Original Article

Women's experiences of infant feeding support in the first 6 weeks post-birth

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Abstract

Research suggests women find the first 2 to 6 weeks to be the most difficult time for breastfeeding. It has been identified that women need and seek support with breastfeeding during this time. Support is a difficult concept to define. When discussed by professionals, support for breastfeeding is generally viewed in terms of providing information and educational interventions. There is little understanding of the different elements of breastfeeding support strategies and the mechanisms by which support operates. Further, there is a paucity of qualitative research specifically reporting women's experiences and expectations of professional support. This paper describes women's expectations and experiences of 'infant feeding support' provided by health professionals in the first 6 weeks post-birth. The findings are drawn from a grounded theory study exploring women's infant feeding decisions in the first 6 weeks post-birth. Participants were recruited from a variety of socio-demographic areas of Sydney and the NSW Central Coast, Australia in 2003–2004. The women in this study discussed aspects of what they considered helpful and/or unhelpful in terms of professional support. In addition, they also provided insight into aspects of interactions that were deemed important to them as new mothers learning to feed their babies. The results are presented in three sections: expecting support, experiencing support and evaluating support. The findings help to better understand components of professional practices and behaviours that can be considered supportive. The support behaviours are far more complex than simply increasing education and knowledge of infant feeding. They demonstrate the need for sensitive individualized care and show that this type of support can increase women's confidence to breastfeed.

Keywords: breastfeeding support, consumer perspectives, health professional, infant feeding, practice, qualitative methods.

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Introduction

Women's need for support with infant feeding varies at different stages in the months following birth, however, research suggests women find the first 2 to 6 weeks to be the most difficult time for breastfeeding (Hailes & Wellard 2000; Dewey *et al.* 2003; Kelleher 2006). Women expect that they will seek and/or receive professional support for breastfeeding during this time (Tarkka *et al.* 1998; Bernaix 2000; Shakespeare *et al.* 2004; Sheehan 2006), viewing this period as a time of learning (Hailes & Wellard 2000) and health professionals as authorities on breastfeeding (Coreil *et al.* 1995).

This paper describes women's perceptions and expectations of professional support for infant feeding in the first 6 weeks post-birth. The findings are drawn from a larger grounded theory study that explored women's infant feeding experiences and decisions in the first 6 weeks post-birth.

Background

Breastfeeding rates in Australia indicate that while 87% of women will initiate breastfeeding, these rates decline significantly over the early post-partum weeks. It has been estimated that 5%–8% of women will cease breastfeeding prior to discharge from hospital care (Fetherston 1995; Scott *et al.* 2001a), with another 9%–10% discontinuing in the first 2 weeks (Scott *et al.* 2001b; Cooke *et al.* 2003) and a further 10%–11% ceasing breastfeeding by 6 weeks post-birth (Scott *et al.* 2001b; Cooke *et al.* 2003). These figures indicate that approximately 25% of Australian women who initiate breastfeeding will have ceased within the first 6 weeks. What makes this even more significant is that this early post-natal period is the time when women have the most interaction with health care professionals.

Assistance for breastfeeding has been identified as the most common post-natal care need for women (Cooke & Stacey 2003). Midwives also view breastfeeding education as a significant component of their role (Henderson *et al.* 2000). Encapsulating this need, Dykes (2006, p. 44) states that 'breastfeeding women are carrying out a partially learned activity which

in the absence of exposure during the socialisation process, combined with low levels of knowledge and support within a given community, requires support from health professionals'. Notwithstanding the apparent shared understanding between midwives and mothers of the need for professional support, it has also been found that health professionals are often unable to provide the support women need and/or want (Coreil *et al.* 1995; Hoddinott & Pill 2000; Stein *et al.* 2000; Cooke & Stacey 2003). This is despite health professionals receiving increased breastfeeding education and the emergence of lactation consultants, particularly in Australia and the United States (IBLCE 2007).

Women describe breastfeeding support from health professionals in terms of having either a positive and/or negative impact on their experiences (Hailes & Wellard 2000; Hoddinott & Pill 2000; Mozingo *et al.* 2000; Shakespeare *et al.* 2004; Sheehan 2006). For example, women in Shakespeare *et al.*'s (2004) study considered professionals were supportive when they 'had time to listen, were non-judgemental and encouraging' (p. 256). Alternatively, professionals considered less supportive were 'bossy, judgemental, gave conflicting advice and were inaccessible' (p. 256).

While the importance of support to the success of breastfeeding has been clearly identified (Hendricks 1998; Hailes & Wellard 2000; Cooke & Stacey 2003; Cronin 2003; Dykes *et al.* 2003; Sheehan 2006), defining support is problematic. The term 'support' is often used generically to encompass caring along with other desirable aspects of encounters and relationships. Dykes (2006) refers to the range of interchangeable and overlapping terms that have been used by authors to describe 'encounters' with health care providers. These include sensitive/insensitive, caring/uncaring, consistent/inconsistent and encouraging/discouraging to name a few.

Williams (2005), in her study of social support for new mothers, raised questions regarding the clarity of definitions around the concept of 'social support'. Her work indicates 'social support in the context of new parenthood is not a discrete concept, rather it is an integrated aspect of social interaction characterised by positive assessments of interaction. Because it is integrated and because assessments of interaction are

idiosyncratic, social support is not easily quantified' (Williams 2005, p. 211). It is likely that women experience support from professionals for infant feeding decisions within this broader and more complex context of support of new parenthood.

The most recent Cochrane Collaboration to assess the effectiveness of support for increasing breastfeeding initiation and duration, reviewed randomized or quasi-randomized controlled trials comparing extra support for breastfeeding mothers with usual maternity care. While all forms of extra support increased breastfeeding duration, what remained and remains unknown are what elements of support are effective or ineffective in increasing breastfeeding initiation and duration (Britton *et al.* 2007).

There is a paucity of research into women's experiences of professional support for infant feeding. Recommendations arising from the Cochrane review suggest the need for research that 'probes the components of support interventions that are effective or ineffective' and explores maternal levels of satisfaction with support (Britton *et al.* 2007, p. 9). This paper adds to the understandings of maternal perceptions of support by describing women's expectations, perceptions and experiences of professional 'support' for infant feeding provided in the first 6 weeks post-birth.

Methods

This study used a constructionist approach to grounded theory methodology to collect and analyse data. This approach was chosen because of its emphasis on the interpretive understandings of the participants (Charmaz 2000). A constructionist approach to grounded theory draws heavily on symbolic interactionism, a key theoretical perspective underpinning grounded theory. Symbolic interaction can be described simplistically as 'the study of how the self and the social environment shape each other through communication' (Lindlof & Taylor 2002, p. 41). Constructionism claims that meanings are constructed by human beings as they engage with the world they are interpreting (Crotty 1998). In a constructionist grounded theory, there is particular emphasis on the emergent constructivist elements. This calls for grounded theory strategies to be applied in a less rigid

manner than other more positivist approaches with a focus on meaning that enhances interpretive understandings (Charmaz 2000). In contrast to a positivist approach, a constructionist theory does not claim a 'true' or 'valid' understanding but rather useful interpretations (Crotty 1998). Charmaz's constructionist approach 'explicitly provides an interpretive portrayal of the studied world, not an exact picture of it' (Charmaz 2002, p. 678).

Data collection and analysis

Grounded theory specifies analytic strategies rather than data collection methods, for example, data collection and analysis occur concurrently (Charmaz 2000). Data for this study were obtained from a study of women's experiences of infant feeding decisions in the first 6 weeks after birth (Sheehan 2006). In-depth interviews with 37 women who had infants aged between 1 and 9 weeks (mean 5.8 weeks) provided the data for this study. Women were recruited primarily through Early Childhood Health Centres and snowball sampling. The women came from a variety of socio-demographic areas in Sydney NSW, Australia's largest city, as well as a regional city on the NSW Central Coast. Participants were theoretically sampled in accordance with the principles of grounded theory. The types of infant feeding experiences or participant characteristics specifically needed were explicated, either directly to the women or to the child and family health nurses who would then identify women who fitted these criteria. Further theoretical sampling of data from an earlier study conducted in 2000 on women's infant feeding experiences was also used with ethical approval (Cooke *et al.* 2003, 2007; Sheehan *et al.* 2003). Interviews for both studies were conducted by the first author who had no previous relationship with the interviewees, at a place nominated by the participant. Typically, interviews took place at the participant's home and lasted approximately 1 h. Interview data were transcribed verbatim and coded and categorized using the constant comparative method, which forms the basis of grounded theory. The constant comparative method is based on the systematic generation of conceptual categories derived from within the data. These categories

are compared against each other for similarities and differences in order to generate properties and dimensions of categories that will eventually form a theory around the problem being explored (Strauss & Corbin 1998). Trustworthiness was ensured by asking questions to the women that aimed at understanding their definition of terms and situations and how these made them feel and respond. Open-ended questions were used such as ‘tell me about . . . , how did that make you feel? What did you mean when you said . . . ?’ This style of questioning is an application of the constructionist approach to grounded theory and according to Charmaz (2002), builds on the symbolic interactionist theoretical perspective. Interpretation of the data was also discussed with the co-authors and fellow doctoral students.

Participants

At the time of the interview, 14 women were fully breastfeeding and 16 women were fully bottle-feeding. Of the 16 women fully bottle-feeding, 12 had initiated breastfeeding but subsequently ceased. Three women were expressing and feeding their babies fully on expressed breast milk (EBM), three women were expressing and giving both EBM and supplementary formula and one woman was breast-feeding, expressing and giving EBM and also supplementing her baby with formula. See Table 1 for participant demographics.

Ethical approval was granted for the research by the relevant Area Health Services as well as the Human Research Ethics Committee of the University of Technology, Sydney. Women were provided with an information sheet during a routine visit to the Early Childhood Health Centre or through friends who had heard about the study. The information provided described the purpose of the study as exploring women’s infant feeding experiences and decisions and the voluntariness of participation. The women then contacted the researcher if they were interested in participating. Women who consented to participate were asked to sign a consent form prior to the interviews being undertaken. All women spoke fluent English. It was necessary to restrict this study to English speaking participants because data involved

Table 1. Participant demographics

Socio-demographics	Number
Parity	
Primiparas	23
Multiparas	14
Age (years)	
Range	20–47
Mean	30
Partner status	
Partnered	35
Separated	2
Level of education	
University degree	16
Diploma	3
Secondary school year 12	7
Secondary school < year 12	11
Health insurance	
Private health insurance	12
Public health cover (Medicare)	25
Maternity care provider	
Private hospital	11
Public hospital	26

language. In the following results, code numbers have been used to present the participants comments and maintain confidentiality.

Results

The results of the larger constructionist grounded theory described the context within which women begin breastfeeding and identified a number of factors that influenced the women’s infant feeding decisions in the first 6 weeks post-birth. These factors formed four categories: ‘it’s really best to breastfeed’, ‘it’s the unknown’, ‘it’s not the only thing going on’ and ‘everybody’s best is different’. Within and between each of these categories’ interconnections, interactions and consequences were demonstrated. These categories were connected through the basic social process ‘deconstructing best’ which was also the core category within the analysis (Sheehan 2006). Within these categories, a number of issues were raised regarding support for infant feeding. The results of the paper reported here are drawn particularly from two categories: ‘it is the unknown’ and ‘everybody’s best is different’. The findings discussed here have been extrapolated from these categories and are presented

under three headings: expecting support, experiencing support and evaluating support.

Expecting support

In the early weeks post-birth, many women described feeling overwhelmed. The majority of women found breastfeeding more difficult than they had expected. They considered breastfeeding to be unpredictable and unknown and talked about their lack of confidence and questioned their ability to breastfeed. It was not surprising therefore that the women talked about the need for and importance of support; making comments such as 'support is very important' (p. 2) and 'when you have someone who sits with you and persists with you, which I had at the hospital the first time and that nurse (midwife) was there my whole stay, it makes it easier' (p. 11).

While the women discussed lay support, there was a strong emphasis placed on the expectation that the health professionals would or should support them as they learned to breastfeed; 'you just expect that they [the midwives] will, you just expect that they will come in and they will show you how to do it' (p. 14). It was not just first-time mothers who expected they would need help. Women having subsequent babies also talked about needing and wanting professional support saying: 'Even if you have had experience with it before you're trying to do it better this time and so you do listen to what they say' (p. 4).

The women talked about their antenatal preparation for breastfeeding. While they considered this information useful when they actually got to breastfeed, it added a whole new dimension to breastfeeding because this experience was new, often unexpected and necessitated further guidance.

You sort of can take it all in at antenatal classes but it when you have to lay it down practically that you just sort of need guidance and someone just to say to you, you're not doing it right (p. 15).

Participants talked about needing practical support in the post-birth period, identifying that information received about breastfeeding prior to birth did not prepare them totally for the actual experience, saying: 'you read stuff but you don't know how to actually do

it' (p. 35) and 'I'm a very practical person, I like to do things' (p. 11).

Consequently, women recognized and acknowledged that this was a period of learning: 'I'd always thought this is going to be a big learning process for at least six weeks' (p. 1).

Experiencing 'support'

A number of women in this study talked about their interactions with health professionals and these were divided into two categories: 'positive support' and 'poor support'. From the women's perspective, what appeared to be most important was that the support they received increased their confidence: 'I think it's not just about showing women how to do it but boosting them up as well, umm, I think that's really important. . . . they need that emotional sort of support that confidence building' (p. 2). In this study, it appeared that 'positive' professional support could ameliorate some of the difficulties experienced by the women by increasing their confidence, 'she sort of gave me the confidence to keep going' (p. 13).

In contrast, poor professional support appeared to contribute to decreasing the women's confidence to breastfeed: 'I had one (midwife) that made me feel really uncomfortable and felt that I couldn't do it . . . my confidence was gone so I thought I can't do it' (p. 16) and 'I was losing confidence in myself when she was saying all of this' (p. 32). Decreasing confidence because of lack of support could then have a negative impact on breastfeeding rates. This was illustrated in the comments made by a number of women who ceased to breastfeed early. When discussing reasons for ceasing to breastfeed, these women talked about not receiving satisfactory professional support, saying: 'I didn't get the support I needed basically' (p. 29) and 'I did really want to breastfeed but it just wasn't working and they didn't explain it enough to me and they didn't spend enough time helping me, showing me' (p. 22).

The following gives examples described by the women of interactions with health professionals. These have been categorized into positive support and poor support. The categories positive support and poor support are explicated by their properties. In the

following discussion, each of the properties has been italicized.

Positive support

Analysis of the data in the category 'it's the unknown' revealed three properties of positive support. The women gave examples of what they perceived as positive support and these included *being available*, 'I mean the midwives were all fantastic, you know, they were great and I knew I could buzz them' (p. 3); *staying with you*, 'it was a special breastfeeding midwife that was in the hospital that came in and she actually sat there' (p. 7); and 'it was having a midwife there . . . I think this is probably how we made it happen' (p. 13). *Practical support*, 'the sister down at the early childhood centre . . . showed me the best position to hold her in is and the midwives in hospital were great' (p. 31).

Poor support

Alternatively, analysis of the data in the category 'it's unknown' also revealed five properties of inadequate support. These included '*lack of help*' (p. 19), illustrated by statements such as 'Sometimes you get the help and sometimes you don't' (p. 11) and 'even if you wanted help it wasn't there sort of thing' (p. 19); '*you're left to your own devices*' (p. 15), illustrated by 'someone tells you something and then they walk out the door, here's your baby. That's what happened to me the first time too' (p. 11); '*they were rude*' (p. 22), which included statements such as 'she was quite abrupt on the phone so that put me back a few steps as well because she was rude' (p. 32) and 'she said oh suit yourself and walked out . . . I just think her saying well suit yourself and walking out was off . . . well she left me there not knowing what to do' (p. 10).

Sometimes what some of the professionals believed to be supportive was considered inappropriate and deemed unsupportive by the women. This included behaviours such as being *directive*, 'oh no, you've got to do this and you've got to do that' (p. 16) and 'they had all different opinions as if they knew better than the other midwife' (p. 19). Directive support contributed to the women's feelings of uncertainty because it

confused them and made the women question 'what am I doing right? What am I doing wrong?' (p. 32) and 'I don't know who to listen to, what to listen to, who's right, who's wrong' (p. 34). Directive support as described by the women in this study appears similar to what others have described as 'conflicting advice' and may explain why advice given in a directive way can be seen as conflicting rather than an alternative option. Finally, some of the women described professional input that was *inflexible* in that the women felt they could not make the feeding decisions they considered were appropriate or best for their baby because any decision apart from breastfeeding was devalued and not tolerated:

the decisions I want made for my baby are being taken away from me. And then not being able to perhaps voice your opinion where you normally would say to people this isn't working why are we doing this if this is not working? Why are we keeping on going? (p. 15)

Evaluating support

The women reflected on their experiences and expectations of interactions with health professionals. They offered strategies they considered were most useful and provided the type of care they most desired. These suggestions included acknowledgement and approval, honesty and being non-judgemental.

Acknowledgement and approval

One important outcome for the women was that they wanted their own experiences acknowledged and approved. This arose because in reflecting on their experiences, the uniqueness of every woman's infant feeding experience became clear and women felt 'everybody's best was different'. This was regardless of whether they were breastfeeding or bottle-feeding. The women made statements such as 'you just want people, you just want people's support and you just want and you don't want people to say well, that's not the best option, you know' (p. 23). Women talked about needing reassurance: 'it's reassurance that it's okay to do that . . . I suppose that I'm doing the right thing for him' (p. 11) and approval: 'I wanted their approval' (p. 23).

It was not just women who had chosen to bottle-feed who talked about needing acknowledgement and/or approval. Particularly when breastfeeding was difficult and painful, it was important for the women that their experience was validated: 'I was really happy with that information that I got because it was more in keeping with how I intuitively felt' (p. 13) and 'I needed to hear that because it reassured me in what I was thinking' (p. 15).

As evidenced in the above quotes, acknowledgement and approval were correlated with positive support. Acknowledgement or approval were either implicitly or explicitly present in most of the examples of what the women considered positive support: 'That's fine, you know, no worries, went and got me the bottle, nobody looked down at me, nobody had a problem with it so it was much better' (p. 26).

Conversely, lack of acknowledgement was also implicit or explicit in descriptions of poor support. Women who were unhappy with the support they received often described support that lacked acknowledgement. In this first example of lack of acknowledgement, the professional caring for the woman did not acknowledge her question:

she didn't answer my question so I thought, well, maybe this instantly was wrong to even be expressing into a bottle and then, you know, it's again 'what am I doing right, what am I doing wrong, you know, am I doing the wrong thing?' (p. 32)

In the second example, lack of acknowledgement occurred because the health professional remained oblivious to the baby's distress and the mother's concern and instead continued persevering with trying to attach the baby to the breast:

the most stressful part was the nursing staff actually physically pushing him on and pushing against his head as he was pushing away and he was screeching. That was the pits (p. 15).

Finally, one of the women talked about the shock of not receiving any positive verbal acknowledgement from one professional she interacted with when she said 'there was no positive at all that came out of this woman's mouth, which absolutely appalled me' (p. 1).

Professional support that acknowledged and approved what the woman was going through

appeared to increase the woman's confidence, 'I just felt a lot more comfortable being able to do it at my own pace and being able to not have someone criticize me for not doing it right' (p. 22) and 'it was her confidence that we'd be able to do it that I really needed at that time' (p. 13).

Alternatively, lack of acknowledgement of what the woman was experiencing or feeling, left the women feeling vulnerable and uncertain. Lack of acknowledgement was perceived as unsupportive and, as previously identified, this decreased the women's confidence:

It's the feeling of being hopeless and helpless, umm, and it shouldn't be like that. You should feel powerful enough to be able to say well, this is what I'm going to do. and you shouldn't be made to feel guilty for the decisions that you're making (p. 15).

There needs to be honesty

The majority of women recognized that infant feeding was very individual and that feeding a baby was different for everyone, making statements such as 'I think it's very individual' (p. 10), 'I knew that it was so different for so many women' (p. 1) and 'everyone is different' (p. 18). In contrast to this individuality, many believed breastfeeding was presented by professionals as being the same or parallel for all women that 'it is easy', 'doable' and problems are 'fixable'. Breastfeeding experiences however, were individual. For some women, breastfeeding was relatively straightforward, while for others it was painful and difficult, even traumatic. For many women in this study, feeding a baby was not what they had expected it to be because, as they described it, 'they' do not really tell you about the difficulties; 'people don't sort of talk about problems' (p. 11) and 'nobody told me any horror stories about breastfeeding. I guess people don't really want to tell you too many bad stories' (p. 27).

Women talked about the effect of not having breastfeeding presented in a realistic and honest way was that they felt it was their fault when things went wrong. They made statements such as: 'like I think oh I know, she can just do it and there's no problems, you know, what's wrong with me?' (p. 6) and 'why can't I

do this if they're telling me to do this why can't I do this?' (p. 15). This trust in the information that everybody can breastfeed led some of the women to believe if they were having difficulties then it had to be their fault: 'when it says it does not hurt it's black and white and it makes you think, well, okay, what's wrong with me or what's wrong with my baby?' (p. 1). Other women talked about blaming themselves when things were not working out, feeling there must be something that they were doing wrong: 'I think you naturally just, you know, blame yourself' (p. 6) and 'I was kind of blaming myself' (p. 28). When breastfeeding was not working, some of the women talked about feeling like a failure, saying: 'I've got so many friends that breastfeed and it's so easy and sometimes you just feel like this big failure' (p. 6). These feelings of failure made the women feel vulnerable and emotional, decreasing their confidence further: 'I started getting really emotional by this stage' (p. 6) and 'when you can't do it there's a feeling of helplessness' (p. 15).

The women therefore argued, that the reality and variety of breastfeeding experiences should be better explicated: 'I think there needs to be, even if it's not documented, that even through the hospitals and things like that, that it's not the easiest thing, breastfeeding' (p. 6) and 'they also need to say occasionally, not all the time but very, very occasionally, there are some ladies and some women that just can't do it and that's never ever said ever' (p. 14). Given the diversity of women's experiences, there was a belief that there was a need for honesty in discussing breastfeeding: 'I think there needs to be honesty about, well, this may be some women's reality' (p. 1). This included being honest about the reality of pain:

there's nothing ever that I've read anywhere to say that it's still going to hurt even a small amount, or even if it says that some women, they may still experience some sort of pain. Even if they just say slight pain, it at least gives you an indication that okay, that's very subjective so women can think okay, my slight pain might be a bit more or less but at least it's like well there could be some (p. 1).

Being honest that breastfeeding is not always doable or fixable, 'I've just realised that it doesn't matter how determined you are for things to go the way you want them to go, you know, but it doesn't

happen like' (p. 25) and breastfeeding is not always natural: 'I'm almost of the opinion that I, it's not necessarily as natural as it's made out to be, it's actually quite hard work or can be' (p. 10).

This led some women to talk about the benefits to them of having breastfeeding presented in a way that included an honest discussion of the realities of the experience, saying: 'I can see that if someone was struggling, a horror story can be so comforting to know that I'm not the only one suffering' (p. 21).

Do not judge

Consequently, a number of women reflected upon how women were often judged if they chose to bottle-feed, 'people sort of look down on you if you bottle-feed . . . that you're not as good of a mother or you are a bit lazy or, you know, didn't want to put in the effort' (p. 9).

Given that everybody's experience was considered to be individual and that breastfeeding may or may not be easy, some of the women talked about how it was impossible to understand what another woman was going through:

nobody knows what an individual personal experience is of anything. You know you can't get inside someone and know their feelings and their thoughts around a situation, and unless you can you've got no right to judge (p. 12).

Some of the women who were bottle-feeding also highlighted how they themselves 'had enough guilt' without others adding to this, saying: 'I was torturing myself enough, I did not need that from anybody else' (p. 8), and

it was like, oh my God, you feel like a failure anyway because you are not breastfeeding, and then to have the pressure from, not only the midwives from the clinic and that, but your friends . . . (p. 26).

These women ultimately argued, 'I think any form of judgement on anybody in any kind of life or circumstance is unfair' (p. 12).

The results presented above demonstrate that while women will seek and expect professional support for breastfeeding, this is not always available or appropriate to their needs. Further to this, the find-

ings illustrate what the women found both helpful and unhelpful in terms of health professional support for infant feeding in the first 6 weeks post-birth.

Discussion

The purpose of this paper was to discuss women's expectations and experiences of professional support in the first 6 weeks post-birth. One of the limitations of this research is that it describes a specific group of 37 Australian women's experiences and therefore cannot be extrapolated to the larger population of breastfeeding women. It does however, confer with and add knowledge to work around women's experiences of professional support for breastfeeding derived from qualitative studies.

The findings demonstrate that while women will seek and expect professional support for breastfeeding, this is not always available or appropriate to their needs. Further to this, the findings illustrate what the women found both helpful and unhelpful in terms of health professional support for infant feeding in the first 6 weeks post-birth. Some of these behaviours were overt in the women's comments while others such as emotional support were more subtle and represented in comments such as needing to be 'boosted up' as one woman described it.

Inverting the negative behaviours and adding these to the positive behaviours provides a powerful list of behaviours that can be seen as positive support for women in the early post-birth period. These include emotional support, acknowledgement, approval, being available, providing practical support, staying with you, being sensitive and being flexible. What is important about this list of behaviours is that they are far more diverse than simply increasing women's knowledge about the benefits of breastfeeding and/or even knowledge about breastfeeding difficulties, which are repeatedly suggested as ways of increasing breastfeeding rates. Findings also strongly suggest that positive professional support can increase women's confidence. Alternatively, poor support was shown to decrease a woman's confidence to breastfeed and arguably also to mother. These are important findings, given that confidence has been associated with breastfeeding success (Dennis & Faux

1999; Papinczak & Turner 2000; Ertem *et al.* 2001; Blyth *et al.* 2002, 2004). Confidence, it would seem, is a modifiable factor.

In a study by Dykes *et al.* (2003, p. 394), the authors found the support needs of breastfeeding women 'were striking in their alignment' to Sarafino's (1998) five-category schema for social support. Sarafino's (1998) schema includes emotional support: the expression of empathy, caring and concern toward the person; esteem support: positive regard for the person, encouragement and agreement with the individual's ideas or feelings; instrumental support: direct assistance of a practical nature; informational support: giving advice, directions, suggestions or feedback about how the person is doing; and network support: provides a feeling of membership in a group of people who share interests and social activities.

While Dykes *et al.* (2003, p. 398) found their analysis of the support needs of women corresponded with Sarafino's (1998) schema, they further identified the complexity of providing breastfeeding support when they said 'no single aspect of support was acceptable in isolation' and the significance of esteem support to the overall concept of support was found to be 'absolutely crucial to the acceptability of other forms of support'.

Similar to Dykes *et al.*'s (2003) findings, this research highlights the significance of providing emotional and esteem support to women learning to breastfeed. Providing this type of support increased women's confidence to breastfeed even when the women were experiencing difficulties. Alternatively, an absence of appropriate support was shown to decrease a woman's confidence to breastfeed and arguably also to mother.

Williams (2005, p. 113), in her study of social support, helps explain this further by saying that while women often 'craved information . . . it was important this information was delivered in a way that increased their knowledge, while at the same time preserving their confidence and growing sense of themselves as competent mothers'. For breastfeeding women in Hoddinott and Pill's (2000) study, their confidence was increased if their own decision making was facilitated. For some of the women in her study, 'if advice was presented as foolproof recipe for success and

then despite perseverance it didn't work, women experienced a sense of failure which was isolating' (Hoddinott & Pill 2000, p. 232).

The importance of communication in building women's confidence to mother was highlighted in Fenwick *et al.*'s (1999) study on mothering in special care nurseries. These researchers found that the verbal exchanges that take place between nurse and mother influence the woman's confidence, her sense of control and her feelings of connection between her and her baby. In order to be effective in providing good outcomes, nurses needed to engage in language that expressed care, support and interest in parents. Importantly, it is not just what is said; women are also sensitive to how it is said (Fenwick *et al.* 2001). Further, Fenwick *et al.*'s (2001, p. 587) study, found that 'the nurses' ability to engage the mother and establish a supportive relationship was largely dependent on the use of language'.

Consistently, it has been shown that emotional support, feeling cared for, listened to and being treated with empathy are important to childbearing women (Stamp & Crowther 1994; Tarkka & Paunonen 1996; Grindley *et al.* 2000; Fenwick *et al.* 2001; Cooke & Stacey 2003; Dykes *et al.* 2003; Shakespeare *et al.* 2004; Williams 2005). As Smale describes it, it is the quality of the psychological environment that is most important to women learning to breastfeed (Smale 2000).

Although midwives themselves have identified a number of important communication skills required to support women to breastfeed, such as listening, comprehension, consistency and good non-verbal communication (Stein *et al.* 2000), it has been identified that health care professionals are often unable to provide the support women need (Coreil *et al.* 1995; Hoddinott & Pill 2000; Stein *et al.* 2000; Cooke & Stacey 2003). It has been found that midwives underestimate women's need for control and confidence in adjusting to the maternal role, with women particularly highlighting the importance of confidence building in relation to baby care (Proctor 1998).

Women have identified time and again the need for and value of individualized care that is based on their particular needs and circumstances (Tarkka & Paunonen 1996; Hauck *et al.* 2002; Dykes *et al.* 2003;

Fredrikson *et al.* 2003). It has also been found, however, that this type of individual care is the type of care least likely to be provided to women (Tarkka & Paunonen 1996). It can be argued that this type of support is least likely to be given to women because the factors deemed important to the women themselves have largely gone unnoticed by professionals.

Currently, policies and practices appear to be entrenched in the concept that 'breast is best' and focus on the needs of the infant and less so on the needs of the women. It has been claimed that the reluctance to acknowledge the range of difficulties that can accompany breastfeeding is because to do so would put breastfeeding into 'a negative light and feeding into ideas that have been used to promote infant formula as the better option' (Wall 2001, p. 599). It can be argued however, we need to rethink these infant-centric assumptions if we are to truly support women to breastfeed.

In addition, it is suggested that current policies and practices are often applied rigidly (Stein *et al.* 2000; Schmied *et al.* 2001). The implementation of the Ten steps to successful breastfeeding in a rigid and non-individualized manner is an example of this. As Chalmers (2004) points out, the Baby-Friendly Hospital Initiative does not encompass the need for sensitive care nor the need for addressing the emotional needs of women. This as well as other research (Dykes 2006), would suggest these are critical elements in supporting women to continue breastfeeding.

Both women and midwives acknowledge that midwives are rushed and busy (Henderson *et al.* 2000; Hauck *et al.* 2002; Brown *et al.* 2005). Given these time constraints, it is not surprising that midwives have been found to 'focus on the "rules" and the 'stuff I'll get the rap for' rather than on women's needs (Kirkham *et al.* 2002). In such a climate, 'truly individualised care, while central to the rhetoric, can be seen as deviance' (Kirkham *et al.* 2002, p. 449). It has however, also been claimed, that a standardized approach to care based on policies is likely to dominate because of the time constraints of midwives (Hauck *et al.* 2002) as well as the objectives of clinical governance and the need to measure performance (Bilson & White 2004). Recently, it has been identified that in Australia, workloads and ways of measuring

workloads for nurses (read midwives) is seriously problematic (Duffield *et al.* 2006). The implication here is that proper assessment of the time needed to deliver appropriate support to women, needs to be undertaken and the workloads of midwives may need to be adjusted accordingly.

Implications for practice

The findings of this research strengthen the suggestion by Britton *et al.* (2007) that professional support for breastfeeding can be effective for increasing breastfeeding rates during this early period. This study has demonstrated that one of the most important mechanisms by which support operates is confidence building. Importantly, this analysis has also identified support behaviours that appear to increase women's confidence in relation to feeding. Given that maternal confidence to breastfeed has been shown to be significantly related to breastfeeding duration and level (Papinczak & Turner 2000; Ertem *et al.* 2001; Blyth *et al.* 2002) and that recommendations have been made to find strategies and or interventions to enhance maternal confidence (Blyth *et al.* 2002), these findings are important. Importantly, this research along with other research (Hoddinott & Pill 1999; Mzingo *et al.* 2000) indicates that inadequate or inappropriate professional support, rather than being neutral, can have a negative effect on breastfeeding rates, contributing to the early cessation of breastfeeding.

Conclusion

During this often unexpectedly challenging period of feeding a new infant, women expressed feelings of uncertainty and a lack of confidence about their ability to breastfeed. What this research demonstrated was in these early weeks, women experienced professional support, and particularly midwifery support, as either having a negative or positive impact on their confidence to breastfeed. Positive support was complex, but comprised a number of behaviours that women have identified in other studies around childbirth. Professionals that provided positive support, as identified in this study, were shown to increase confidence levels

while poor support increased the women's uncertainty, decreased their confidence and contributed to cessation of breastfeeding.

Conflicts of interest

None declared.

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