflect themselves before bringing any theoretical filters to look at it. The quality of the interpretation could be provided by the

researcher's openness to reality, and their capacity of helping others to see the richness and complexity of other people's experience, rather than providing answers that shut down people's openness (ibid.). The limited application of the reductionistic approach was argued as due to the shift in the structure of medical practice. The researchers found the high innovation of technology increased the uncertainty in medical practice, rather than decreasing it or informing the best solution (Williams 2005). As a result, the researcher's concern came to focus on the context of the medical practice, thus a research approach was required with a format that could illuminate the context of the practice. The results obtained by this new approach changed the style of communications, so that doctors are expected to share the uncertainty of illness and medical treatment with the client, rather than just to fix their clients in 'a right solution' or 'an definitive answer' (ibid.).

In breastfeeding research, the importance of context is also highlighted. Hoddinott (1998) argued that breastfeeding was assumed as women's embodied knowledge, which was stored in women's action. In her research context, the women's embodied knowledge appeared 'bottle-feeding'. It happened because the women lived in the social environment, in which they came to learn infant feeding through seeing other women's bottle-feeding. As a result, breastfeeding was stored in the theoretical knowledge and bottle-feeding appeared as the embodied knowledge. Scott and Mostyn (2003) reported the women experience of breastfeeding in a small community in Glasgow. The women described breastfeeding as a problematic event, as they could obtain little support for breastfeeding or the support was based on providing theoretical knowledge. The women experienced the difficulty of accessing practical knowledge. The research was undertaken in a community, in which bottle-feeding was found as a cultural norm, and again the embodied knowledge of infant feeding was clarified as bottle-feeding. Those studies could illuminate the interactions between the women's experience of infant feeding and the nature of the field. In other words, the nature of the field directs the women's embodied knowledge of infant feeding.

I perceived the current discussion as a positive shift, through which I could discuss the important role of 'context' in understanding other's experience. It creates the space for researchers to bring different ways of seeing and knowing. The following discussion will explore the key themes in my study; understanding breastfeeding with women's context with my 'ZEN-JIN-TEKI' approach.

11-2. Exploring the meaning of baby and her/his mother in tune

In this section, I will look at the elements of 'baby and her/his mother in tune' by synthesising the six women's context, and clarify the further themes to understand breastfeeding within the women's context.

11-2-1. The women's attitude towards breastfeeding: from 'to learn' into 'to know'

The main theme of 'the woman and her baby in tune' appeared as a result of reading women's narratives as a whole story, in which I read spoken and unspoken part of women's interviews together. In the final interview, I simply asked each woman how she felt about the hospital stay, from which I could re-clarify the meaning of breastfeeding. Mrs M and Mrs H, both were first time mothers, illuminated their initial attitudes and its influence their breastfeeding. Mrs M described the six day's hospital stay as long enough 'to know' about breastfeeding, whilst Mrs H thought it was not long enough 'to learn' about breastfeeding. Her idea of 'to know' informs that Mrs M's narrative was about her experience of 'to know' her child, whilst Mrs H's experience was about 'to learn' about child caring.

I would like to discuss their attitudes in light of 'their reflection'. The meaning of 'to know' was described in the process in that Mrs M became to know about breastfeeding by repeating it. She also described breastfeeding was different

from the other activities that were performed once or twice each day. The process of breastfeeding was based on her bodily senses and also baby's response to her. The hospital environment was described as comfortable for her, as she did not need to check the baby's weight before and after breastfeeding or to go to the feeding room. The usage of formula milk was advised, but not regulated for each feeding. It may have allowed her to decide whether she used it or not according to her baby's condition. I perceived that breastfeeding had already become her part of life from the first encounter with her. I would like to note my awareness that Mrs M told of her difficulty to do other child care following her intuitive sense. However, she illustrated that breastfeeding was different. I assumed that Mrs M's basic attitude towards breastfeeding could be 'to learn' in the beginning as it was the cultural expectation to do for people engaging a new activity. However, Mrs M could shift her attitude from 'to learn' into 'to know'.

I also identified the significance of breastfeeding was the direct engagement with the woman's and her baby's bodily part, and its frequency of performing it. The meaning of engagement is described as the process of exchanging their reflection through the bodily senses. The first key theme was identified; breastfeeding is the process of 'bodily reflection'.

Mrs H's attitude towards breastfeeding started from 'to learn'. I found the hospital environment did not give her a chance to shift her attitudes of 'to learn' into 'to know' about breastfeeding. Moreover the experience gave her the sense of limitation. Mrs H described the postnatal visit was a time when she shifted her idea towards breastfeeding. The follow-up interviews were used as time when Mrs H could reflect her child caring through talking with me. I felt that Mrs H's attitudes towards child caring shifted over time, from 'to learn' into 'to know', from which I perceived the message of Mrs H and her baby in tune appeared in her story. The women required a chance to switch the direction of reflecting self from

'to learn' into 'to know'. She started to reflect herself in relation her breast and her baby.

In my research context, the women's attitude towards breastfeeding of 'to know' is about 'their condition', and their emotions or reasons were all part of it. The condition of 'to know' requires women's time and space, in which she can immerse in breastfeeding; to feel and to reflect what is happening between her and her baby through her bodily parts and bodily senses. In this process, their babies also took the active role that the woman could know about breastfeeding. Medical anthropologists argued the common elements in human experience as 'bodily experience', which started from the universal facts such as that the human body has two hands and one nose (Eriksen and Nielsen 2001). The human walks by two feet, and eats by mouth, which is experienced as universal human behaviour. However, the social manner such as how to walk or how to eat was defined by social and cultural expectations, which people unconsciously learnt through seeing and interacting with others in the community. The meaning of everyday activity was constructed through each individual bodily senses and a part of the human body, which was personal. Its meaning was culturally constructed, which was public (ibid.). Thus some aspect of 'bodily experience' could be considered as universal but the meaning and the manner was considered social and cultural representation, which led ones to difficulty in understanding the complex nature of human experience (ibid.).

The women's narratives illuminated this complex nature of breastfeeding, and illuminated some universal facts of breastfeeding, which is the element; 'bodily interaction and performance', and the fact breastfeeding is undertaken through two people's bodily parts and their bodily senses. The women and their baby developed their pattern of breastfeeding through exchanging 'their bodily reflection'. It also contains the elements of biophysical shift, which takes place accordingly as their babies are growing.

11-2-2. The concept of 'SHI-KATA-GA-NAI'

In my study, the mixed-feeding and bottle-feeding women's experience illustrated their bodily shift of 'not having enough breast milk'. I compared the message of 'the woman and her baby in tune' across the cases, from which mixed-feeding could have the character of breastfeeding; the woman and her baby have a chance to came to know each other through bodily reflections in breastfeeding. However, bottle-feeding women's experience was different from mixed-feeding women's experience. In this section, I will look at the Japanese concept of 'SHI-KATA-GA-NAI', which I will discuss in relation to 'bodily limitation', and in the next section discuss the meaning of isolation in bottle-feeding women's experience.

The Japanese concept of 'SHI-KATA-GA-NAI' is based on the Japanese cosmology to view the human body as a part of nature and breastfeeding as a natural cycle. 'SHI' means 'following', 'KATA' means 'rules or regulations', 'GA' is a conjunction, 'NAI' means 'not possible'. In women's context, the condition of 'not having breast milk' occurs as the consequence; their bodies show not being able to work for breastfeeding. In the women's reproductive health context, breastfeeding is viewed as a part of a reproductive cycle; from pregnancy, childbirth, and child caring. The nature always shows the exceptions. When breastfeeding did not happen, the women accepted it as a part of natural law and described as 'SHI-KATA-GA-NAI', in which they could not control their bodies by their own wish. The concept itself gives a negative connotation, but it is used for people to accept their bodies and adapt themselves to the alternative approach with positive thinking.

Corbin (2003) discussed the concept of 'bodily limitation' in a Western context. In everyday life settings, people knew that each individual body worked differently, which we came to know simply in daily actions such as walking or running or even watching a live sporting event such as the Olympic games. However, in the research context, somehow bodily limitation was dismissed. The research was

focused on the capability rather than the limitation of the human body. The bodily limitation did not meet with the Western social expectation; to live with one's own life with the sense of 'control' or 'success' (ibid.).

The women described that they enjoyed breastfeeding in a hospital feeding room. At the same time, it appeared as the time when the women became to know their bodies are not able to have enough breast milk. The feeling of 'SHI-KATA-GA-NAI' was developed through seeing other mothers' breastfeeding whilst they breastfed in the same room, in which they saw the differences in their breast size, the shape of nipples, and the amount of breast milk that each mother produced each time. The women noticed the difference among babies such as fussy or a lot of crying or always sleeping. In my research context, the experience of seeing other mothers' breastfeeding appeared as a chance for the women to know about its own bodily limitation as well as to learn about other women's bodily limitation to breastfeed.

The Japanese concept of 'SHI-KATA-GA-NAI' made mixed-feeding a more cultural event. Firstly, I considered the women's positive attitude to breastfeed with others in the hospital feeding room as cultural. In my prior-ethnography work, the British woman described her uncomfortable feeling to breastfeed in the feeding room with others due to the lack of private space. Hoddinott (1998) argued the embodied knowledge of breastfeeding could be learnt by seeing other mothers' breastfeeding. However, there is a question about the privacy and people's manner to look at each others' body. As I reviewed in chapter 8, the meaning of the body in the Japanese historical context, the Japanese culture has a tacit manner 'MITE-MINU-FURI' (pretending not to see each other) and it still used as a part of tacit manner with tacit rules. The feeding room was described as a shared space in which all women were engaged in the same task of breastfeeding. They also undertook 'MITE-MINU-FURI' there; women did not gaze at each other's body or breast directly as they made others to feel being observed. It was used for avoiding the feeling of embarrassment about

themselves and others. Breastfeeding in public was described as a different issue, in which breastfeeding would not be seen within the tacit manner of 'MITE-MINU-FURI'. The Japanese society came to be used to Western ideas of women's body; therefore the social perception of women's upper bodies is used for symbol of sexuality, which could be perceived as a recent social product in Japan.

Secondly, the concept of 'SHI-KATA-GA-NAI' implies the reason why Japanese women try to continue breastfeeding, even it is partially. Jitsukawa (1997) discussed the meaning of control of women's bodies in the context of Japanese women's contraception. She argued that the Japanese women showed negative attitudes regarding pills as artificial chemicals, which were also considered to interfere with the natural bodily cycle. Especially menstruation was considered 'TSUKI-no-MICHI' in Japanese ('TSUKI' means 'a moon' and 'MICHI' means 'a path'), in which the menstruation was taking place following the lunar calendar. The regular menstruation was considered as the state of health, therefore people tried not to interrupt this natural rhythm. Lock (1998a) argued menopause was accepted as a natural biophysical shift rather than a medical condition in the Japanese context. The women did not use any medical treatment, which would interfere with the natural biophysical process. The 'control' in a Japanese context means to stay in natural rhythm. In the Japanese explanation, 'try not to block the 'THUSKI-no-MICHI'; a path of blood stream'. The condition of women 'not having enough breast milk' is considered as 'the moon path was blocked' by some reasons. The Japanese local ritual, warming up breast, eating hot soup, and taking Japanese herbal medicine, are all performed to improve the blood stream, hence women are encouraged to continue breastfeeding. When women completely give up breastfeeding, it is considered unhealthy as the blood stream remained being blocked. It will cause the further reproductive health problem.

Lastly, in a Western breastfeeding research context, the women's lack of confidence in their own body was argued as a factor that the women gave up

breastfeeding (Hoddinott 1998). It reflected the Western assumption; the feeling of confidence could enable women to succeed at breastfeeding. It led to the limited space for women to discuss 'bodily limitation' in breastfeeding. As I described, the concept of 'SHI-KATA-GA-NAI' was used to accept the bodily differences in each individual body. They found that breastfeeding could not be controlled by their wish or intention or even by improving their eating or sleeping. Until the women try to it, they are not able to know whether it would happen or not. Having subsequent children, the women came to know their bodies responded differently as each baby performed breastfeeding differently or even their age difference. As a result, youngest children could not be breastfed as it happened for the eldest children. The concept of 'SHI-KATA-GA-NAI' made Japanese breastfeeding as social expectation, which at least the women enable to try before making prior judgement. The result of women having and not having enough breast milk is considered as a part of human life.

As a result of women's experience of mixed-feeding, a further key theme is identified as 'bodily limitation'. Through the actual engagement in breastfeeding, the women developed their bodily reflection, which is also the time when the women would know about 'bodily limitation' in breastfeeding. I consider the Japanese women's favour of mixed-feeding is informed by the Japanese idea of 'control', which keep their lives staying close to the nature or natural cycle. Even though partially, as far as women breastfeed, they could live close to a natural rhythm. Bottle-feeding means the total separation from nature; therefore women lose the sense of 'control' of their own body and their lives. In my study, the breastfeeding and mixed-feeding women's life gained the sense of 'the mother and her baby in tune'. However, the bottle-feeding mother's story was different, which I will discuss further next in relation to women's feeling of isolation.

11-2-3. Feeling of isolation

In my study, the experience of bottle-feeding appeared as a shift from mixed-feeding. The concept of 'SHI-KATA-GA-NAI' was used to describe the situation when she came to give up breastfeeding, and then her experience turned into the feeling of isolation from others. In the follow-up study, I had only one case of bottle-feeding. However, her narrative reminds me Mrs D's experience, which was in my exploratory work. She also shifted into bottle-feeding in the early stage of the postnatal period and experienced the same feeling. The feeling of isolation could be discussed from following two aspects:

- Women's anxiety about the lack of 'SKIN-SHIP'.
- Other people's attitudes to respond to the women, when they came to know the women did not breastfeed.

Firstly, the narrative of bottle-feeding illuminated the lack of 'SKIN-SHIP', which means skin-to-skin contact between the woman and her baby. The Japanese society has this unique concept of 'SKIN-SHIP'. I presumed this was invented from the combination of English words; 'skin-to-skin contact' and 'relationship'. 'SKIN-SHIP' represented a Japanese strong belief that breastfeeding makes children healthier and happier. The bottle-feeding mothers described that they could not feel 'SKIN-SHIP' as they felt from breastfeeding. They identified the lack of 'SKIN-SHIP' as their loss. As a result, the bottle-feeding women's narrative increased the sense of uncertainty as their life was going on. I consider bottle-feeding women's experience as another example to reflect cultural expectation of infant feeding. Murphy (2000), in a U.K. study, argued that the British women have strong belief that they could maintain the skin contacts whilst they bottle-fed. However, they believed that the nutrition and biological factors of breast milk could not be replaced by formula milk. In contrast, the women in my study did not worry about the quality of formula milk, but they believed that 'SKIN-

SHIP' in breastfeeding could not be replaced by extra cuddles or other child caring technique such as baby massage.

Secondly, the women's feeling of isolation appeared as a result of social interactions with other people. The women described not having enough breast milk was 'SHI-KATA-GA-NAI', as they accepted as it as a part of natural consequence. The shift to bottle-feeding was described as her personal matter. However, this personal matter was brought into their social context; when their other families or friends or even strangers asked 'are you breastfeeding?' to the women. The feeling of isolation was also described by Mrs K, who had to suspend breastfeeding due to her cracked nipples. She could not tell her problem to even her close relative. The women perceived other people's high expectation of breastfeeding and social pressure through an unspoken part of communication. In order to avoid the conflicts, the women became less in contact with others, and selected the people who could support, rather than undermining them.

Lastly, looking at the relationship amongst fellow-mothers, the women's narrative illuminated the tension amongst them regardless their feeding methods. There was a tacit rule not to interfere with other mothers' child caring. It implies that the relationship between mothers should be equal. Breastfeeding could be perceived as a difficult area to talk about between them; it was so idiosyncratic for each woman and her baby. This illuminates the problem of support in breastfeeding amongst mothers, which the women have only once or twice experienced as an idiosyncratic event in their lifetime. The tacit rule of 'not talking about breastfeeding' was based on the shared view; breastfeeding could not be done by all women due to the individual bodily difference. However, the women who experienced breastfeeding without problems could not understand and support the bodily limitation of breastfeeding. Even though the women did not interfere with each other, the social expectation of breastfeeding was there in the women's

environment; therefore it creates unspoken pressure for bottle-feeding or even mixed-feeding mothers.

The women's feeling of isolation in bottle-feeding reminded me to reconsider my community practice. In one of the community mothers' meetings, Mrs I came to me to say something, whilst Mrs M came to ask to check her breasts due to the mastitis. Mrs I said to me, 'please, do'. I felt surely Mrs I wanted to talk about something to me. However, I had to move for breast care due to the limited time. I admitted the disadvantage that bottle-feeding mothers experienced in the meetings. When the women came to midwives for breast care, they used their time of breast massage for talking about their other problems to the midwife. The inequality between breastfeeding and bottle-feeding mothers in access to the midwifery care was illuminated. In addition, my research suggests that the bottle-feeding mother required more support, which I will discuss in the next section.

11-2-4. The concept of 'MI-MAMORU'

In my earliest literature review (in chapter 2: women's decision and choice of breastfeeding), I identified that people in the women's immediate environment were the most likely to influence women's uptake of breastfeeding. The importance of social network and family's role of supporting breastfeeding was discussed (McCourt 2006). However, the meaning of support was not explored or studied from the women's point of view. In my research context, the women required a very few selected people, who could take the role of 'MI-MAMORU'. The essence of 'MI-MAMORU' was giving the sense of protection without direct interference towards each other.

In the women's stories, two concepts appeared to inform the meaning of support.

- YO-YUU': 'YO' means 'extra', 'YUU' means 'widening'.
- 'MI-MAMORU': 'MI' means 'seeing', 'MAMORU' means 'protecting'.

Both concepts represent the reciprocal nature of Japanese way of understanding others. 'MI-MAMORU' means the family members give each other space, in which individual time and space is respected by each other. It could be a very Japanese way of considering others, in which the person was not to interfere with others, but they are caring for each other. This could only happen among the people relating each other with the profound sense of trusting. The sense of 'YO-YUU' was created when the person felt to be in the situation where other people set them in the position of 'MI-MAMORU'.

Looking at the Mrs M's context of breastfeeding, the sense of 'MI-MAMORU' is flowing in her story. Mrs M described the experience of breastfeeding as different from something one could do only once or twice a day. She showed her hospital feeding record, from which I came to know she breastfed her baby at least seven times a day, but in a very flexible manner. Coming back to her mother's home, her mother supported her breastfeeding, but her mother seemed not to say anything about her breastfeeding; how often Mrs M breastfed. In addition, her mother got up at night and supported her to sleep whilst her baby was going to be settled. Mrs M's mother helped her daughter to be able to follow her intuitive feeling. Mrs M's husband did not actively say anything about what Mrs M decided. I did not interview her husband, but I could feel his presence and his role of 'MI-MAMORU' in their child caring context. Their support is much about 'being with the woman' and 'sharing each other's feelings'.

Mrs K and her mother described the concept of 'YO-YUU' and 'MI-MAMORU' as a two-way interaction. Her mother took the role of 'MI-MAMAORU', whilst Mrs K felt more 'YO-YUU' in her life. The sense of 'YO-YUU' was perceived as the time when the women could reflect their child caring and recharge their energy. Mrs K's mother described her child care was supported by 'wisdom', which was given by close relatives and community members. In the current situation, this support did not exist, therefore her daughter came to relay on reading books and talk to

with her friends and fellow-mothers, which was described 'information exchange', not 'wisdom'. The wisdom could only emerge when the different generations are involved in the life events.

My further concern was with the impact of 'MI-MAMORU' on women's biophysical function of lactation. In the women's narratives, the lack of sleep and the extra worries about their lives seemed to influence breastfeeding. Their babies were sensitive enough to feel their mother's anxiety of child caring, which made their babies more crying and unsettled. Raphael (1976) argued that when people lived in the extended family, child caring existed under the shared responsibility within various family members. She argued that the women's lactation or let-down reflex took place only when the women were totally relaxed. This informs the current problem of women not having enough breast milk as cultural phenomena; in which the shared responsibility in child caring was removed from the modern family life. It led to the new invention of a paid 'Doula', who could support women's childbirth and breastfeeding (ibid.). In addition, their husbands were put under the pressure of supporting their wives and child caring. In my study, the women illuminated the limitation of support from their husbands; they are also new fathers who did not know about child caring and required support from others, or they were too busy and did not have time to spend for helping child care.

In my study, 'MI-MAMORU' was identified through my experience of sharing their time and space. It appeared as a philosophical action, based on people's sensitivity to other's feelings, the sense of caring, and the feeling of trust to others decision. It is also based on the cultural assumption, in which people viewed human life as full of uncertainty. The meaning of support in breastfeeding is clarified as 'MI-MAMORU'; to help the women to live with the uncertain nature of child caring, and to share the responsibility and the uncertainty of child caring with the women.

11-2-5. My reflection: a baby and the mother in tune

The baby's role in breastfeeding is described in midwifery textbooks; the anatomy and physiology of breastfeeding, baby's suckling mechanism, which stimulates let-down reflex (e.g. Fraser and Cooper 2003). The baby's behavioural scale was applied for women to know the right timing of breastfeeding (Karl 2004). These ideas failed to see a woman and her baby as a whole or as a dynamic shift. I adjusted 'a woman and her baby in tune' into 'a baby and her/his mother in tune', which sounds more appropriate to me to illuminate the women's baby-centred attitude towards child care. I represented women's interviews as their narratives, in which I could illuminate the shift of time and space in their child caring. As a result, two elements appeared:

- Breastfeeding is almost immersed in the women's background, once it becomes as a part of women's everyday life.
- Their babies are key performers in breastfeeding.

These two key elements are explored by the theme of women's space and time:

- The baby's fourth month is a time when the message of the mother and her baby in tune starts to flow in the women's everyday life.

In this section, I will explore the former two elements, and then I will discuss the importance of the baby's fourth month in the following section.

In the women's narratives, the baby's message was illuminated whilst the women talked about their perception of them. My monthly attendance at the interview settings could illuminate the significance of baby's role in breastfeeding. Below I will explore the meaning of 'a woman and her baby in tune' with my reflection from the field.

I saw the women breastfeeding in the interview settings whilst we were talking. The women said to me like; 'my baby will sleep very soon' or 'it will not take long'. The women described their prediction of breastfeeding when they latched on their breasts; it was either a real hunger or needs for a bit of comfort. The women also touched their babies' hands and feet during breastfeeding, and mentioned them getting warm as the sign their babies would fall asleep very soon. The women seemed to know the timing of stopping breastfeeding by feeling the rhythm of baby's suckling as well as baby's body temperature. As a result, the breastfeeding mothers could predict how long the baby was going to sleep and how they could manage other housework. Breastfeeding is often perceived as unpredictable and inconvenient due to the women not knowing the amount of intake of breast milk. However, once the women became able to know their babies through bodily reflections, breastfeeding appeared as more predictable events, in which the women can live their lives with the sense of 'being settled', or even the sense of 'control' or 'predictability'.

The women's narratives also illuminated that their breastfeeding patterns were different each day, and the direction of feeding pattern did not necessarily follow from many to less. The women understood their babies' message of breastfeeding accordingly, and the weather and their stress were considered as a reason why their babies came to ask more for breastfeeding. In their stories, the women did not perceive it as they were demanded by their babies. The baby-centred attitudes towards breastfeeding made their decision making process practical. The women were expected to introduce weaning food following the medical guideline. Once they tried and their babies did not like it, they just stayed waiting until their babies came to be ready to eat them. They followed their babies response rather than medical advice, which was based on their attitude of 'to know' their babies and 'bodily communication' developed through breastfeeding. As I followed-up the babies' growth and development from time-to-time, the babies came to show their favour of breastfeeding in an explicit manner. It helps the women to become more confident to believe in their intuitive feeling.

Their interactions seem to bring the positive cycle they can live together in their lives.

The women could follow their intuitions when they decide to complete breastfeeding. My narratives include Mrs O's experience of completing breastfeeding at the baby's 10 months. In the process, she used baby's reflections as the first place to make their decision (not her own decision), so I could say that their choice was made through very baby-centred manner. Whilst I perceived their breastfeeding was practiced in their being in tune, I just listened to her ideas. I could believe that she could come to know their right timing of completing breastfeeding with negotiating with her baby.

As a result of study of 'a woman and her baby in tune' across cases, the meaning of the bodily experience in breastfeeding is clarified by the following elements:

- 'Bodily performance'.
- 'Bodily reflection'.
- 'Bodily limitation'.
- 'Bodily communication'.

These phrases are all followed by the phrase 'between a woman and her baby'. A holistic picture of breastfeeding was developed as 'two people's bodily experience'.

11-2-6. The baby's fourth month in breastfeeding

In my follow-up study, the baby's fourth month (up to five months after childbirth) appeared as the time when the women could feel their lives started to get in rhythm. When I first identified the baby's fourth month as a key in breastfeeding, I was feeling that this gave a new aspect of understanding breastfeeding. Beforehand, I had my personal assumption; the baby's third month should be the

time when the women came to be settled in their lives and breastfeeding. However, the women's narratives illustrated that the women and their babies, and also their families, required a longer time.

I asked myself why I had missed the importance of baby's fourth month. Firstly, in the maternal care system, babies are followed up in one month, three months, six months, nine months, and 18 months of the baby's age. In this routine schedule, I did not have a chance to see the mothers and their babies in this formal follow-up process. Secondly, thinking about my community practice, the women request the private visit, when they have a problem in breastfeeding. In the women's narratives, the baby's fourth month appeared as the time when the woman and her baby get into a good rhythm in their lives, I am not likely to be asked to visit them in this particular time. Lastly, looking at the nature of maternity services, the baby's fourth month is considered the time for introducing weaning food. In a Western context, the mothers are asked to make an arrangement to sleep their baby in a separate space. Whilst the women have become more comfortable with breastfeeding, the medical professional's attention has already shifted into other issues. It illuminates the gap in women's time and the medical professional's time in breastfeeding.

I clarified the significance of baby's fourth month, as a result of looking at breastfeeding in women and their babies' continuous time. In other words, if I just picked up this time and interviewed the women about breastfeeding, the significance could not have been illuminated. During the first few months, the women breastfed their baby so often, in Mrs M' story it was said to be 14 times a day, and she experienced not having enough sleep due to baby's night crying. I noticed the women's faces were pale during that time, even though they did not tell me they were tired. I identified the women required at least five months to recover from their biophysical shift in pregnancy and childbirth and to adapt to live with their babies. The baby's fourth month was also significant to think about women's space, in which they started to go out with their babies and to meet their

friends or to join in the mothers' community meetings. This change was also related to the women's physical condition and also baby's physical growth, which made the women feel confident enough to go out with their babies.

The baby's fourth month was also illuminated the importance of time for the other family members to be able to adapt with a new life or making balance with each other's life. In my study, a difference towards child caring was found as the first time mothers required more time to settle their lives due to their need to learn about child care. For the second time mother, the child caring was not a new experience, which was found in their embedded part of life. However, they had a different issue to manage, to make a good balance between a new baby and the eldest child. In my study, the significance of baby's fourth month was informed by Mrs N's eldest boy; the episode of drawing a family picture including a new baby, which gave me a trigger to reconsider the meaning of 'time' for the all families to become a new family unit.

Looking at the elements of bodily reflections and communications in breastfeeding, I was concerned that the women did not have those skills from the beginning. It was developing through repeated breastfeeding; maybe the women started from touching baby's body unconsciously, and then gradually it was developed and became their intuitive knowledge. Mrs M's episode, taking her baby due to her intuitive feeling about something being wrong, Mrs I's episode, unable her to realise the baby's high temperature, and Mrs O's episode, knowing her baby by touching whilst breastfeeding, are all about how their intuition gained through the bodily attachment in breastfeeding. All those illuminated the practicality of breastfeeding and its importance for their child caring.

I also perceived that the baby's fourth month was practically important to think about midwifery care in breastfeeding. At the end of each interview, all women asked me to check their breast condition. We talked about the flow and the quality (the colour) of breast milk, their feeling of 'having or not having enough

breast milk', softness or hardness or any sort of feeling about their breasts. Especially the women who had the strong engorgement in the first few weeks after birth said their feeling of softness was the sign of not having enough breast milk. Whilst I checked the condition, I explained the softness of her breasts was not a sign of emptiness. It was a sign of milk flow as the breasts were relieved from the process of engorgement. Coming towards the baby's fourth month, after repeating the breast check two or three times, the women seemed to develop bodily senses to tell me about their breast condition and skills to look after their breasts by themselves. Therefore my role was shifted to just listening to them and reassuring their ideas. I also came to believe the women could decide when to complete breastfeeding using their bodily senses and reflecting the response from their babies.

This is a great lesson for me to identify the meaning of 'continuity of care' in breastfeeding and the role of midwife; if the women see the same midwife every month, they could more easily develop their bodily reflections to know about breastfeeding. The women also come to know when and how they should contact their midwife before the problem becomes a real problem. In fact, I did not perform any 'proper breast massage' ('proper' means to ask the woman to lie down and apply the hot towel for massaging the breasts) during the interview period. Once for Mrs M, I did breast massage as she said she had developed mastitis the previous week, but it was just to check the breast condition. The women's bodily reflections made me less work as a midwife for the women such as helping their breastfeeding by doing 'breast massage'. To perform breast massage under the condition of mastitis is the last thing I want to do, because I can feel their pain through my hands. This is why I had been looking for the way in which the women can develop self-awareness about their own body. My follow-up study gave me a trigger to develop a practical idea of supporting breastfeeding in the community based practice:

• Facilitating a monthly visit until baby's fourth month, initiated by the same midwife.
• The midwife's role is; 'listening to women's feeling, checking their breast condition together with the woman, and making sense from the point of 'shift' in her breast condition, and helping the women's bodily sensors to know their breast condition'.

In order to facilitate this practice, the midwives themselves are required to develop their skills of touching to women's bodies, and their bodily senses to feel and understand what is happening to women's breasts. This point will be discussed again in relation to the concept of 'craft'.

11-3. The meaning of a holistic approach and its impact on women's lives

In the follow-up interviews, the women used me accordingly; I was their friend, neighbour, a PhD student, a researcher, and an interviewer. The women used my knowledge and skill as a midwife, but interestingly they described 'HITO-GARA' ('HITO' means 'a person', 'GARA' means 'character') as more important than my profession. The women's perception informed 'ZEN-JIN-TEKI' as a Japanese common assumption to understand others, which 'HITO-GARA' includes philosophical attitudes to self and others. I tried to look for the English concept so that I could translate the women's feeling towards me. The following section shows the process of my enquiry; which introduces the concept of 'embodiment', and then further discussion will be undertaken to explore the meaning of the key elements of my study.

11-3-1. The evolution of concept of 'embodiment'

I clarified that Japanese people view human and nature, and nature and environment in oneness, and so I could not easily understand the reason why the human body could be a distinct object of study in sociology or medical

anthropology. Lawler (1997) argued that the human body was neglected in nursing, although the body was the subject the nurses were working with. The women's body was studied more than the men's body. It stemmed from the women's pregnancy and childbirth issues, which were made visible in the process of industrialisation and the social concerns about reproduction (Williams and Bendelow 1998). Newman (1997) also argued that very little was known about the men's emotions in the experience of health and illness, which occurred due to the social expectation towards gender roles; emotions were associated more with women.

In sociology, the conventional way of understanding the body was claimed to be a disembodied approach, which was based on body and mind in separation (Shilling 1993). Williams and Bendelow (1998) argued the sociological community started to move to research the human body in an embodied way (as discussed in Turner (1984) and Shilling (1993)). The embodiment could be something filling the gap between body/mind, emotions/reasons, nature/culture, and subjectivity/objectivity. Since the body has become a clear subject of study, it took nearly two decades before the concept of embodiment became salient in the empirical research context. In breastfeeding discussion, the dualistic approach was commonly applied; discussing breastfeeding whether it was natural law or social construction (Maher 1992), and the question between science or art, theory or practice (Britton 2003). The breastfeeding research seemed to require an approach which could break this dualistic paradigm.

The limitation of a dualistic approach was argued as follows:

> *'The number 2; is a very dangerous number: that is why the dialectic is a dangerous process.... Attempts to divide anything into two ought to be regarded with much suspicion...'*
>
> *(Snow 1998 [originally published 1959], p65)*

In a Japanese proverb, 'when three people are gathering, they could create some wisdom'. The number two is also considered a cause of conflict. The concept of embodiment could open the way to depart from the conventional dualistic approach.

In midwifery practice, the women's bodies are the focus of the midwives work. The area of midwifery has the problem of representing the wholeness of the practice; which could understand women's experience of breastfeeding as a part of women's whole life. I assumed that midwifery required an alternative concept, that of embodiment, which could discuss the wholeness of women's experience of pregnancy, childbirth, as well as breastfeeding.

From the result of my focused reading, the theory of embodiment is in the process of evolving. I categorised the following three features; describing it in the literature or the researchers applying it in their research context:

• Sports or arts, especially in dance performance, where the human body is the interface between the performer and the audiences (Wright 1998, Zhang 2005, Lokman 2005, Parser 2005).
• The area of body modification such as tattoo or piercing. The embodiment was the way of expressing self (Stilwell 2005).
• The cyber space in the electronic communications, which discussed how the faceless communication influenced the process of people's information usage. In turn, the embodiment was used for discussing the significance of communicating with others in their bodily presence (Kitchin 1998).

In those contexts, the human body was perceived as 'an agent', the human body itself delivered a certain meaning to others. In the 1980s, the women's body was discussed as a container of self, in which the body could be worked as a mechanical law or a clock (Martin 1987). Whilst the discussion viewed the human body in a passive position, the idea of the body as an agent provided a big shift,

in which the human body could have the subjective voice to express one's own self.

The concept of embodiment was also discussed as the researcher's philosophical position, which was described as follows:

> *'If embodiment is an existential condition in which the body is the subjective source or inter-subjective ground of experience, then studies under the rubric of embodiment are not "about" the body per se. Instead, they are about culture and experience insofar as these can be understood from the stand point of bodily being-in-the world. They require what I would call a cultural phenomenology concerned with synthesizing the immediacy of embodied experience with the multiplicity of cultural meaning in which we are always and inevitably immersed'.*
>
> *(Csordas 1999, p143)*

Csordas (1999) argued that the concept of embodiment did not require any particular type of data such as non-verbal data. Embodiment could be a paradigm of the researcher's mode of 'being-in-the-world'. It was about how the researcher used self-consciousness and self-awareness for understanding others. The embodiment was argued as the departure from the conventional Western philosophical framework, as it could be the way of understanding with the sense of attachment with others or the environment.

Bourdieu (1972) argued human's experience as 'habitus', in which the ordinary bodily actions were unconsciously learnt through seeing other people 'doing' and the meaning of bodily actions were constructed through the interaction with one's own social, cultural and physical environments. Shilling (1993) argued that the bodily performances were universal but the meaning was constructed by cultures. In this argument, the language, which was used for describing 'habitus' or 'bodily performances', was also culturally constructed. Hastrup (1995) argued

that the translation work implied a transformation of the unknown into something known. The representation in anthropological work was argued as a micro-macro transformation, which transferred a personal experience such as personal perception, feeling, ideas and memories into a public explanation of language, symbols, images and performances (Linger 2005). Williams and Bendelow (1998) argued that there was something missing in the process of micro-macro transformation work, which was about people's emotions.

I consolidate the above discussions into three aspects:

- The researcher's philosophical framework of 'being-in-the world'; which would influence the researcher's attitude to the informants.
- The attitude towards the data; which would influence the process of data analysis.
- The presentation of the findings; which would influence the transformation and the translation from my empirical work.

In the following section, I will explore the above three issues in relation to the theme of embodiment in my research context.

11-3-2. The engagement with women's lives: myself as an embodiment of midwife

In my research, the interview setting was experienced as the time women invited me to engage in their lives rather than that I interviewed them. Reading women's series of interviews as a whole, I was invited to engage in the women's uncertainty in child caring. The women used me accordingly, through which I became their friend, or midwife, or a researcher or a neighbour who lived in the same community. The variation in my role meant that I was engaged in the different aspects of their lives. At the final interview, I asked each woman about

the timing of the interview and their feeling of being interviewed, which is summarised as follows:

• One month interval was good, as they experienced enough to talk about and they could remember the things they wanted to talk about.
• The experience of one month interview by the same person was good, because they did not need to describe their life from the beginning or repeatedly.
• The interviewer should be female. The profession was not the women's concern. They wanted somebody who would listen to their experience. Moreover, it depended on 'HITO-GARA' in Japanese.
• The open approach was good, because they did not need to guess what my research was for.

The second time mother's concern was the eldest child, for which the researcher could be a person who could support knowing about the child caring for the eldest child. They supposed that midwives were only working with newborn babies, not with toddlers, which they did not expect to happen. Mrs K said that the interviewer should be a midwife, otherwise she could not tell about her story of breastfeeding. Mrs I mentioned that the interviewer should be a midwife. I perceived she used my midwifery aspects of knowledge and experience to know she was alright.

The final interview was the time to know how I had been observed by the women and their families. As I described, my open approach was consistent with my philosophical idea of being open, through which I could set myself in the value-free mode. If they needed my knowledge or experience as a midwife, however, I was ready to share it with the women and discuss it with them.

The women perceived my open approach as a positive side of having me in their life settings. Mrs N described it in the episode of seeing my hands, which revealed how women were practical in their life settings. The women were

sensitive and sensible enough to choose who was good or who was not for each of them. In the interview settings, the women asked me to check their breast condition. I was very aware of how and when I appeared as a midwife in their context. In my perception, though, I did not change the practical outcomes such as the duration of breastfeeding.

During the fieldwork, I asked my sister to help with my transcription work, and at the end I asked her if I had any impact on women's lives and child caring. My sister was laughing at me and answered; 'Of course, you did'. I brought her comment into the context of human and environment in oneness, in which the women's attitudes or the behaviours appeared as the reflection of the mirror. At each interview, I played or talked with their babies and eldest children. It was the chance for the women to see and to know how they could communicate or interact with their babies. As a result, the women described my presence in their life settings as an embodiment of a midwife. My knowledge, experience, personal belief, and the experience of studying in the U.K. are all perceived 'myself'. The women did not perceive 'midwife' as my profession. They perceived myself as a whole and the profession as a part of myself, but they also perceived my attitude as a midwife. It illuminated 'ZEN-JIN-TEKI' as a cultural way of knowing, and the women's narratives illustrated the practical aspects of 'ZEN-JIN-TEKI' and its relation to the context.

11-3-3. The meaning of women's message in my research context: the Japanese concept of 'MA'

In my study, I described the theme from each woman's narrative as 'women's message', which I obtained through the holistic reading of the series of interviews. In this section, I will discuss its meaning in relation to my research framework of a holistic reading.

Suzuki (1973), a Japanese linguist, argued language was like an iceberg. The spoken part of language was one of seven parts of the iceberg, which flowed above the water. In his argument, six of seven parts of the iceberg, the non-spoken parts of language, could not be seen as they were under the water. He argued the difficulty to develop the shared value from looking at only the spoken part of communication. Silverman (2002) argued the researchers were required to understand the qualitative study materials by looking at the 'textuality', which was not only to look at what was written, but also how to read it. Hendry (1993) argued Japanese communication as a form of 'wrapping', the women's emotions are wrapped by their unspoken part of communication. My role of studying the women's narratives were about; how to read the wrapping part of women's narratives.

The emergent theme of 'a baby and her/his mother in tune' means the meaning of rhythms between two people, which appeared as the combination of actions and silence or pause. I described the understanding of the woman and her baby's rhythms as reading their 'context', which was flowing when I read the women's series of narratives. I will describe the meaning of 'context' in my research approach in relation to the reciprocal understanding of others; which is called 'MA' in Japanese.

Kenmochi (1978) argued 'MA' was one of the Japanese concepts, which was based on multidimensional cycles of time and space. He argued there was no equivalent English word to 'MA', instead he suggested eight possible English interpretations:

- Space.
- Interval.
- A pause.
- A room.
- Time or while.

- Leisure or spare time.
- Luck.
- Timing.

I tried to feel 'MA' from each interview setting, which was there in the women's atmosphere. When I interviewed the women, I felt their emotions from their rhythm in talk. When I read the transcribed text, I read 'MA' between the woman and her baby, the woman and her husband or her family, the woman and other people, and also the woman and myself. The women's narratives are developed whilst I was reading 'MA', which I named 'women's message'. I personally defined 'MA' as about people's breathing, which I found universal across cultural bodily performance such as Tai-Chi or Yoga or ballet or contemporary dancing. In the interviews or in everyday practices, when I am with women whilst they are breastfeeding, I read the women and their babies' rhythm in breathing. I could predict how long the breastfeeding would take place from their rhythm.

The meaning of 'MA' and wrapping was also discussed with the features of Japanese language. Kenmochi (1978) argued that 'MA' was the mode of emotion of 'ZERO', which would bring neither subjectivity nor objectivity. 'MA' could be imagined as nothingness or blank space, in which participants could reflect own thought. The mode of 'ZERO' was used to synthesise each other's emotion, which informed the reciprocal nature of Japanese communication. As I described, Japanese people do not show their emotions in a direct manner. Kenmochi (1978) argued twenty-six percent of Japanese sentences were constructed by the mode of 'ZERO' word and fifty-four per cent imply 'sympathy'. In addition, the five emotions were located into an emotional cycle; hate-anger-happiness-joy-love and back to hate. Hate and love exist next to each other, which means love and hate are not opposite concepts. The core of Japanese communication was sympathy, and the mode of 'ZERO' was used just to describe one's own condition as it is.

I perceived the 'MA' or the mode of 'ZERO' emotions gave me a chance to step back and to reflect during the interview. My role in the interview was as a medium to reveal women's experience and also represent them to the wider audiences. The narrating of the context was the way of representing 'MA' in Japanese communication, and also the way of creating space so the audience could use their own reflections and imaginations in reading them.

The process of identifying women's message was about reading 'MA' in our communications. As a consequence, I came to understand Japanese women's view of 'self'. In the Western anthropological work, time was argued as the element influencing and influenced by the view of life and by human experience (Frankenberg 1992). In my study, the women were very conscious about what had happened in their lives, and they made sense of their experience. However, the women's concern during the interview was to understand 'from now', rather making sense of themselves such as 'being a good mother' or 'success in child care'. The final interview was used for reflecting their experience of interviews, but the women did not describe any particular sense about their child caring. I felt their perception to time was prospective, and their reflection to the past events was used for understanding the current situation and doing their best for future. In the final interviews, the women seemed not to perceive it as the end of our relationship. When I heard the word 'MEGURI-AWASE' in Mrs K's interviews, ('MEGURI' means 'circling', 'AWASE' means 'encounter or come across'), I felt the people's appreciation to live with others exists even though the society itself seems to be influenced by the Western individualistic thought.

11-3-4. Embodiment in breastfeeding: between 'art' and 'science', 'nature' and 'culture'

The narrative representation was chosen, in which I could reflect my idea of embodiment; to represent breastfeeding with women's context under the cultural belief system of viewing human and environment in oneness. It meant that my

holistic picture of breastfeeding was developed by multiple elements brought together; women and her baby's interactions, her and her baby's emotions, and their relationship to their environment.

I was concerned about the narratives as a method, in which the application and the extracting of meaning from the narratives were highly dependent on the researcher's framework; researcher's knowledge and cultural background. Akrich and Pasveer (2004) argued that narratives could be the way of filling the disassociation between body and 'self'. Their argument was based on the idea of body as the manifestation of 'self' and one's identity. Chesney and Davies (2005) suggested the framework of reading narratives as a whole; themes could emerge from the whole reading. The narratives were argued to be culturally constructed. I agree with the idea of culturally constructed part of narratives, in which three people's reflections are brought into the process of narrative construction:

- The informant to tell the story.
- The researchers to listen and to illuminate the informant's message.
- The audience to read the stories and to emerge their own interpretation from them.

In my translation work, I carefully examined the differences between Japanese and English. Considering the cultural assumption of dualistic nature of English language, I started to examine the simple English word like 'a body'. 'KARADA' was given by an English-Japanese dictionary. However, 'KARADA' in Japanese was written in two characters of which one means 'a body' and the other means 'KOKORO' ('inner-self' in English). In the women's context, when the word of 'KARADA' was used, I had to think about how they perceived their bodies and its relation to 'KOKORO'. For the same kind of reasons, I avoid using the phrase of demand-feeding or the term confidence.

Raphael (1976) argued that the term of demand-feeding appeared as the reflection of North American arguments about women's bodies. It was based on the feminist arguments that women's body was considered as a reproductive machine. Breastfeeding was described following the idea of a mechanical job. Dykes (2005) argued that breastfeeding in the hospital postnatal setting took the form of 'a labour', which included the process of demanding, producing, and supplying. The idea of 'a labour' illuminated the oppression of women's bodies within the Western social value system.

In my study, the women were told to breastfeed as much as they could or when the baby cried by the hospital midwives. I had to examine the women's perception and ask myself; whether I could describe it as 'demand-feeding'. For example, Mrs M experienced breastfeeding 14 times a day for the first month, as she just breastfed as her baby asked. I perceived that Mrs M did not have the feeling of 'being demanded by her baby'. I clarified the term 'demand' could be applied to the context when the women were considered as the passive position. In my study, the women's reaction was an active response. The women seemed to consider listening to their baby's voice as an active part of their child caring.

I had to use the sentence of 'the body produces breast milk' in the case of Mrs N. When she talked about her body and breast milk, she used a Japanese term 'TSU-KURU'. The direct translation is 'to make', but I could not make a sentence of 'the body makes breast milk'. In the Japanese context, breast milk was considered as naturally coming out after birth as hot spring was coming out from the earth. Jitsukawa (1997) argued that language had real effects in shaping and regulating social behaviour, which I learnt as its real meaning in the process of narrating women's experience.

The other word I did not use in the translation work was an English term of 'confidence', for which in Japanese the closest word is 'JI-SHIN' ('JI' means 'self', 'SHIN' means 'believing'). In the Western context, 'confidence' seems to be used

as a positive condition. In breastfeeding promotion context, the women's lack of confidence in their own body was discussed as the reason why the women did not choose to breastfeed or quit in the early stage. Therefore the people's support was focused for women to be able to develop the sense of confidence in their body, which was encouraged by telling women; 'you did really well'. I felt a gap in this approach, which Hoddinott (1998) argued that the women required to know more embodied aspects of breastfeeding

In my fieldwork, I heard only twice the women said 'JI-SHIN'. However, I only translated it as she felt a bit of 'JI-SHIN' or described as 'she felt alright'. In the Japanese context, the term 'JI-SHIN' was considered a negative status. When somebody started to get 'JI-SHIN', the person would get into the narrow mind, lose the sensitivity to listen to others, and came to less self-reflective and a poor state of 'KOKORO'. In my study, the people in the women's environment supported the women not to become too confident about their child caring. The people's support seems to be undertaken for women to know and to live with the uncertain nature of child caring. The concept of 'confidence' and 'JI-SHIN' was based on each cultural assumption towards human life, which again illustrates the point; there was no way of understanding natural language independent from social and experiential context (Hastrup 1995).

The women's narratives illuminated the nature of knowledge in breastfeeding, in which theoretical, traditional, common-sense, intuitive knowledge, and women's emotions and reasons are all stored in the women's actual performance. The women's narratives were identified each as the embodiment of breastfeeding. It suggests to me to think the alternative explanation, which I could discuss breastfeeding beyond the dichotomy between art or science, nature or culture, and emotions or reasons. The concept of 'embodiment' can change the direction of breastfeeding discussion, which can view biophysical aspects and socio-cultural aspects as a whole, which I will explore more introducing the concept of 'craft'.

11-3-5. The meaning of 'craft' in breastfeeding and its meaning for midwifery practice

As I described in the previous section, during the first few months, the women's faces were very pale and they could not sleep due to the night breastfeeding. I perceived that breastfeeding was physical work. However, the women did not ever complain they were tired. I did not want to describe breastfeeding as a physically constrained task or demanding work.

I perceived that the notion of 'craft' would possibly fill the gap between the dichotomy of breastfeeding as either 'art' or 'science'. The concept of 'science' is to represent breastfeeding as technical work, in which the practice is oriented by scientific reasoning, skill, and knowledge. On the other hand, the concept of 'art' is more focused on 'the beauty' of the product, whilst breastfeeding was symbolised in terms of the beauty of motherhood. In this discussion, the concept of 'process', the women and their babies engaging with the physical work, was missing. Especially I considered that the element of 'process' became important in discussing breastfeeding in relation to women's time and space. In this section, I will use the term of 'a craft work', rather than just 'craft', through which I could emphasise more the aspect of 'a continuous physical process' in breastfeeding.

Carmel (2003) discussed the sociological concept of 'craft' from several aspects; it was a metaphor rather than an established concept, the comparison between the art, and also the craft in carpentry. He argued medical work was similar to carpentry, which requires the continuous judgement through the hands, it is a complex and sequential process, the early stages of layout and the design influences the later stage of the process, manual skills and dexterity is the core of work, and problems are uniquely developed in each job yet the job have many of the same, basic, common features (Reckman 1970, cited in Carmel 2003).

Carmel (2004) further explored the idea of 'craft' in his ethnographic study in an Intensive Care Unit (ICU). When one patient was dying and the heart rate monitor showed a flat line, the doctor took off all the monitors and checked the patient's pulses by his hand. He described the doctor's hands as 'doing craft work'. In the ICU, in which monitors and technological aids are in the very forefront of operating the medical work, he was very impressed that the crucial part of work, diagnosing a death, relied on clinician's hands, rather than the technology. I perceived breastfeeding is much in this line of work, in which the moment of engaging with the craft work cannot be measured by technological aid or described by words. In the section below, I will explore the idea of 'craft' in relation to three issues; breastfeeding as a bodily experience between a mother and her baby, midwifery practice as a bodily sensory job, and the craft nature of knowledge and its relation to research in midwifery.

Firstly, I consolidate the elements of breastfeeding from the women narratives. The word 'craft' indicates that certain physical skill and knowledge are required to perform breastfeeding. Especially the baby's first four months appeared as the essential phase to establish breastfeeding as a co-operative craft work between a woman and her baby. As the women's narratives demonstrated, the women firstly needed to learn how to do it; from cuddling their baby and latching them onto breast properly. At the same time, the local rituals, personal beliefs and family knowledge were all used in their performance. In this process, babies were key players, giving constant feedback to their mothers. Through repeating breastfeeding from time-to-time together, the woman and her baby developed their unique pattern of breastfeeding. The uniqueness should be a key feature of considering breastfeeding as craft. The knowledge and skill appeared firstly to guide the women and their babies to engage in a craft work, and then these were transformed into an individual form. The transformation work was made through women's and babies' bodily senses. In the women's narratives, the utility of the craft work is 'to engage with breastfeeding', not only to get the benefits of breast milk or breastfeeding or becoming a good mother. Once the women got into

engaging with breastfeeding and breastfeeding became 'a craft work', it was immersed in women's life context and not perceived as something special for them.

I have already discussed breastfeeding as a bodily performance between a mother and her baby, in which two people are involved in the performance. As a result of studying breastfeeding with the concept of 'a craft work', five elements are clarified to describe the nature of breastfeeding:

- Breastfeeding is practiced in a flexible manner; no fixed pattern in each performance.
- Breastfeeding includes the common skills and knowledge that is used to perform it, but the problem is experienced uniquely in each couple of a mother and her baby.
- Breastfeeding is more than a technical matter, in which women's emotions, especially their compassion to their child, became a driving force to overcome the obstacles and physical constraints in their performance.
- Breastfeeding is a series of performance. The former breastfeeding influences the following breastfeeding such as the interval and the length of time required for the next breastfeeding.
- The reflections gained through the bodily senses are considered the most convincing resource that the women have to know about breastfeeding.

Secondly, I discuss the meaning of 'craft' in relation to midwifery practice. In my study, Mrs N's story of my hands illuminated the craft nature of midwifery work. In her story, she said my hands (whilst I massaged her baby's tummy) did some magical work. The effects of my massage was sensed whilst Mrs N was holding her baby's hands. This illuminated that 'bodily senses' are developed as three-way interactions amongst three people. My hands or 'touching' were perceived to be 'a medium' that the woman, her baby, and myself were engaged in a moment of sharing a bodily sensory experience. I perceived that women are sensitive and

sensible enough to know who they feel is and is not a good midwife. The midwife's hands doing a craft work or 'touching' is almost perceived as a representation of midwife's sensitivity to the women and their babies' bodies and emotions, through which the bodily experience is shared and understood with the midwife. The women came to know the midwife first by observing her manner of talking to them, through which they developed a feeling about the midwife's experience, knowledge, and skill. The craft work 'touching' that is performed by midwife's hands provides confidence so as the women could put their trust in the midwife. The feeling of 'trust' is important to make women's bodies, their babies, and the atmosphere relaxed. It increases the level of women's bodily reflections so as the 'craft work' of breastfeeding would be performed in the higher level.

In my practice, I was often asked by women and also other midwives how I could tell if the women have enough breast milk or not, which is the most difficult question to answer. I can only say, 'because my hands feel this'. It could be about the mixture of my hands feeling the softness or heaviness or warmness in women's breasts, but I have no words to describe my understating obtained from 'touching'. I started to learn my skill and knowledge seeing other older midwives doing breast massage; their manner of how to touch women's breasts. The theoretical knowledge, such as physiology of breastfeeding, enhances the development of logic to my care. However, the most crucial part of sensing through my hands was only developed through the actual practice. I recognised there is a potential limitation in being able to articulate my 'bodily sensory' knowledge and skill. However, the women perceived that 'a good midwife' has an ability to deliver some explanation for them, help them to understand about their bodies with regarding to the limitation of each individual body, and to create the best practice using the available resources. In this context, the midwives need to use their sensitivity to feel women's needs and to make a balance between their usage of verbal information and hands-on care. I know that some of the women are not comfortable with their bodies 'being touched' by others. The notion of 'a craft work' allows illuminating the creativity and uniqueness of the process of the

midwifery practice, yet the process of practice is based on the same, common, and basic principles.

Lastly, this unspoken or un-measured or un-objectified nature of midwifery practice is important to clarify the meaning of research and knowledge in midwifery practice. Especially, with the current rise of evidenced-based care, the physical skills and manual aspects of midwifery seems to be overwhelmed by the notion of 'scientific' knowledge. The notion of 'craft' illuminated the limitation of research so as the bodily sensory parts of knowledge are not fully articulated by research approach. Re-defining midwifery practice as 'craft work', I could bring the scientific nature and the artistic nature of midwifery practice together. The concept of a craft work considers all of the knowledge and skills in the equal position. Scientific techniques and knowledge, personal beliefs, skill, reason and emotions, local rituals and cultural knowledge, and spiritual and intuitive knowledge are all stored in midwifery practice.

The concept of 'craft' helps to re-examine the context of midwifery care. In chapter 4, I discussed that the extensive use of technology could influence women's perception towards breastfeeding. However, when the nature of 'craft' in breastfeeding practice appeared in my study, I realised that I had experienced so many episodes that illuminated the 'craft' nature of midwifery practice. However, I was also aware how the technology hinders the midwives from using their hands, so that they lose their sense or ability to do craft work. For example, reflecting back on my own training, when I first learnt how to touch women's abdomen, it was not only about learning the technical procedures but also to know the manner; how to touch the women's body with respect. Whilst the hospital practice did/do not use any pain control for childbirth, I was staying at the mother's bedside and massaging their back. I could sense the progress of birth whilst the women's pain was moving from the lower back to the hip. The progress of birth was perceived through my hands. I also knew that the levels of reflection were different among midwives. However, the monitoring devices made midwives

stay in nurses' stations and their job is more on monitoring the machines than in interacting with women. The meaning of 'a craft work' in midwifery disappeared from the context of caring for women, and I suspect now that midwives need to rely on more theoretical knowledge or objective information provided from technological aids than traditionally.

I had perceived the idea of 'touching other's body' was something cultural, in which Japanese culture is more relaxed than Western cultures. However, the description 'a midwife grabbed the woman's breast, and latched their baby's mouth on it' is found as a common scenario in hospital breastfeeding across cultures, and the midwives actually touch women's breasts, if not with gentleness or respect. The idea of 'craft' includes the sense of philosophical aspects, in which the midwife should assist women's breastfeeding with the understanding of a craft work; the woman and her baby require time and space to engage with the task and the midwives need to support and respect their time and space to know about it.

In the final section, I will explore the meaning of embodiment in breastfeeding in relation to the meaning of support in breastfeeding.

11-3-6. The meaning of support and embodiment

In my study, I observed other midwife's postnatal visits, which made me think about the meaning of support. I observed a new midwife who had just started work as a community midwife. The woman seemed to perceive her as a good midwife, as the midwife was honest about what she knew and did not know. The woman did not perceive the midwife's lack of experience in a new environment as a problem. It returns me to think about the meaning of support and philosophical position, which I addressed to the explanation of 'with women' in the background work. From women's perspective, the women need a person who

could take the role of 'MI-MAMORU' in their lives and share their uncertainty or worries or anxiety of child caring.

Hunter (2001) described the emotional aspects of midwifery work, in which the support in midwifery meant a two-way process; the midwives were also supported by the women whilst they supported the women. In my research, I described that I was observed whilst I observed the women. The women knew how much I could support them through sharing their time and space. As I tried to clarify the embodied knowledge of breastfeeding through women's experience, the women also used my embodied knowledge by questioning me or through having breast care. Certainly the women used my theoretical knowledge and experience as a place where they could reflect themselves. However, the women informed me that the most important part was that I was there with them. It reminds me of the phrase 'less doing was doing more' in midwifery practice (Leap 1985). The current movement of evidence-based care made midwives concerned more about to integrate midwifery knowledge into a format of the scientific rigour of knowledge. In my observation work, I saw some midwives were trying to do more and their reflection was undertaken how much they did for the women. In the process of reflection, the midwife became the centre of the practice, rather than the women,

The philosophical aspect of support was further discussed in the context of health care assistants, and the volunteer counsellors. Graffy and Taylor (2004) reported that the women perceived the volunteer counsellors were better than the other written information. Beake et al (2005) studied more detailed aspects of benefit of the health care assistants to support breastfeeding. The women reported more positively about the health care assistant being able to sit with them, and their attitudes such as friendly, encouraging, non-dogmatic, and non-didactic. The care assistants were selected from the women who met the criteria; having the ability to listen, maturity and life experience, and engaging with the women's

condition rather than teaching. The content of the discussion was about people's philosophical attitudes to listening to others.

Csordas (1999) argued embodiment as the researcher's mode or the attitudes to the world; the condition of the researcher's physically 'being-in-the-world'. In my research context, my position of 'stepping back from what I knew about breastfeeding' was perceived positively by the women. As I described, my attitude to 'listening' was based on the Japanese concept of 'KOKORO', in which I tried to understand women's experience as I experienced it. I tried to feel how the women felt in their condition, which is different from listening to their stories as an object of my study. It was based on attachment and involvement with the women's lives. I found; the more I could listen, the more the women felt supported. I assumed it was based on my openness or honesty to say about the things I do not know. The meaning of embodiment of a midwife means that I was perceived as one of their people who 'MI-MAMORU' their lives, through which their uncertainty of child caring was shared with me.

The meaning of 'being-in-the world' was more about sharing time and space with the woman, which I found the most important thing I could learn from the women. I constantly used my improved skill of 'listening' in my everyday practice, I could engage more quickly with the women's perspective of their lives. My listening helped the women to reflect their emotions in their lives, through which we could discuss the possible ideas that would help their child caring in the future.

11-4. Mrs M's experience of completing breastfeeding

I will conclude my study with Mrs M's story of completing breastfeeding. The information was exchanged via e-mail and telephone conversation, whilst I was in the U.K.. The story illuminated the key elements that were considered in the final discussion; the meaning of the mother and her baby in tune, women's bodily

reflections, the baby's embodied role of breastfeeding, and my presence in her life.

How are you? 'YU' is very well and healthy, had no illness. It has become hot (in July) and 'YU' plays around the waterside in the park. Children, they love water and they play and jump around the waterfall. 'YU' is breastfed, but only once in the morning. During the day and also at night, she is going to sleep while I am sleeping with 'YU'. I took 'YU' for the dental check. I tell them; after dinner I cleaned her teeth and then I breastfed whilst 'YU' was going to sleep. The dental hygienist said it would cause decayed teeth, and I decided to stop night breastfeeding. To my surprise, 'YU' did not cry. 'YU' is going to sleep whilst I was patting her back. She mumbled something to herself and then fell asleep. Maybe... I feel... Is she very close to 'SOTSU-NYUU' (Japanese: 'SOTSU' means 'graduating', 'NYUU' means 'milk')? The other two mothers in the group start to go to driving schools, and I did not see them. Now I meet with a mother who lives in the same apartment block. He (her son) is one month older than 'YU'. I am always amazed how children are different! It is very interesting to see what he is doing. Boys are so different from girls! I think few weeks ago he was on 'DAN-NYUU' (Japanese: 'DAN' means to stop or to refuse, NYUU means milk. The mother decides to stop 'breastfeeding'). Every night I heard his crying, sounds like he asked his mother for breastfeeding. It continued one week. I hope 'YU' will not be like him (By e-mail:19 months)

Next day I phoned and Mrs M talked a bit about her life. She spent one week for decreasing the frequency of breastfeeding from three times to once a day. The morning breastfeeding took 20-30 minutes, and it seemed essential for 'YU'. Still her breasts showed let-down reflex, and Mrs M could see her breast milk flashed out whilst she hand expressed it. Since breastfeeding became once a day, breast milk became thick and yellowish. Mrs M worried if it might be mastitis. Mrs M was on her strict diet and would take 'YU' to the allergy clinic for her blood test in the next month.

'YU' grew up well and talked in two word sentences, and showed a big favour to grandmother. At the dental clinic, Mrs M was advised to stop giving the dummy, which would develop a bad jaw joint. Mrs M hid it from 'YU', but 'YU' remembered the place where her dummy was kept. If 'YU' could not find it, she came to her and asked for it. 'YU' did not like teeth brushing, and escaped from her lap and cried whilst her teeth were brushed. Her mother said, 'is it such an important thing to do at her age?' The news of completing breastfeeding arrived one week later:

At last! My daughter graduated from my breast. Today is the sixth day since 'YU' left my breast. Last Sunday, 'YU' asked for morning breastfeeding, instead of breastfeeding, I made a special banana shake and gave it to her. After drinking it, she did not say 'Pa! Pa!'. Next day, I did the same thing. 'YU' asked me 'Pa! Pa!' but now banana shake replaced to her 'Pa'. She is very happy with it and no breastfeed as if she totally forgot about breastfeeding. She did not cry. The things went very smoothly, which I, my husband and my mother did not expect. We are a bit reluctant. For the first three days, I feel pain inside my breasts, now I don't have any pain. But I still feel some cysts in the breasts, I wonder if it is better to go to breast massage? (By E-mail: 19 months)

Mrs M asked me about breast massage, and I phoned her the next day to talk about it. Talking on the phone, Mrs M sounded ambivalent about completing breastfeeding: it made her happy, but she felt sad that she could not breastfeed 'YU' again. The story of Banana shake was talked about again. Mrs M made a banana shake and gave it with saying to 'YU', 'it is your Pa from today'. And then 'YU' understood 'Pa!' meant banana shake. Next morning 'YU' got up with crying and saying 'Pa!', as Mrs M gave banana shake. 'YU' stopped crying and took it happily. Mrs M's mother was prepared for YU's crying, but it did not happen.

Mrs M explained to me about her breast condition and asked about breast massage, since she read a book advising mothers to go for a breast massage after completing breastfeeding. It was useful for breastfeeding next child, and would prevent breast cancer. She had already hand expressed her breasts once after she finished breastfeeding. Her breasts were soft and sticky breast milk came out, but no signs of mastitis or lumps inside. From the conversation, we decided not to go to the breast massage.

One month later, I had an e-mail, which told me the result of the blood test.

Japan had become autumn. It is windy due to the typhoon. It has become two months since 'YU' did 'SOTSU-NYUU' (graduated from breastfeeding). 'YU' totally forgets about 'BO-NYUU' [breastfeeding]. I went to her allergy blood test and the result was bad. The total indication number became higher, especially eggs. I sometimes gave her eggs, which increased the level of allergy. The doctor said egg was different from other allergy factors, so I should not give any eggs until 'YU' will show no signs of allergy. I plan to have a family trip at the end of this month. It is a long trip and I am a bit nervous. Otherwise, everything is alright. Please take care, and see you soon. (By e-mail: 21 month)

Those e-mails confirm the women's attitude to time and space and my role in her life of child caring. As I assumed, Mrs M could make a good negotiation with her baby to stop breastfeeding. The final message suggested her view of child caring as an on-going process and she developed the strength of getting ready to the next problem and looking forward to the future events.

In the next chapter, I will draw my conclusions from reflecting on the entire process of my doctoral study.

Chapter 12
Further reflections, conclusions and implications

In this study, I tried to develop a holistic picture of breastfeeding. The theme of 'women's time and space' was used to study breastfeeding in a holistic manner, and the women's narratives illuminated the biophysical, social, and cultural elements of breastfeeding and its impact on their breastfeeding practice. The role of 'a practitioner researcher' was examined to refresh my practitioner's eyes that helped me to look differently at breastfeeding practice and midwifery. The significance of my study is that infant feeding was studied with the concept of 'a shift', therefore the empirical work included women's experience of breastfeeding, mixed-feeding, and bottle-feeding together. As a result, the meaning of 'material culture' in infant feeding was illuminated; how 'feeding bottles' changed the women's whole context of child caring and also the meaning of support in child caring. In turn, it illuminated the bodily nature of breastfeeding and the meaning of 'craft' both in breastfeeding and midwifery practice. In this final chapter, I will reflect upon the entire research process, and re-address three key elements; 'a craft work', 'the baby's fourth month', and the Japanese concept of 'MI-MAMORU' (protecting by seeing) to draw the final implications, limitations and conclusion from the study.

The features of my research

As a result of a long journey to investigate breastfeeding, my personal theory, 'breastfeeding as a mother and her baby in one unit', was explored and supported by the women's narratives. The concept of embodiment was introduced to clarify and to discuss the wholeness of breastfeeding, which the key elements; 'bodily performance', 'bodily reflection', 'bodily limitation', 'bodily communication' integrated into the concept of 'a craft work'. The women used theoretical knowledge and their emotions or feeling to practice breastfeeding, which illuminated the meaning of embodied knowledge in breastfeeding. My role

in the research was clarified as 'embodiment' of a midwife, and the women's narratives were 'embodiment' of breastfeeding, which each person and a phenomenon was understood as a whole. The long engagement with the field, in which I was involved and attached with the women's lives, enables my study to illuminate the real essence of breastfeeding. It could be considered as something universal across cultures. The concept of 'embodiment' could expand the space to discuss the embodied knowledge of breastfeeding and to study the other area of midwifery practice in the attachment with woman's individual context.

My study began with my enquiry about the theory-practice gap in breastfeeding practice; why it happens and what it means both for researchers and midwives. In my study, I tried to develop a framework for understanding breastfeeding with my 'ZEN-JIN-TEKI' approach, which I assumed to be able to address some ideas to understand the theory-practice gap in breastfeeding. My research became complicated due to the following three reasons. Firstly, the topic of breastfeeding appeared as not a simple phenomenon to study. Secondly, my research dealt with two languages, as a result of which I spent my time to examine the concept differences that exist across two cultures. Lastly, as the research started to illuminate the fact that breastfeeding was also stored in women's unspoken part of communication. I had to develop a further framework for representing them to the wider audiences. My study had two empirical phases and two reflective phases, in which I was able to explore, reflect, and build-up a concrete framework for studying breastfeeding. I also aimed to make a small contribution to three areas; to add some knowledge about breastfeeding, about midwifery practice, and the area of research. In this chapter, I will readdress my initial enquiry and discuss the implications and conclusions from my study.

Theory-practice gap in breastfeeding practice

At the beginning of the research, I highlighted three assumptions about a theory-practice gap in breastfeeding; theory-practice gap would occur, when knowledge

itself was missing, or it was wrong, or it was used in the wrong context. I added my assumption; the context itself was missing.

Within my research context, the theory-practice gap, the women's perception and the theoretical knowledge about breastfeeding, was caused by the lack of explanations of breastfeeding. My holistic approach developed a picture of breastfeeding as a continuous physical engagement between a woman and her baby. The lack of explanations stemmed from the lack of space in the research framework, in which researchers could discuss breastfeeding as a whole. The traditional research approach of constructing knowledge from abstraction, nomothetic generalisation, and dualistic approach did not suit to illuminate the complex nature of breastfeeding; which is a woman's personal event including her biophysical and emotional aspects as well as her social and cultural background.

The women's narratives can inform the theory-practice gap from the women's perspective. The strong consumerism seems to structure child caring as a market, which is symbolised by the fact that the women were instructed to use follow-up milk by medical professionals. Child caring is mixed between the modern and the traditional ideas, which creates breastfeeding in a Japanese context as complex. Some aspects of tacit manners and rituals exist in the unspoken part of women's communication; which has been called 'soft rules' (Lock 1987). The social expectation was conveyed by the form of 'soft rules'. In my study, the women sensed the social expectation of child caring through feeling other people's attitudes towards them and their babies. The women actively collected updated information and also exchanged their information with other mothers. However, there was a tacit rule; the women should not advise to other women's child caring. The women chose their way of child caring accordingly by examining their own resources. Lock and Kaufert (1987) also argued that the women had to get on with their lives, and had no time to examine their own resources or even to collect information. Therefore the women have limited choice, and just live in their

everyday life following their practical decision; therefore the consumerist concept of choice was just illusion or could be applied for in a very limited number of women, which was influenced by social environment and cultural belief (ibid.). In my study, the women's practicality in child caring was illustrated in one of the interviews; she did not like the feeling of her body occupied by breastfeeding. However, she breastfed as her baby asked, which illuminated the fact breastfeeding could not be understood by just asking her feeling about it. The women's decision or choice does not always follow their emotions.

As I adapted naturalistic inquiry, my research was based on investigating breastfeeding in a natural setting. I considered a natural setting in my study means the society in which breastfeeding, mixed-feeding, and bottle-feeding mothers live together. This idea was based on the strong sense that I gained from my midwifery practice in my community. In my follow-up interviews, attending women's life almost every month, I clarified breastfeeding as a bodily performance, which includes two people's bodily parts and bodily reflections. It is a moment of two people engaged in a process of 'a craft work', in which women's emotions and reasons are all stored in the practice. My study also highlighted that 'a bodily limitation' exists within breastfeeding practice. Understanding breastfeeding in a holistic way, the women considered the positive and negative aspects of breastfeeding as a part of their life. In contrast, the previous breastfeeding research tended not to look at these issues together; breastfeeding was argued from marketing of formula milk or the problem of hospital protocols. The attention was not much given to the aspect of 'bodily experience'. Especially 'bodily limitation' was almost dismissed from the discussion, which I perceived as one of the reasons why a theory-practice gap of breastfeeding is experienced by women.

Although I tried to describe a holistic picture of breastfeeding in my study, I could not illuminate all my concerns about breastfeeding. For example, in my follow-up study, mixed-feeding mothers were both from a background of working outside

the home. I considered that it might be possible that their physical condition such as stress or physical constraints from the work might influence their bodies not to fully work for breastfeeding. However, my study could not address those issues. From my everyday practice, I know some of the working mothers could breastfeed without problems and not all housewives could breastfeed. I need to add more explanations from my tacit knowledge.

I will add some more personal theory about breastfeeding. In my everyday practice, when I just listen to a woman's story of menstruation, pregnancy and childbirth, I can make a guess as to whether the woman is likely or not likely to breastfeed. As I considered breastfeeding as involving women's hormonal shift, the women who had no complications in their biophysical shift are more likely to achieve breastfeeding. I could develop some ideas of whether the women could breastfeed or not. When I saw their breastfeeding with their babies; checking their breast condition and seeing their babies' response, I can make a further guess about breastfeeding. I develop my knowledge through my bodily senses, especially with my hands. I know each midwife uses this type of practical assumption, and a bodily limitation exists as a profound part of midwifery practice.

Lock (1987) argued that the experience of health and illness was constructed by the social and cultural perception to the human body and aging. However, she identified the biophysical symptom itself could be different across cultures, which presumed the bodily limitation was related to ethnicity, diet, seasonal variations, lifestyles so on. I considered breastfeeding was a phenomenon, in which biophysical differences would influence the actual performance. The question is how research could illuminate this tacit part of knowledge, which I experienced as the limitations of researching breastfeeding.

While I was in the field, I was searching for the best available information to inform about 'the timing of completing breastfeeding'. The Japanese official guideline indicates that the women should stop breastfeeding by the time the

baby reaches 18th months, but it was not given with theoretical reasons. When I talked it over with a senior midwife in my community, she told me it was believed that when the child was able to walk properly, it was time to leave breastfeeding. She further described the rationale; proper walking could be seen as a sign that children's digestive system is sufficiently advanced as they could keep an upright position. The child is considered more capable of eating ordinary food, less likely to have the problem of constipation, and more importantly the child is ready to become independent from its own mother. Through my community practice, I shared this idea with the women, and they liked the idea. Especially, this approach is based on the baby's individual growth, so that the women do not need to be restricted in their breastfeeding by 'the rigid time frame'. This knowledge could be called personal knowledge or moreover a local and cultural type of knowledge. It reflects the traditional idea of Japanese child caring, so called 'a heaven for children' and 'very decent to child caring' (reviewed in Chapter 8). The idea has been used by the women and the effectiveness and ineffectiveness of the knowledge was evaluated through their everyday life experiences.

Oakley (2000) argued that medical practitioners tested their knowledge by using them in everyday practice, which was termed 'an informal experiment'. Sometimes they made a mistake in their practice due to the personal belief, local rituals, and local knowledge taking precedence over the theoretical knowledge. She also argued that 'formal research', especially a large scale experimental study or randomised controlled trial, was considered by medical practitioners to provide the best answer for practice. In the current context, it gives the hierarchical order among knowledge (ibid.). Concerning midwifery practice, as I perceived pregnancy, childbirth, and child caring are all about people's normal life, it seems natural for me that practice is based on personal knowledge and local rituals, which gives more 'effectiveness in child caring' than purely theoretical knowledge. As I experienced from my research, 'a research study' is important, whilst I could illuminate the important points which I had missed in my everyday

practice. However, the more I came across personal theory type of knowledge in my fieldwork, I came to know more about the nature of midwifery knowledge and the position and the limitation of 'formal research' in midwifery. A 'narrative approach' is able to explore the nature of bodily sensory knowledge in midwifery practice, but still there are still limitations in how to articulate it.

Positive aspects from my study include the discussion of 'embodiment' as the concept, through which I could create the space to discuss breastfeeding as 'a woman and her baby in one unit'. I clarified the meaning of embodiment in my study as a condition, which includes emotions and reasons, and all the knowledge that is and was stored in the women's social and cultural environment. This is important to think about the other areas of midwifery practice such as pregnancy and childbirth. With the assumption of seeing pregnancy or childbirth as a condition of 'embodiment', midwifery research could create the space to describe women's experience as they were experiencing them. I discussed the concept of embodiment as a researcher's philosophical position, in which the data were read with attachment or involvement. The researcher's reflections are the core in the research activity. The concept of 'objectivity' means that the researcher came to aware its unconscious thought and articulated them into the explicit ideas. I also suggest the possibility that the embodiment could be 'a cultural concept'. Within my research context I used it under my philosophical framework of 'ZEN-JIN-TEKI'; viewing body/mind and human/environment in oneness. In order to illuminate the significance of ways of knowing in midwifery practice, I would like to recommend all midwives to experience some form of research. It helps the midwives to identify the nature of practice, the nature of knowledge, and also the position of research in midwifery practice.

Within the framework of naturalistic inquiry, I took a viewing position of believing multiple realities. Each case was understood as unique, and was considered as having contextual boundaries. In my study, the key elements of breastfeeding were developed looking through a variety of explanations; the picture of

breastfeeding was enriched by those explanations. As a result, the women's narratives illuminated breastfeeding as 'bodily experience', which allows the researcher transferring the common elements that are found across the cases into something 'universal'. I perceived that the limitations of the study also were depended on the nature of the topic, which was the reason why background work and the exploratory work were important in the process of research. Within the ideographic generalisation, I perceived the limitations and implications of the research will be established with the audience's participation. My narratives could be used as the study materials; the audience could use to compare them for reconsidering breastfeeding in their own cultural context.

As a result of sharing time and space with the women and their babies, my study touches on some universal part of breastfeeding. The implications of my study will be consolidated into three aspects:

- The nature and the knowledge of breastfeeding: the elements within the phrase of 'bodily', it could be considered as applicable across cultures.
- The cultural and social elements of breastfeeding: the women's perception, feelings or people's perception to the meaning of support.
- The limitation of research or ways of knowing: the problem of research framework and research design.

Implications of the research

I will begin with discussing the implications of my study by readdressing the nature of the topic of breastfeeding, which I clarified in the exploratory work. It gives the real basis of understanding of breastfeeding.

- Breastfeeding is talked about as a problematic event by women who shifted into the other feeding methods in the early stage of their postnatal period.
- Breastfeeding is not perceived as something special to talk about by women

who are breastfeeding and also after as it becomes a part of their ordinary life.
• Breastfeeding is not allowed to be a subject to talk about whilst women are overwhelmed by the uncertain feeling about child caring. The uncertainty seems to hinder women to be reflective or objective enough to talk about their experiences.

As a result of studying breastfeeding with the concept of 'shift', the theme of 'a mother and her baby in tune' appeared to describe the real essence of breastfeeding. Further three key elements are identified; 'a craft work', 'baby's fourth month', and 'MI-MAMORU'. They will take the interdependent roles to develop a platform to understand the nature of topic in the first place, and then to understand the meaning of support in the context of breastfeeding practice.

• The breastfeeding as 'a craft work':
Breastfeeding is a bodily performance and a biophysical process, which is performed by two people's bodily parts.
The practice is developed uniquely for each mother and her baby, and each time performance is different as it is influenced by the previous performance.
Theoretical skills and knowledge, local rituals and personal belief are all used for developing the craft work.
The women's initial concern about breastfeeding is 'to engage with it', which is only possible to achieve when other people work to protect and to respect women and their baby's time and space in breastfeeding.
• The importance of the baby's fourth month:
The women start breastfeeding 'to learn' how to do it, and their mode of learning is shifted into 'knowing it' through every practice. The shift is undertaken through women and baby's bodily senses; exchanging the bodily reflections with their baby.
Once breastfeeding has reached the level of 'a craft work', the women stop talking about it or even it is immersed into women's background information.

The concept of 'MI-MAMORU' gives the meaning of support in breastfeeding. It requires three elements of support; practical help and also philosophical support:

- The women need a very small number of people to support them.
- The people can help the women doing housework and create the relaxed atmosphere. Therefore the women could have time and space to immerse themselves in breastfeeding. It helps to develop the women and their baby's bodily reflections and bodily communications.
- Breastfeeding should be considered as the time when the women start to be engaged in the uncertain nature of child caring. The people in women's immediate environment need to support the women to be able to live with the uncertainty in child caring and also to share its responsibility with them.
- The people also need to realise the possibility that the women and their babies may have bodily limitations to perform breastfeeding. In this case, the women need more emotional support as well as practical support for child caring.

The critique of hospital task-oriented care stems from the lack of framework to understand breastfeeding with the women's time and space, which enable midwives to view breastfeeding as a long time frame of 'biophysical shift'. In the current modern context, almost all women start to breastfeed their babies in the hospital environment. The theoretical knowledge and practical skills taught by hospital staff could help women to avoid 'sink and swim' type of learning. However, the task-oriented care represented they view breastfeeding as a short term task within the hospital environment. As a result, the women could fail to engage with the future process of breastfeeding, the manual aspects of breastfeeding, and the time required getting to know it. For the policy makers, it is important to develop a support system taking account of the process of breastfeeding and the meaning of time in breastfeeding. Especially further discussion is required on the point of how to support the uncertain nature of child caring regardless of infant-feeding methods. It is also important to develop the network or resources for volunteer counsellors or health care assistants to be

supported whilst they are engaged with the other women's uncertainty in breastfeeding.

I would like to suggest a model of community-based care for breastfeeding here again (from the discussion of 'baby's fourth month in chapter 11) and discuss the further obstacles to implementing it:

• Facilitating a monthly visit until baby's fourth month, initiated by the same midwife.
• The midwife's role is; 'listening to women's feeling, checking their breast condition together with the woman, and making sense of 'biophysical shift' in the breast condition, and helping the women's bodily senses to know their breast condition'.

This model can clearly answer the following points:

• Who implements the care? – The same midwife.
• How, where, and when? – By visiting women at home every month.
• By what? – Simply start to talk about their child caring and breastfeeding, and then 'checking the breast conditions and breastfeeding' together with the women.
• How long? – Until baby's fourth month.

I found the real implementation of this idea is challenging. In the current Japanese maternal care system, the postnatal visits are only offered as a free service twice within 60 days after birth. Further visits are paid by the women and their family directly to the midwives, and this is not possible for all women. In the U.K. context, the postnatal visits are implemented by midwives, generally for 10 days after birth, and are then taken over by health visitors. The current system could not provide continuity of care for postnatal visits over five months after childbirth. I found that the idea of baby's fourth month made a challenge especially for the Western notion of motherhood. Miller (2002) argued that the

current postnatal visits were initiated by medical professional's definition of 'coping' or 'adapting' rather than women's perceptions towards their new lives. As a result, the women could not request further postnatal visits over long period of time. The women also tried not to tell their honest feeling to the medical staff (ibid.). McCourt (2006) argued that the Western societies have the strong expectation for the women to make a swift transition to a new role such within a few weeks after birth. The current postnatal visits reflect this notion of 'swift' recovery and transition, which reflected the implementation of postnatal visits as for the first 10 days by community midwives and until around 40 days by health visitors. The prolonged transition was considered as 'a difficult mother' and the feeling of 'anxious' or 'unhappiness' of child caring was labelled as 'a postnatal depression' (ibid.). In my research, the women's narratives illuminated the meaning of 'support' in postnatal period of time, in which the positive and negative aspects of their experience together should be considered as a normal part of child caring and should be supported by other people. It will invite the further enquiry about the medical professional's assumption of 'normal' in postnatal care and the Western cultural notion of the transition of motherhood. Especially the continuity of care until the baby's fourth month is used for renewing the idea of community midwifery (it was not new, when breastfeeding existed as a part of people's normal lives), which requires the further debate in the structure of the maternity care service.

I also would like to emphasise the key point of midwife's role in breastfeeding is:

- How to reveal or facilitate the women's bodily reflections.
- How to promote the transition of women from learning about breastfeeding into knowing about it.

I considered that 'talking' about their experience of breastfeeding is one of the ways to stimulate women's self-awareness. However, the meaning of 'bodily reflections' is more about the inner sensations. As I described, breastfeeding is 'a

bodily sensory job' and also having worked as a practitioner-researcher in my study, I re-examined the real importance of 'touching' in breastfeeding care. This is a further way for women to be able to develop their bodily senses and bodily reflections in a real practical manner. After the women develop 'bodily communication skills' with their baby, the whole child caring is in tune and less stressful. Therefore the subsequent stages of child caring are less problematic, which makes less work for the medical professionals. I also argued that 'touching' is a philosophical act. In order to implement the hands on care in breastfeeding, the midwives require a genuinely trusting relationship with the women. The women are very intuitive to know who is a good and not a good midwife. The midwives should remember; 'We see the women, but we are also seen by the women'. As I perceived 'touching' is the topic of cultural sensitivity, it is not easy to implement this idea including the issue of how midwives can get those hands on skills (I know some of the midwives do not like to touch women's body), and the feasibility of applying this practice for lactation consultants or volunteer counsellors.

The implications of my holistic approach will be discussed so that other midwives could illuminate their own philosophy for midwifery practice. The holistic approach starts from examining one's own framework:

- The view of time and space.
- The personal belief of human life.
- The view of own environment.
- The personal desire; how to relate or not relate to other people's lives.

Secondly, the researcher could move to identify the nature of its own field:

- To clarify what sort of value systems are used in the field.
- How it influences the people's personal philosophy.
- How it influences the nature of the research topic.

My thesis illustrated the process of a holistic approach; how self-reflection and tacit-knowledge, which are stored in people's actions, could be brought into the research context:

- Personal reality is the starting point.
- Empirical work is used to address further or other realities.
- Self-reflection and tacit-knowledge is used to understand the data.
- The theoretical knowledge is used for reference to stimulate and challenge the self-reflection and to articulate tacit-knowledge in order to establish the communication with others.

Limitations of the research

Below, I will report on the limitation of my study from reflecting my experience of researching a way of researching breastfeeding.

Firstly, I cannot deny the question about the limits of my sample. In the final interview, I asked about their social and economic status, which confirmed that they were coming from the average group of young couples. They were all stable in the social conditions, which I could think was the reason why all the women stayed in the follow-up study. In the invitation letter, it was clearly stated; I would be visiting every month until the baby's first birthday, and the women saw me at the postnatal visit, which the letter have put off women who did not want to spend the time for the research. The women in my follow-up study offered their experience to share with others through my thesis, which I perceived as the result of our relationship developed through sharing their time and space in child caring. The limitation of the research is about the research design and also the researcher's attitude to others.

Secondly, I experienced two research phases; exploratory interviews by a one-

stage type of approach and follow-up interviews. At the stage of writing-up my thesis, I read my exploratory-interviews several times. As my understanding of breastfeeding was explored more in follow-up interviews, I came to understand more about the exploratory interviews. I clarified women's emotions as the key element to understand breastfeeding in the exploratory work. Therefore the findings from the follow-up study re-located the meaning of women's emotions as a part of 'embodiment' and embodied knowledge of breastfeeding. It implies to me the need to know the limitation of the study stems from the research design, the researcher's limited reflection, and the limitation of the research framework for understanding of it.

Lastly, although I could learn a lot from my follow-up interviews, I felt that the same type of study would not be feasible due to the accessibility of the informants in such as the U.K., where the women are more likely to stop breastfeeding within six weeks. It will be also difficult for the researcher to have time for the long engagement with the fieldwork. The sample size of six cases was experienced as my maximum to combine my research activity and practical work in the field. The limitation is given by the nature of the field and the researcher's time.

I would like to emphasise the point; the limitation of the research was examined from a practitioner's point of view. As I considered, the women in my study were not coming from the disadvantage of women such as single mothers or little support from their husband or families. It is important to note that the women in my study experienced the problems of breastfeeding, even though they came from a stable social and economic condition. It is not difficult to imagine those women coming from difficult conditions would experience more problems in child caring, as well as breastfeeding. I will not choose to replicate the same study, which requires the women's time. I will bring back my learning outcomes to the actual practice and look for the alternative approach to address their experience as well as supporting breastfeeding. This will develop a two-way process to

examine the limitation of the study across the research and the practical context.

Making a closure of my study

Whilst I was doing my follow-up interviews, the women often asked me; what I was writing about in my thesis. When I told them that I was writing about the philosophy of midwifery practice, they were all surprised and asked me why I was not writing about my practical knowledge of breastfeeding. In my practice, I broadly applied the knowledge from the traditional Japanese wisdom, tacit and spiritual part of knowledge, and theoretical knowledge, in which I could examine the meaning and its practicality through my everyday practices. I consider that my attitude to knowledge is the reflection of my personal philosophical framework, which I had to write about before writing about my practical knowledge. As a result of my long engagement with the women's lives, the women's narratives informed my philosophical framework, which I did not expect to happen during the time I was in the field.

I personally believe that breastfeeding practice should be as a part of midwifery practice, even though the social system provides some regulations for the midwife's role and the place of work, and the possibility of working with continuity of carer. My concern is about the personal level of framework of understanding and support for it. In my perception, midwifery is one of the few professions, who could understand breastfeeding as a continuous biophysical change and socio-cultural shift through adolescence, pregnancy, and childbirth. In addition, midwives are those very few people who could be with women while they are breastfeeding. The women have somebody to listen to them and to give the practical support as well as to help them to understand it. The idea of sharing the sense of uncertainty with others is not an easy task to do; therefore I perceive my everyday practice, sharing experiences with other midwives, are important for myself to share the women's uncertainty as my uncertainty.

During my PhD study, I came across several people who influenced my thoughts. Last (2001), who is a medical anthropologist and is continuing his fieldwork in an African community, argued the discomfort of seeing other cultures with their native framework. He talked about his experience:

> *'... Nowadays anthropologists try to wear the native's framework as wearing contact lenses, realising its itchiness, irritated, and feel uncomfortable to wear it ...'.*

His metaphor emphasises my discomfort of trying to understand a Western dualistic approach such as body and mind in separation, and still feel I cannot fully understand it. I also apply this metaphor into my midwifery practice. When I tried to understand women's ideas, I often confront the different personal values, which I felt uncomfortable with while I support them. Midwifery practice is about understanding women's experience from women's lenses, which may not be always easy or pleasant to do. Whilst I was working with two different cultures, I was often perceived as flexible to work between the Japanese and Western value systems. It might be because I am always trying to do my best to understand women's experience from the women's point of view. I unconsciously try to wear other people's philosophical lenses, but I also came to know it is not always comfortable to do so.

I would like to bring in my personal feeling of living in two cultures. The living with two different languages was experienced as though I am living in two different characters. Henser (2000) argued that it was commonly found among any bilinguals. Somehow Japanese-English speakers experienced 'blank mind' in the process of translation work from Japanese into English, which was not experienced by English-Japanese speakers. In the process of translation work, the brain dealt with the complex concepts in the native language, which might appear as 'blank moments'. I experienced this blank moment when I talked especially about philosophical differences. The reason why it happened was not

known but it illustrated that interpretation is more than a technical matter, and is highly complex. I feel I could never become a native English speaker, as I always experience this 'blank moment' in my writing.

When I was engaged in my PhD study, I was often told that 'PhD means I should become an expert in research as well as breastfeeding'. However, my feeling was totally opposite; PhD means to come to know my limitation; how little I know about breastfeeding, and how little I could address it within the research context. In turn, each research should be considered as valuable that could expand the midwifery knowledge. I have to make clear the differences between 'a clinical report' and 'a research study'. From my experience of PhD study, I identified that 'a research study' has a theoretical framework, and the process of research includes the conscious discussion about the researchers' viewing position. As I demonstrated in my study, midwifery research could be based on the practical framework, which is based on each individual's view to life, time and space. It will also define the attitude and the usage of knowledge in practice.

As I mentioned, the time spent for my study as well as the timing of writing up my thesis was important, in which the people and society started to seek profound philosophy that people could live with. Lock (1998) argued that since God disappeared from many people's lives, the concept of danger and purity was replaced by the concept of risk. The physical disorder was considered as the result of people's lack of risk management, as the society came to live in terms of probability given by numbers. I did not explore the idea of 'risk' in my research context. However, the women's narratives showed; there is a hope that women would not see breastfeeding solely from the risk calculations of health. Breastfeeding is more about their passion; do their best for children are able to grow up healthier and happier.

I perceive academic discussion is moving and the concept of 'embodiment' is a topic that will become a main concern to understand the people's experience of

health and illness in the next few decades. In midwifery practice, I am hoping that midwifery could make a shift from the dualistic discussions such as art/science, scientific knowledge/spiritual knowledge as using the concept of 'craft'. I consider that scientific knowledge, technology, and obstetric medicine are all part of midwifery practice as well as traditional wisdom, tacit knowledge and spirituality. The concept of 'embodiment' could create the space to bring all those elements together, whereby the meaning of 'embodiment' should be discussed and explored by the midwives, within its own social and cultural context.

After completing my study, I will return to community midwifery work, in which I will be able to see women and their babies and to know more about breastfeeding. My findings 'MI-MAMORU', 'bodily experience', ' bodily reflection', 'bodily limitation', 'bodily communication' are all useful to discuss the nature of breastfeeding practice to women and other disciplines, even though I have not found a Japanese concept, with which I could translate the English word 'bodily' into Japanese. Through further practice in my community, I will be able to reflect and expand my learning outcomes from this study further. It is my personal belief as a midwife:

'Without practice, midwifery could not exist'.

Epilogue

In my study, the women's narratives illuminated breastfeeding and midwifery work as 'a bodily sensory job'. This view necessitated that I reflect on my own practice differently, and then to look at the current social and cultural context of breastfeeding as a whole. From my ethnographic approach of studying breastfeeding in my own culture, I learnt a lot from women and their babies. Especially I came to understand the importance of 'sharing time and space with the women and their babies' both for research study and for midwifery practice. The two-way interaction between the women and the researcher are often dismissed within a research context; whilst I am observing the women's breastfeeding in the field, they are observing me. The women are sensitive and sensible enough to know who they perceive is a good midwife or not. The women's narrative illuminated the importance of midwives' sensitivity to understand women and their babies. The term 'sensitivity' contains three further elements; midwives' self-reflections to understand the bodily nature of women's and their babies' experience of breastfeeding, their integrity to illuminate the significances and the limitations of the women's experience, and their sincerity to transform their experience, skills, and knowledge into a form of 'wisdom'. Midwives' hands to perform 'a craft work' provided the confidence so that the women could put their trust in the midwife. The women's narratives also illuminated breastfeeding as 'a mother and her baby in tune' and 'a craft work', whereby the process, the product and the ultimate goal of breastfeeding are all stored in women's and their babies' actions.

My study was about Japanese women's experience of breastfeeding in the current Japanese context, and the women's narratives were collected only in a Japanese setting. However, my research was undertaken whilst I physically located myself in the U.K. and in Japan. My lived experience of living in two cultures led me to study women's narratives with comparative ideas about cultural differences. As a result of the long engagement with the women, seeing

them almost every month until their babies' first birthday, my study could illuminate the universal elements of breastfeeding. The significance of my study was based on my 'holistic approach'; studying breastfeeding, mixed-feeding, and a bottle-feeding mother's experience together. The physical aspect and the continuous shift in breastfeeding were discussed by introducing the concept of 'a craft work'. It could further illuminate the meaning of 'material culture' in infant feeding; once 'infant bottles' was introduced into women's breastfeeding, it changed the whole context of child caring and the women's uncertainty in child caring. The concept of 'a craft work' also informed the existence of the bodily sensory part of knowledge in midwifery practice, although research has the limitations in conveying the bodily sensory parts of knowledge as a form of theoretical knowledge.

My question is why the bodily sensory job of breastfeeding has been missing from so much of the previous breastfeeding discussion. One of the assumptions could be found in the dichotomy of nature and culture in breastfeeding, in which people become to believe that civilisation was 'doing the things by less manual work'. As a result, the current breastfeeding promotion only teaches the theoretical skills and techniques, but fails to provide knowledge of the physical work in breastfeeding and the time that is required for the women and their baby to come to know 'a craft work'. When breastfeeding was embedded in people's ordinary life, the women came to know the physical aspect of breastfeeding by seeing the other women breastfeeding their babies, which was the meaning of embodied knowledge. My study illuminated the women's strength and practicality of getting on with the physical work in the current Japanese social context. In addition, the women's emotions, especially, the women's passion and compassion to their own child, appeared a driving force for the women to be able to persevere in breastfeeding. In a Japanese context, the meaning of 'control' was defined as living with the natural cycle, which maximises the women and their babies' opportunities to live a healthy life: thus, mixed-feeding was practiced, which the women could have the sense of connection with the natural

cycle. The women perceived that breastfeeding helps more understanding of their babies, which increases the sense of control in their lives. The Japanese idea of 'control' could provide an alternative way of thinking about understanding women's choice of breastfeeding, which is about how to live with the uncertain nature of child caring.

I will summarise the practical idea of breastfeeding as follows;

'If the women could see the same midwife, every month, at least until the baby's fourth month, talking about breastfeeding, and knowing their breast conditions through touching with the midwife, they are more likely to develop their bodily senses to know their babies and to look after their breast condition'.

I know this idea will invite further questions. Firstly, the current maternal care system has limitations around midwives being able to work with continuity of carer. Secondly, it includes the discussion of resources to launch this idea as a part of maternal care services. Lastly, it is the most crucial point; how midwives can gain the experiences to know the physical shift in women's breast condition, and also the skills to 'touching women's breasts' which is about a philosophical question rather than a technical matter.

During the study, I was often involved in pessimistic discussions about breastfeeding among midwives; we could not make any changes about breastfeeding due to the poor hospital policy or the lack of human resources. I will not deny the practitioner's dilemma as I am experiencing the same problem in my practice. I am always thinking that midwifery is a job for assisting the women and their baby to engage with the endless marathon of child caring. A Japanese proverb said;

> 'The new parents are only bringing up their own children as they had been brought up by their own parents'.

This idea illuminated that child caring is embodied in people's everyday life, rather than learning through reading books. Therefore it is really important that each midwife helps each woman and each family's child caring practices to the highest level, and to create a woman's narrative of breastfeeding, including difficulties and enjoyment of child caring together. The narrative would be told among women, and through generation to generation. This could be considered as a very grass-roots movement, but my study showed that breastfeeding was more about individual level of encounter and reflections. I personally believe making a change is starting from an individual level of practice.

At the end of the follow-up interviews, the women came to know how I should write about their experience of child caring more than me. They were also generous about sharing their experience with others through my research. I took the role of 'a medium' to transfer other women's experience to them, thus the women came to know the importance of knowing child caring from other women's experience. Owing to the other explanations of the role of women's narratives, it could give a recipe for the women to bake a cake, from which the women could smell and taste it, and create their own recipe with reflecting their own resources.

Since the Western societies shifted into a bottle-feeding culture, the embodied knowledge of breastfeeding, which is stored in people's ordinary life, was also lost. Still in the current Japanese context, breastfeeding exists as a social and cultural expectation, rather than a question. Therefore women's narratives deliver the embodied knowledge of breastfeeding. With my great gratitude to the women and their babies, I would like to share the women's narratives of breastfeeding with my audience. For the midwives and medical professionals, the narratives help to re-set the starting point to reflect each individual's practice and re-think the meaning of 'being with the women and their babies' in their own cultural context. For the women, it will help to know the real insight and the richness of breastfeeding. For the people who wish to support breastfeeding such as

lactation consultants or the volunteer counsellors, it helps to understand the bodily limitation in breastfeeding and to reconsider the meaning of support. I would like to forward the women's narratives with my strong wish; at least all women and their babies have a chance 'to know' about breastfeeding.

References

Aida, Y. (1972) *Nihonjin-no-Ishiki-Kouzou (Japanese: Japanese way of knowing).* Tokyo: Koudanshya.

Aoki, T. (1999) *Nihonbunkaron-no-Henyou (Japanese: the modern history of Japanese studies).* Tokyo: Chyuukou Bunko.

Akrich, M. and B. Pasveer (2004) Embodiment and disembodiment in childbirth
narratives. *Body and Society,* 10(2-3): p. 63-84.

Asad, T. (1986) The concept of cultural translation in British social anthropology,
In: Clifford, J., Editor, *Writing Culture: The Poetics and Politics of Ethnography.* University of California Press: California. p. 141-164.

Barnes, J. (1997) Extreme attitudes to body shape, social and psychological facts and reluctance to breastfeed. *Journal of the Royal Society of Medicine*, 90: 551-559.

Basier, K. (1997) Baby feeding: the thoughts behind the statistics. *New Zealand*
Medical Journal, 110: 184-187.

Beasley, A. (1991) Breastfeeding studies; culture, biomedicine and methodology. *Journal of Human Lactation,* 1: 2-14.

Beake, S., C. McCourt, C. Rawan, and J. Tayler, (2005) Evaluation of use of health care assistants to support disadvantaged women in the community. *Maternal and Child Nutrition*, 1: 32-43.

Birbili, M. (2002) Translating from one language to another. *Social Research Update* [online]. Guilford: University of Surry. Available from: <www.sco.surry.ac.uk/sru/sru31.html>

Bloch, M. (1989) *From cognition to ideology.* In: M. Bloch, Editor, *Ritual,*

History and Power: selected papers in anthropology. The Athlone Press: London,

Bourdieu, P. (1972) *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.

Bramwell, R. (2001) Blood and milk: construction of female bodily fluids in Western society. *Woman and Health*, 34(4): 85-96.

Britton, C. (2003). Breast feeding: a natural phenomenon or a cultural construct? In: C. Squire editor, *The Social Context of Birth*. Radcriffe Medical Press: Oxford. p. 297-310.

Bryar, R.M., (1995) *Theory for Midwifery Practice*. London: Macmillan.

Bruyson, B. (1991) *Mother Tongue*. London: Penguin Book

Carmel, S. (2003) *High Technology Medicine in Practice: the organisation of work in intensive care*. PhD thesis, London School of Hygiene and Tropical Medicine.

Carmel, S. (2004) Knowledge and practice: the craft of high technology medicine. In: *35th British Medical Sociology Conference held at the University of York*. University of York.

Chesney, M. and S. Davies (2005) Women's birth experiences in Pakistan: the importance of the Dai. *Evidence Based Midwifery,* 3(1): 26-32.

Chia, R. (2003) From knowledge-creation to the perfecting of action: Tao, Basho, and pure experience as the ultimate ground of knowing. *Human Relations,* 56(8): 953-981.

Clark, D. (2004) The field as 'habitus': reflections in inner and outer dialogue, *Anthropology Matters Journal* [online]. 6(2). Available from: <www. anthropologymatters.com>.

Clifford, G., and Marcus E.G. (1986) *Writing Culture: a school of American*

research advanced seminar. London: University of California press.

Clifford, G. (1997) Spatial practices: fieldwork, *travel, and the disciplining of anthropology,* In: G. Clifford, *Routes: Travel and translation in the late 20 century.* Cambridge: Harvard University Press. p. 52-89.

Cohen, A. P. (1994) *Questions of Identity: An alternative anthropology of self consciousness.* London: Routledge.

Corbin, M. J. (2003) The body in health and illness. *Qualitative Health Research*, 13(2): 256-267.

Csordas, J.T. (1999) Embodiment and cultural phenomenology, In: G. Weiss and H.F. Haber, Editors, *Perspectives on Embodiment: the intersections of nature and culture.* London: Routledge. p.143-162.

Davies, C.A.(1999) *Reflexive Ethnography: A guide to researching selves and others*; ASA research methods in social anthropology. London: Routledge.

Dick, M. J., M. Evans, J. Arthurs, J. Barries, R. Coldwell, S. Hutchins, L. Johnson (2002) Predicting early breastfeeding attribution. *Journal of Human Lactation,* 18(1): 21-28.

Dix, D.N. (1991) Why women decide not to breastfeed ? *Birth*, 18(4): 225-226.

Doi, T. (1971) *The Anatomy of Dependence.* London: Koudanshya.

Douglas, M. (1984) *Purity and Danger: an analysis of the concepts of pollution and taboo.* Ark edition ed. 1966. London: Ark Paperbacks.

Dykes, F. (2005) Supply and demand: breastfeeding as a labour. *Social Science and Medicine,* 60(10): 2283-2294.

Earle, S. (2000) Why some women do not breast feed: bottle feeding and father's role. *Midwifery*, 16: 323-330.

Edmondson, R. and C. Kelleher (2000) *Health Promotion: New Discipline or Multi-Discipline?* Dublin: Irish Academy Press.

Ellis, C. and A. Bochner (1999) Bringing emotion and personal narrative into medical science. *Health,* 3(2): 229-237.

Emerson, R.M., R.I. Fretz, and L. L. Shaw (1995) *Writing Ethnographic Fieldnotes*. Chicago and London: The University of Chicago Press.

Ericksen, H. T. and S.F. Nielsen (2001) *A History of Anthropology*. London: Pluto Press.

Frankenberg, R. (1992) *Time, Health and Medicine*. London: Sage

Freed, G. L. (1993) Accuracy of expectant mother's predictions of father's attitudes regarding breastfeeding. *The Journal of Family Practice,* 37(2):148-152.

Fraser and Cooper (2003) *Myles Textbooks for Midwives*, 14th edition. London: Churchill Livingstone.

Fukuda, M. (1996) Rooming-in, breast milk and breastfeeding (Japanese). *Shyuusanki-Igaku,* 26(4): 521-524.

Furo, H. (2001) *Turn-Taking in English and Japanese: projectability in grammar, intonation, and semantics*. New York: Routledge.

Giugliani, J. (1994) Effect of breastfeeding from different sources on mother's decision to breastfeed. *Journal of Human Lactation,* 10: 157-161.

Goksen, F. (2002) Normative vs. attitudinal consideration in breastfeeding behaviour: multifaceted social influences in a developing country context. *Social Science and Medicine*, 54(12): 1743-53.

Graffy, J.P. (1992) Mothers' attitudes to and experience of breastfeeding: a primary case study. *British Journal of General Practice* 42: 61-64.

Graffy, J. J. Tayler, A. Wiliams, and S. Eldridge (2004) Randomised controlled trial support from volunteer counsellors for mothers considering breast feeding. *British Medical Journal,* 328:26-29.

Hachiya, S. (1998) Promoting rooming-in: the case of Kitami red cross hospital (Japanese). *Jyosanpu-Zattushi*, 52(10): 59-63.

Hamylun, B., S. Brookers, K. Oleninikova, S. Wands (2000) *Infant Feeding 2000.* London: Stationary Office.

Hastrup, K. (1995) *A Passage to Anthropology: between experience and theory*. London: Routledge.

Hatakeyama, T. (1983) Promoting breastfeeding (Japanese). In: H. Kato, Editor, *Bonyuu- Hoiku*, Medica Science: Tokyo. p. 170-183.

Hayakawa, K., Y. Wanamaker, K. Kato, M. Onoi (2003) Features of the Japanese health care system and its impact on nursing practice. *Home Health Care Management and Practice*, 15(6): 500-504.

Hendry, J. (1993) *Wrapping Culture: politics, presentation, and power in Japan and other societies*. Oxford: Clarendon Press.

Hendry, J. (1999) *An Introduction to Social Anthropology*. London: Sage.

Hendry, J. (2003) *Understanding Japanese Society,* Third Edition. London: Routledge Curzon.

Henser, S. (2000) *Thinking in Japanese?: what have we learned about language-specific thought such Evin Tripp's 1964 Psychological tests of Japanese-English bilinguals?* Nissan Occasional Papers Series, 32. Oxford: Oxford University.

Hirayama, T. (1983) Epidemiology of breastfeeding (Japanese). In: H. Kato, Editor, *Bonyuu-Hoiku (Japanese)*. Medica Science: Tokyo. p. 130-139.

Hoddinott, P. C. (1998) *Why don't some women want to breast feed and how might we change their attitudes?* Master's thesis, University of Wales: Cardiff.

Hunter, B. (2001) Emotion work in midwifery: a review of current knowledge. *Journal of Advanced Nursing*, 34(4): 436-444.

Ienaga, S. (1982), *Nihon-Bunkashi (Japanese)*. Tokyo: Iwanami Shinshyo.

Iwai, Y. and K. Kawayoshi (2001) Grandmothers' attitudes to breastfeeding and its influence on their daughter's breastfeeding (Japanese). *Jyosanpu-Zattushi,* 55(6): 72-78.

Janesick, V.J. (1998) *Stretching Exercises for Qualitative Researchers*. London: Sage.

Japan Statistical Association (2004) *The report on the maternal status before and after childbirth (Japanese).* Tokyo: The Ministry of Health and Welfare in Japan.

Japan Statistical Association (2005) *Life expectancy in Japan (Japanese).* Tokyo: The Ministry of Health and Welfare in Japan.

Jitsukawa, M. (1997) In accordance with nature: what Japanese women mean by being in control. *Anthropology and Medicine*, 4(2): 177-199.

Jones, D.A. (1987) The choice to breastfeed or bottle-feed and influence upon that choice. *Child: care, health and development*, 13: 75-85.

Karl, D. J. (2004) Using principles of newborn behavioural state organisation to facilitate breastfeeding. *American Journal of Maternal/Child Nursing,* 29(5):292-298.

Kato, H., N. Kobayashi, and T. Hirayama (1983) *Bonyuu-Hoiku (Japanese: breastfeeding)*. Medica Science: Tokyo.

Kato, T. (1988) A report on the current 'Sato-Gaeri' *(Japanese). Perinatal Care,* 9(1): 9-21.

Kearney, M.H. and J. O'Sullivan (2003) Identity shifts as turning points in health behaviour change. *Western Journal of Nursing Research*, 25(2): 134-152.

Kenmochi, T. (1978) *MA-no-Nihon-Bunka (Japanese: the meaning of MA in Japanese culture)*. Koudan-Shya: Tokyo.

Kiriyama, K. (2004) *Edo-Ucyuu (Japanese: Cosmology in Japanese Edo period)*. Tokyo: Shinjinbutsu Ouraishya.

Kirkham, M. (1999) The culture of midwifery in the national health services in England. *Journal of Advanced Nursing*, 30(30): p. 732-739.

Kitchin, R. (1998) *Cyberspace*. Chichester: John Wiley and Sons.

Kitou, H. (2002) *Bunmei-toshiteno-Edo (Japanese: Analysing Edo era as a cultural system)*.Tokyo: Koudanshya.

Kojima, H. (1989) *Kosodate-no-Dentou-wo-Tazunte (Japanese: Reviewing the history of Japanese child caring)*. Tokyo: Shinyousya.

Krumeich, A., W. Weijts, P. Reddy, A. Meijer-Weitz *(2001)* The benefits of anthropological approaches for health promotion and practice. *Health Education Research*, 16(2): 121-130.

Kvale, S. (1996) *Interviews: an introduction to qualitative research Interview*. London: Sage.

Last, M. (2001) Panel discussion: medical anthropology in the 21st century. In: *5th International Medical Anthropology Conference held at the Brunel University,* Brunel University: London.

Lawler, J. (1997) Knowing the body and embodiment: methodologies, discourse and nursing. In Lawler, J., *The Body in Nursing*, South Meruborne: Churchil Livingstone. p. 31-52.

Leap, N (2000) The less we do, the more we give. In M. Kirkham, Editor. *The Midwife-Mother Relationship*. Macmilan Press: London. p. 1-18.

Leininger, A. M. (1985) Nature, rational and importance of qualitative research Methods in nursing. In: A.M. Leininger, Editor, *Qualitative Research Method in Nursing*. London: W.B. Sunders. p. 1-25.

Lincoln, Y. S. and G. G. Egon (1985) *Naturalistic Inquiry*. London: Sage

Linger, D. (2005) *Anthropology through Double Lenses: public and personal worlds in Human Theory*. Philadelphia: Philadelphia University Press.

Littman, H.(1994) The decision to breastfeed: the importance of father's approval. *Clinical Paediatrics*, April: 214-219.

Lock, M. (1987) Introduction: health and medical care as cultural and social phenomena. In: E. Norbeck and M. Lock, Editors, *Health, Illness, and Medical Care in Japan*, Honolulu: University of Hawaii Press. p. 1-23.

Lock, M. (1988) A nation at risk: interpretations of school refusal in Japan. In: M. Lock and D.R. Gordon, Editors, *Biomedicine Examined*. London: Kluwer Academic Publishers. p. 377-414.

Lock, M. and A.P. Kaufert (1998a) *Pragmatic Women and Body Politics*. Cambridge: Cambridge University press.

Lock, M. (1998b) Anomalous ageing: managing the postmenopausal body. *Body and Society*, 4(1): 35-61.

Lock, M. (1998c) Breast cancer: reading the omens. *Anthropology Today*, 14(4): 7-16.

Lökman, P. (2005) Narrative of self?: researching embodiment through auto-ethnographical methodology. In: *New Scholars Symposium, (Re)creating: Methodologies, Practices, Concepts held at Gold Smith College*, Gold Smith College: University of London.

Maclean, H. (1989) Implication of a health promotion framework for research on breastfeeding. *Health Education* 3(4): 355-360.

Macfarlane, A. (1997) *The Savage Wars of Peace*. Oxford: Blackwell.

Macfarlane, A. (2002a) *Infant feeding in Japan*. Available from: <www. alanmacfarlane.com /savage/infants.pdf>

Macfarlane, A. (2002b) *The carrying of infants in Japan*. Available from: <www. alanmacfarlane. com/savage/A-child.pdf>

Maher, V. (1992) *The Anthropology of Breastfeeding: Natural Law or Social Construct*. Berg: Oxford.

Martin, E. (1987) *The Woman in the Body: a cultural analysis of reproduction*. Boston: Beacon Press.

Masataka, N.(1999) *Ikuji to Nihonjin (Japanese: Child caring in a Japanese context)*. Tokyo: Iwanami Shyoten.

Matsumoto, Y. (1992) The future practice of Japanese midwifery (Japanese). *Journal of Japan Academic Midwifery*, 6(1): 6-11.

Matusmura, T. (1996) The policy of maternal health in the social welfare in Japan (Japanese). *Perinatal Care*, special issues: 52-56.

McCourt, C. and L. Page (1997) *Report on the Evaluation of One-to-One Midwifery*. London: Thames Valley University.

McIntosh, J. (1985) Barriers to breastfeeding: choice of feeding methods in a sample of working primepara. *Midwifery*, 1: 213-224.

Miller, T. (2002) Adapting to motherhood: care in the postnatal period. Community Practitioner, 75(1):16-18.

Miyazaki, K. (1983) The breastfeeding practice and manual for early postnatal period (Japanese). In: H. Kato, Editor, *Bonyuu-Hoiku*. Medica Science: Tokyo,

p. 453-469.

Mothers' and Children's Health and Welfare Association (2004) *Maternal and Child Health Statistic of Japan*. Tokyo: Mothers' and Children's Health Organisation.

Murphy, E. (2000) Risk, responsibility, and rhetoric in infant feeding. *Journal of Contemporary Ethnography,* 29(3): 291-325.

Murphy, E. (1999) Breast is best: Infant feeding decisions and maternal deviance. *Sociology of Health and Illness*, 21(2): 187-208.

Namihira, E. (1996) *Inochi-no-Bunka Jinruigaku (Japanese: Japanese people's view of life and death)*. Tokyo: Shinchyou-Senshyo

Nanbu, H. (1983) Promoting breastfeeding (Japanese). In: H. Kato, Editor, *Bonyuu-Hoiku*. Medica Science: Tokyo. p. 158-169.

Newman, S. (1997) Masculinities, men's body and nursing. In: J. Lawler, Editor, *The Body in Nursing*. Churchil Livingstone: South Melborne. p. 109-134.

Nezu, Y. (1992), A new instruction for breastfeeding (Japanese). *Shyuusanki Igaku,* 22(1): p. 47-51.

Niki, T. (1983) Breastfeeding and the mechanism of baby's suckling (Japanese). In: H. Kato, Editor, *Bonyuu-Hoiku*. Medica Science: Tokyo, p. 201-226.

Nishikawa, S. (1992) *Osan no Chie (Japanese: Wisdom of Japanese childbirth and child caring)*. Tokyo: Koudan-Shya.

Norbeck, E. and M. Lock (1987) *Health, Illness, and Medical Care in Japan.* Honolulu: University of Hawaii Press.

Oakley, A. (1984) *The captured womb: a history of the medical care of pregnant women*. Oxford: Blackwell.

Oakley, A. (2000) *Experiments in Knowing; gender and methods in the social sciences.* Cambridge: Policy Press.

Obermeyer, C. and S. Castrle (1997) Back to nature?: historical and cross-cultural perspectives on barriers to optimal breastfeeding. *Medical Anthropology,* 17: 39-63.

Oketani, S. (1983) Breast massage (Japanese). In: H. Kato, Editor *Bonyuu-Hoiku.* Medica Science: Tokyo, p. 468-489.

Oobayashi, M. (1985) *Jyosanpu-no-Sengo (Japanese: Japanese midwifery after the Second World War).* Tokyo: Keisou-Syobou

Ooide, H. (2000) From Sanba to midwives (Japanese: from modern to post-modern Japanese midwifery). *Jyosanpu-Zattushi,* 54(12): 1019-1024.

Oxby, H. (1994) When do women decide? *Health Visitors,* 67(5): 161.

McCourt, C. (2006 in press) Becoming a parent. In: L. Page, Editor, *The New Midwifery, Second editions.* Oxford: Elsevier.

Page, A. L (1995) *Effective Group Practice in Midwifery: working with women.* Oxford: Blackwell.

Palmer, M.Q. (1993) *The Politics of Breastfeeding,* Second edition. London: Pandra Press.

Patton, M.Q. (1990) *Qualitative Evaluation and Research Method,* Second edition. London: Sage.

Pearse, J. (1990) Breast-feeding practices in Japan. *Midwives Chronicle and Nursing Notes,* (October): 310-315.

Penny-Simkin, P.T. (1992) Just another day in a woman's life? part 2: nature and consistency of women's long-term memories of their first birth experiences. *Birth,* 19(2): 64-81.

Purser, A. (2005) Health and self: exploring embodiment through dance. In: *British Medical Sociology Group; 37th annual Conference held at University of York.* University York: York.

Raphael, D. (1976) *The Tender Gift: Mothering the Mother; the way to successful breastfeeding*. New York: Schocken Books.

Roth, W. H. (1999) Review essay: Harry. F. Wolcott (1999) Ethnography: a way of seeing. *Forum Qualitative: Social Research.* [online]. 4(3). Available from: < www.quaitative-researchnet/fg-texte/3-03/3-03review-roth-e.html>

Ruspini, E. (2002) Longitudinal research in the social sciences. *Social Research Update* [online]. Available from: < www.soc.surry.ac.uk/sru/sru28.html>

Sandelowski, M., D. Davis, and B. Harris (1989) Artful design: writing the proposal for research in the naturalist paradigm. *Research in Nursing and Health*, 12: 77-84.

Sandelowski, M. (1993) *With Child in Mind: studies of the personal encounter with infertility*. Pennsylvania: University of Pennsylvania Press.

Sandelowski, M. (1996) One is the liveliest number: The case orientation of qualitative research. *Research in Nursing and Health,* 19: 525-529.

Sandelowski, M. (1999) Time and qualitative research. *Research in Nursing and Health,* 22: 79-87.

Sasaki, M. and N. Taki (1998) The new direction of breastfeeding: practising rooming-in (Japanese). *Jyosanpu-Zattishi*, 52(10): 64-67.

Sato, T. (2000) Cultural studies in Japan. *International Journal of Cultural Studies,* 3(1): 11-25.

Sawada, K. (1983) An anthropological view of breastfeeding (Japanese). In: H. Kato editor, *Bonyuu-Hoiku.* Medica science:Tokyo. p 34-45.

Seale, C. (2005) Conversation analysis. In: *a qualitative research seminar held at King's college*. University of London: London.

Scheper-Hughes, N. and M. Lock (1987) The mindful body: a prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly*, 1(1): 6-41.

Schmied, V. and L. Barclay (1999) Connection and pleasure, disruption and distress: women's experience of breastfeeding. *Journal of Human Lactation*, 15(4): 325-334

Schön, A. D. (1983) *The Reflective Practitioner*. New York: Basic Book.

Scott, J. and T. Mostyn (2003) Women's experience of breastfeeding in a bottle-feeding culture. *Journal of Human Lactation*, 19(3): 270-277.

Scott, J.A. (1997) The influence of reported paternal attitudes on the decision to breast-feed. *Journal of Paediatric Child Health*, 33: 305-307.

Senoo, T., M. Nanba, E. Kouoto, Y. Matushisge, F. Makabe, T. Kouzu (1995) The management of breast care and protocol for child caring in the baby friendly hospital (Japanese). *Perinatal Care*, 14(11): 1025-1032.

Shilling, C. (1993) *The Body in Social Theory*. London: Sage.

Silverman, J. (2002) What is the textuality? *Phenomenology Online*. [online]. 4(2):56-64. Available from :< www. phenomenologyonline.com/articles/ silverman1.html>.

Slife, D.B. and R. Willams (1995) *What's Behind the Research?: discovering hidden assumption in the behavioural sciences*. London: Sage.

Snow, C. P. (1998) *The Two Cultures*. Cambridge: Cambridge University Press, [originally published in 1959].

Soo, I. (1988) Psychosomatic factors in the choice of infant-feeding: a pilot study. *Journal of Psychosomatic Obstetrics and Gynaecology*, 8(2): 137-145.

Steiner, J. C. (2002) The techinicity Paradigm and scientism in qualitative research. *The Qualitative Report* [online], **7**(2). Available from: <www.nova.edu/ ssss/QR/QR7-2/steiner.html>.

Steslicke, W. E. (1987) The Japanese state of health: a political-economic perspective. In: E. Norbeck and M. Lock editors, *Health, Illness and Medical Care in Japan*. University of Hawaii Press: Honolulu. p. 24-65.

Steavens, T. (2003) *Midwife to MID WIF: A study of caseload midwifery*. PhD thesis, Thames Valley University: London.

Stilwell, N. (2005) Body modification, In New Scholars Symposium, *(Re) creating Methodologies, Practices, Concepts held at Gold Smith College,* University of London: London.

Sueshige, K., A. Nakao, Y. Ito (1998) Promoting rooming-in: in a hospital context of breastfeeding practice (Japanese). *Jyousanpu-Zattishi*, 52(10): 55-58.

Suzuki, S. (1983) Breastfeeding and medical advice (Japanese). In: H. Kato, Editor, *Bonyuu-Hoiku*. Medica Science: Tokyo. p. 501-508

Suzuki, T. (1973) *Kotoba-to-Bunka (Japanese: Japanese language and culture)*. Tokyo: Iwanami Shinsyo.

Takahashi, E. (1996) The social background of breastfeeding (Japanese), *Shyuusanki Igaku,* 26(4): 459-464

Takaishi, M. (1983) Infants' development and breastfeeding (Japanese). In: H. Kato, Editor, *Bonyuu-Hoiku*. Medica Science: Tokyo, p. 140-150.

Takei, T. (1998) Breastfeeding and breast care in the Soka city hospital (Japanese). *Jyosanpu-Zattushi,* 52(10): 38-43.

Takemura, T., K. Okamoto, H. Nagahama, S. Azuma, K. Inoue (1993) The history of Maternal and children's Handbook (Japanese). *Perinatal Care*, 12(1): 62-69.

Tamogami, Y. and N. Osaki,(1996) *The Historical aspects of childbirth: comparison between Europe and Japan (Japanese). Jyosanpu-Zattushi,* 50(12): 1013-1021.

Tayeb, M. (2001) Conducting research across cultures: overcoming drawbacks and obstacles. *International Journal of Cross Cultural Management,* 1(1): 91-108.

Tuneyoshi, R. and S. Boocock (1997) *Ikuji no Kokusai Hikau (Japanese: a comparative study of child caring).* Tokyo: NHK books.

Tsunoyama, S (1984) *Tokei no Shyakaishi (Japanese: The concept of time in a Japanese social context).* Tokyo: Chtyuukou Shinsyo.

Turner, B.S.(1996) *The Body and Society.* London: Sage.

Van Esterik, P. (1989) *Beyond the Breast ~ Bottle Controversy.* New Jersey: Rutgers University Press.

Vincent-Priya, J. (1992) *Birth Traditions and Modern Pregnancy Care.* Shaftsbury: Element.

Wakayama, K., Y. Kamiya, K. Suita, T. Tsukahara, M. Saito, H. Oya, C. Hashimoto, K. Sato, N. Ando (1989) The discussion about the importance of breast care during pregnancy (Japanese). *Bosei- Eisei,* 30(1): 92-96

Watanabe, M. (1976) *Nihonjin-to-Kindaikagaku (Japanese: the history of modern science).* Tokyo: Iwanami shinsyo.

WHO/UNICEF (1990) Protecting, promoting and supporting breastfeeding: the special role of maternity services. *International Journal of Gynaecology and Obstetrics,* 31(1): 171-183.

Williams, J.S. and G. Bendelow (1998) *The Lived Body: sociological themes, embodied issues*. London: Routledge.

Wolcott, H.F. (1994) *Transforming Qualitative Data: description, analysis and Interpretation*. London: Sage.

Wright, G.D. (1998) *Creativity and Embodied Learning*. PhD thesis, University of Western Sydney Nepean: Sydney. Available from on line: <hppt: //library. uws. edu. au>.

Yamamoto, K. (1983) *Bo-nyuu* (Japanese: Breastfeeding). Tokyo: Iwanami-Shinsyo.

Yamshita, S. (2006) *Reshaping anthropology: a view from Japan*. In: G. Riberio and A. Escobar, Editors, *World Anthropologies: disciplinary transformation within system of power*. Berg: Oxford. p. 29-48.

Zhang, G. (2005) Re-making the body/ Re-imaging Martial Arts, In: New Scholars Symposium, *(Re)creating Methodologies, Practices, Concepts held at Gold Smith College*. Gold Smith College: University of London.